

# WEST GLOUCESTERSHIRE PRIMARY CARE TRUST MAJOR INCIDENT PLAN

Compiled by the  
West Gloucestershire PCT  
Emergency Planning Lead



## **WARNING**

IF AN INCIDENT HAS OCCURRED DO NOT READ THIS PLAN

**GO STRAIGHT TO RELEVANT 'ACTION CARDS' &  
CARRYOUT PROCEDURES**

## FOREWORD

This Major Incident Plan outlines the operational arrangements to be undertaken by West Gloucestershire Primary Care Trust (WGPCT) and Community Hospitals at the time of a critical/major incident or civil emergency. It has been prepared in the light of advice from the Department of Health (DH), NHS guidance and consultation with many other agencies. This plan must be read in conjunction with the Gloucestershire Health Community Joint Critical and Major Incident Manual (HMIM) and has formal links with Cotswold & Vale (C&V), Cheltenham & Tewkesbury (C&T) PCTs, NHS Trusts and external agency plans, especially the Major Incident Co-ordinating Group (MICG) Joint Procedures Manual. The Director of Operations is the Lead Director for NHS Emergency Planning and is supported by the Assistant to the Director of Operations (ADO) and the Emergency Planning Manager (EPM) at C&T PCT.

This plan has been written in close liaison with the Gloucestershire Emergency Services, Local Authority Emergency Management Service, the Health Community and other relevant agencies. This process ensures integrated approach to emergency management and escalation procedures have been agreed with the Strategic Health Authority. The Director of Service Provision and the EPM sit on the Gloucestershire MICG and appropriate Health staff are members of relevant MICG Sub Groups.

The arrangements described in this tactical plan reflect the procedures detailed in the strategic HMIM and will be supported by Incident Operational Guides, issued to key appointments and staff, containing 'Action Cards' and, if required, an Emergency Telephone Directory to enable them to quickly implement procedures. Alerting procedures will be robust and regularly tested.

Incidents can be wide and varied, which makes it very difficult to plan for every eventuality. This will require staff to display flexibility, professionalism and initiative. What must always be borne in mind is that an individual's response to an incident may have an adverse effect on the incident as a whole. Staff, when acting on their own initiative, must consider the consequences of their actions with regard to planned procedures and to those responsible for managing the incident.

All relevant WGPCT staff must familiarise themselves with the contents of this plan, not only as preparation for their response to an incident, but to feed back useful information and suggested improvements to the ADO.

The ADO will train staff to fulfil their responsibilities and conduct appropriate exercises to test preparedness. Structured debriefings will follow all exercises and real incidents to identify improvements in the planning procedures. By agreement, funding will be made available for training and exercising.

As the Chief Executive, I acknowledge that final responsibility for emergency planning rests with my appointment. However, it is incumbent on all personnel to monitor their individual areas of responsibility and submit any suggested changes to procedures to the ADO.

I am satisfied that this plan ensures that this PCT has effective arrangements in place to respond to a critical or major incident. The ADO will conduct an annual, or earlier if required, review of this plan and the Incident Operational Guides.

Name: Stephen Golledge

Signature: \_\_\_\_\_

**Chief Executive  
West Gloucestershire PCT**

Date: \_\_\_\_\_

## VERSION CONTROL

The West Gloucestershire PCT Major Incident Plan was first circulated in 2002, which has been reviewed, re-written and circulated as this second edition.

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### Document Management

The ADO is responsible for conducting an annual, or earlier if required, review of this Major Incident Plan. All stakeholders were consulted during compilation and, where appropriate, will be included during annual reviews. Evidence of consultation will be retained by the ADO.

### Issuing Authority

A controlled numbered copy will be issued to selected appointments and also distributed in Acrobat Portable Document Format (PDF) format. PDF will allow the user to quickly access required sections/ paragraphs and enable operational staff to carry the plan on their laptops. Permission is granted to copy/print the PDF. See 'Distribution' at Section 9, however, additional PDFs will be issued as required.

### Commissioning

The arrangements for writing this manual were agreed between relevant Health Emergency Planning Leads and written after consultation with all stakeholders and agencies involved. The ADO is responsible for ensuring that the document has formal links and complies with the following County emergency plans:

Major Incident Co-ordinating Group (MICG) County Joint Major Incident Procedures Manual  
Gloucestershire Health Community Joint Critical & Major Incident Manual  
Gloucestershire Ambulance Trust Major Incident Plan  
PCT Major Incident Plans  
Hospitals Trust Major Incident Plan  
Partnership Trust Major Incident Plan

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## GLOSSARY OF ABBREVIATIONS

The following is a list of abbreviations used in this document:

ADO	- Assistant to the Director of Operations
Asst Dir (E&CP)	- Assistant Director (Emergency & Contingency Planning)
A&E	- Accident & Emergency
BCM	- Business Continuity Management
C&T	- Cheltenham and Tewkesbury PCT
C&V	- Cotswold and Vale PCT
CBRN	- Chemical, Biological, Radiological and Nuclear
CCDC	- Consultant in Communicable Disease Control
CE	- Chief Executive
CGH	- Cheltenham General Hospital
CH	- Community Hospitals
DH	- Department of Health
DPH	- Director of Public Health
EMS	- Emergency Management Services
EPM	- Emergency Planning Manager
GHFT	- Gloucestershire Hospitals NHS Foundation Trust
GIS	- Gloucestershire Industrial Services
GPs	- General Practitioners
GRH	- Gloucester Royal Hospital
HMIM	- Health Major Incident Manual
HPA	- Health Protection Agency
HPT	- Health Protection Team
ICC	- Incident Control Centre
ISC	- Incident Support Cell
JHAC	- Joint Health Advisory Cell
MICG	- Major Incident Co-ordinating Group
MIP	- National Health Service
PCT	- Portable Document Format
PHT	- Public Health Team
PTSD	- Post-Traumatic Stress Disorder
RDsPH	- Regional Directors of Public Health
RHEPA	- Regional Health Emergency Planning Advisor
RRT	- Regional Resilience Team
SHA	- Strategic Health Authority
WGPCT	- West Gloucestershire PCT

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Countywide Gloucestershire Joint Agency Major Incident Media Plan – Gloucestershire Major Incident Co-ordinating Group

Dealing with Disaster – Home Office, Revised 3<sup>rd</sup> Edition

Gloucestershire Ambulance Service NHS Trust Major Incident Plan – Ambulance Trust

Gloucestershire Community Hospitals Major Incident Plan

Gloucestershire Health Community Joint Critical and Major Incident Manual – Cheltenham and Tewkesbury Primary Care Trust

Gloucestershire Hospitals NHS Foundation Trust Major Incident Plan – Hospitals Foundation Trust

Gloucestershire Joint Major Incident Procedures Manual – Gloucestershire Major Incident Co-ordinating Group

Gloucestershire Partnership Trust Major Incident Plan – Partnership Trust

Handling Major Incidents, 'An Operational Doctrine' – Department of Health

Planning for Major Incidents – NHS, issued 1996



## SECTION 1

### INTRODUCTION

1. The purpose of this Major Incident Plan (MIP) is to enable West Gloucestershire Primary Care Trust (WGPCT) and Lydney and the Dilke Community Hospitals (CH) to respond to, or prevent an occurrence escalating into a major incident. The objectives are to:
  - a. Enable the PCT/CH to respond in a planned and co-ordinated manner, to effectively manage and support health service providers involved in a major incident.
  - b. Provide guidance for PCT/CH personnel in the assessment and management of incidents, regardless of their nature.
  - c. Integrate and operate with the emergency plans of other Trusts, emergency services, County Council Emergency Management Service, other responding agencies and provide an integrated approach in compliance with the Major Incident Co-ordinating Group Countywide Joint Major Incident Procedures Manual.
  - d. Provide on-call directors and managers, as agreed, with Cotswold & Vale (C&V) and Cheltenham & Tewkesbury (C&T) PCTs.
2. This plan will be supported by Incident Operational Guides, containing relevant Action Cards, roles and responsibilities and, if required, an Emergency Telephone Directory. The Guides will enable key appointments to initiate an appropriate response, alert required appointments/organisations and establish an appropriate level of command and control.
3. The ADO will maintain the Operational Guides and ensure they are available to key appointments and staff, who will be trained to carry out required actions. The documents will be carried by on-call directors/managers and CH staff. Guides relating to establishing/managing the PCT Control Centre are held within the Control Centre Major Incident Cupboard. See Section 4.
4. This plan must be read in conjunction with the Gloucestershire Health Community Joint Critical & Major Incident Manual (HMIM).

### Emergency Planning Lead

5. The WGPCT Chief Executive (CE) is responsible for ensuring that the PCT has robust plans in place to initiate, manage appropriate response and provide support to health service providers. These plans also include restoration to normality and the post incident management of Public Health issues. The CE has devolved responsibility for emergency planning to the Director of Operations.
6. The ADO is responsible to the Director of Operations for:
  - a. Compiling both the HMIM and this PCT plan.
  - b. Annually reviewing all major incident plans and co-ordinating the issue of amendments.
  - c. Liaising with CHs and ensuring that they are integrated into the emergency planning process
  - d. Maintaining the PCT Incident Operational Guides
  - e. Ensuring that all plans conform to statutory requirements and comply with the Department of Health (DH) Emergency Planning Doctrine and guidance.
  - f. Liaising with other health service providers regarding emergency planning.
  - g. Ensuring a standardised approach to integrated emergency management.
  - h. Reviewing training needs and maintaining training records.
  - i. Planning and monitoring tests/exercises and ensuring that planning documents are amended to reflect required changes to procedures.

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- j. Monitoring communications procedures linked to emergency response.
- k. Monitoring new guidance issued and ensuring countywide reflect new procedures and initiate appropriate training.

### Major Incident Planning

- 7. Successfully dealing with a major incident requires a large number of organisations, including the emergency services, Local Authorities, the NHS, utility companies, voluntary agencies and other responding agencies to work together in the most effective manner possible. The HMIM details incident management and this document identify how to put those procedures into practice.
- 8. This MIP has been produced in accordance with the HMIM and DH guidance. PCTs are defined as a Category 1 Responders within the new Civil Contingencies Bill and have statutory responsibilities to have appropriate emergency plans and procedures in place to support health service providers. The procedures, legal requirements to conduct and guidelines surrounding emergency planning are outlined in Section 1 of the HMIM.

### Major Incident Co-ordinating Group

- 9. As part of the organisation of UK Resilience, the Civil Contingencies Secretariat requires Gloucestershire to have a Local Resilience Forum. In 1990 the County established a Major Incident Co-ordinating Group (MICG) to provide a forum for the co-ordination of the emergency services and Local Authorities response to a major incident. A MICG sponsored County Joint Major Incident Procedures Plan has been produced covering incidents within Gloucestershire and all plans must conform to this document. The composition of the MICG and its function is outlined in the HMIM.

### County Council's Emergency Management Service

- 10. When required, the PCT will work closely with the County Council's Emergency Management Service (EMS). Their roles and responsibilities are outlined in relevant sections of the HMIM. EMS produces a number of major incident plans and guidance documents which are held in the Control Centre Major Incident Cupboard. See Section 5 regarding providing medical support at a Local Authority Rest Centre.

### Business Continuity Management

- 11. In addition to planning for critical or major incidents, the PCT and Community Hospitals have comprehensive Business Continuity Management (BCM) plans in place for dealing with internal incidents, which includes action cards for dealing with each identified area of risk. The PCT plan identifies alternative locations for Trust personnel to deploy to in the event that the PCT building is not available.
- 12. An internal major incident is one that would affect day to day operations and service continuity. The BCM plan identifies certain procedures to avoid such an occurrence and the actions to follow should an incident happen.
- 13. The ADO is responsible for co-ordinating the BCM plans for the PCT and both Dilke Memorial and Lydney & District Community Hospitals.

### Incident Command System

- 14. Health has adopted the national recognised Gold (strategic), Silver (Tactical) and Bronze (Operational) incident command system. A comprehensive explanation of this command structure is provided in the HMIM.

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## SECTION 2

### MAJOR INCIDENTS

1. This Section outlines the different types, categorisation, levels of response and phases of a critical or major incident.

#### Definition of a Critical or Major Incident

2. The NHS defines a major incident as, ***'any occurrence which presents serious threat to the health of the community, disruption to services, 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.'*** However, there is no standard definition of a major incident that would satisfy the NHS, the emergency services or Local Authorities, as each tends to look at such incidents from the point of view of its own responsibilities. A major incident is any event or circumstance (happening with or without warning) that causes or threatens death or injury, disruption to the community or damage to property or the environment on such a scale that the effects cannot be dealt with by the emergency services, Local Authorities and other organisations as part of their normal day-to-day activities.
3. The NHS may have to face a variety of potential major incidents. A major incident can have a huge impact on one part of the health service while leaving others relatively unaffected. In a similar way, an NHS major incident is not necessarily a major incident for the other emergency services, such as the Police, Fire Service or Local Authorities - and vice versa. A 'Critical Incident' is any occurrence which may cause the NHS to respond with special arrangements but does not require a 'Major Incident' to be formally declared.

#### Alerting Categorisation of 'Major Incident'

4. The objective of categorising 'Major Incidents' is to ensure immediate economical response of required resources best suited to deal with a particular type of incident. The system will allow the PCT to quickly establish an appropriate command and control structure in accordance with the procedures outlined in this plan. There are three categories of major incident:
  - a. **Major Incident Standby** will alert the PCT/CHs that information has been received or there is an escalating situation, which may develop into a major incident. Placing individuals and key staff on 'Standby' provides time for them to come to a state of readiness in preparation for a co-ordinated response. It is far better to be ready to respond to an incident than initiate procedures after a major incident has been declared. The CHs will take predetermined action as outlined in Section 8.
  - b. **Major Incident Declared** will require the PCT/CHs to initiate specific procedures and alert appropriate agencies to support the NHS response. This will require this MIP to be invoked and appropriate Operational Incident Guides implemented. The size and type of incident may require the involvement of some or all of the County Emergency Services and other outside agencies. A main consideration is the support that the Community Hospitals may have to provide to the Acute Hospitals, which may require the decanting of in-patients. (See section 8)
  - c. **Major Incident Cancelled** will be declared when a 'Standby' or 'Major Incident' has been cancelled it is incumbent on Health to implement stand down procedures as quickly as possible. The PCT must support the Health Community to return to normality as quickly and efficiently as possible.
5. A key to successfully managing a mass casualty incident is an early declaration of a category of major incident combined with a best estimate of the number of casualties and type of injuries expected.

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## Levels of Response

6. The NHS is accustomed to normal fluctuations in daily demand for services (peaks and troughs). Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without the activation of special measures. To ensure that the NHS is capable of initiating an appropriate response, three levels of major incident have been devised to ensure an appropriate organisational management structure is established. Incidents have been categorised into the following three levels:
- a. **Level 1** – The Health Community is well versed in dealing with incidents such as multi vehicle motorway accidents within long established major incident plans. These plans typically anticipate conventional and relatively small scale incidents.
  - b. **Level 2** – Are much larger scale events affecting potentially hundreds rather than tens of people, possibly also involving the closure or evacuation of a major facility e.g. because of fire or contamination or persistent disruption over many days. This scale of incident will require a collective response by several or many neighbouring Health Communities, requiring a co-ordinated approach by the SHA.
  - c. **Level 3** – Is when events of potentially catastrophic proportions which severely disrupt health and social care and other functions (power, water etc) and that exceed even collective capability within the NHS. This level relates to a mass casualty scenario and the procedures for dealing with large numbers of casualties are detailed in Section 10 of the HMIM.

## Categorisation of Incident

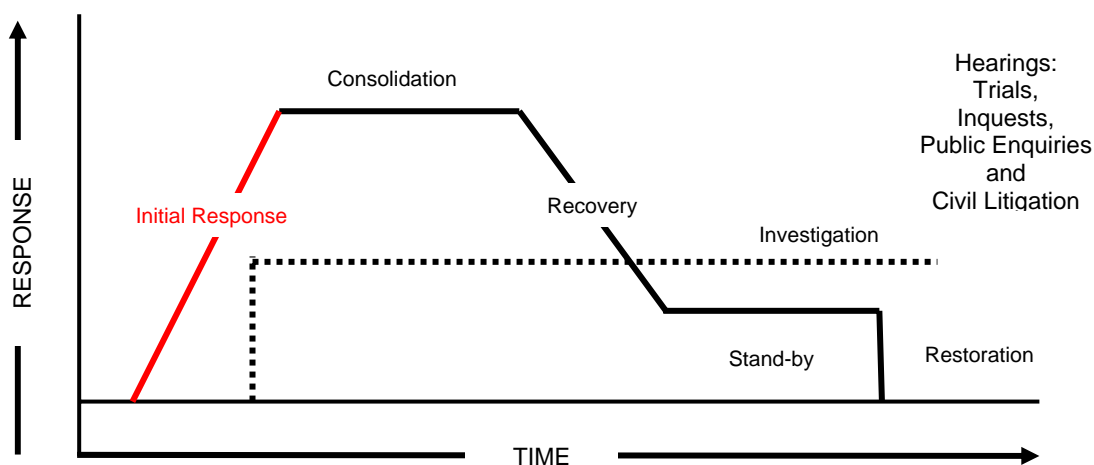
7. A major incident may involve large numbers of casualties, a serious threat to the health of the community or an internal disruption to the health service itself. A major incident may start in a number of ways and the following examples will need to be considered:
- a. **Major Accident or Incident** An NHS major incident is classically triggered by a sudden major transport or industrial accident.
  - b. **Slowly Developing Incident** This is when a problem creeps up gradually such as occurs in a developing infectious disease epidemic or traffic accident on a fog bound motorway.
  - c. **Incidents Evolving Elsewhere** Preparatory action is needed to respond to an evolving threat elsewhere, even overseas, such as a conflict in another country.
  - d. **Headline News** A wave of public or media alarm over a health issue as a reaction to a perceived threat may create a major incident for the health service.
  - e. **Internal Incidents** The NHS may be affected by its own internal major incident or by an external occurrence that impairs its ability to work normally. A fire or breakdown of utilities has the potential to cause a breakdown of services.
  - f. **Hazardous Material Incidents** This may be an unforeseen event leading to acute exposure of two or more individuals to any non-radioactive chemical substance. The incident may result in illness or a potentially toxic threat to health, or two or more individuals suffering from a similar illness which might be due to such an event.
  - g. **Terrorist Incident** The consequences of a terrorist incident, especially a deliberate release of chemical, biological, radiological or nuclear (CBRN) agents, are potentially enormous. It is likely that the number of casualties would far exceed that resulting from any previous major incident in the UK and all agencies would be required, at short notice, to find solutions to exceptional problems. As with other first responders, Health will adopt the dictum of 'doing the greatest good for the greatest number.' Section 7 provides a brief regarding dealing with a CBRN incident.
  - h. **Public Health Incident** There may be an outbreak of a communicable disease or environmental incident with risks to public health, which may require special procedures to be implemented.
  - i. **Environmental** National guidance may be provided for dealing with health issues linked to the environment e.g. Heatwave Plan.

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8. These categories of incident are further defined in Section 2 of the HMIM.

### Phases

9. Most major incidents can be considered to have four phases - Initial Response, Consolidation, Recovery and Return to Normality.



10. The PCT response will usually follow these phases as follows:

- a. **The Initial Response** The initial response will correspond with the time when action is being taken by the emergency services and may occur very rapidly. Once a major incident has been declared, it is essential that liaison quickly occurs with other agencies involved. This is particularly important for the external agencies e.g. SHA, who may be expected to provide support.
- b. **Consolidation** The consolidation phase involves on-going action by the PCT to support the Health Community and other agencies as required. During this phase, the PCT Control Centre Co-ordinator may need to call a Strategic Incident Control Team meeting to discuss an appropriate management approach to what may become a prolonged incident. The formation of this group will be dependant on the type of incident and may require attendees from other Trusts and external agencies.
- c. **Recovery** The recovery phase can be occurring when life saving is complete and the caring for those involved or affected less seriously can then begin. In terms of the Health response, this phase will encompass the instigation of further investigations, on-going communication with the other agencies, health professionals, press and the public. The PCT may need to provide support to health service providers with these issues.
- d. **Return to Normality** This involves action by all concerned to restore normal conditions, investigate the causes/circumstances of the incident, evaluate the costs incurred and recommend ways to reduce risk and improved response in the future. The PCT will support the Health Community return to normality and will work closely with Public Health regarding any long-term health issues resulting from the incident.

### Prolonged Incident

11. During the early stages of an incident, directors/managers must be aware of staffing levels and seek information regarding the length of time the incident may be expected to last. This may be difficult to assess and the worse case scenario should be planned for. This may require a shift system to be implemented and managed.
12. During a prolonged incident, it is the responsibility of the Control Centre Co-ordinator to manage staffing levels and organise rostering. Good management is essential during this type of situation and areas like catering, rest periods, duty and travelling time should be monitored. Certain situations may be very demanding and stress levels will also need to be considered.

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13. The Co-ordinator should also take a strategic overview of the incident and liaise with other Trusts, like an Acute Hospital, which may have become totally involved with an incident and may require assistance regarding aid and support.

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## SECTION 3

### ROLES AND RESPONSIBILITIES

1. This Section outlines the roles and responsibilities of key PCT appointments and individuals involved with incident management. The HMIM provides additional information relating to the roles and responsibilities of other NHS organisations, responding agencies and the Gold, Silver, Bronze command structure.

#### Primary Care Trust

2. The primary areas of PCT responsibility are as follows:
  - a. Initiating and supporting the Health response to an incident where appropriate.
  - b. Delivering primary and community health services by:
    - i Mobilisation of community resources.
    - ii Supporting the NHS infrastructure for hospitals by enabling increased hospital capacity through avoiding admission and caring for early discharges.
  - c. Developing a major incident plan for the PCT in conjunction with all emergency responders and partner organisations including the Health Protection Agency (HPA).
  - d. Assessing the impact on the Health Community of every potential major incident.
  - e. Providing the Health input to the Gold strategic management of a major incident involving a range of agencies.
  - f. Ensuring that services of all providers of Health care are supported to meet the needs of the local population.
  - g. Providing a strategic view of long-term threats.
  - h. If necessary, arranging follow-up of persons affected or exposed to risk e.g. those receiving chemoprophylaxis or whose health needs to be monitored.
3. The role and function of the PCT Control Centre is outlined at Section 4.

#### PCT On-Call Staff

4. The PCT on-call arrangements comprise a Countywide On-Call Director, provided by rotation from each of the PCTs, and a Senior Manager On-Call for each PCT area.

#### Countywide On-Call Director

5. The roles and responsibilities of the Countywide On-Call PCT Director are as follows:
  - a. Maintaining a 24/7 contactable presence within the County during the duty period.
  - b. Immediately reporting any change of contact details to Ambulance Control and arrange for another Director to cover any periods of absence.
  - c. Having the ability to contribute a strategic overview to management issues and be able to respond to incidents involving suspicious death, incidents of media interest, and implementing procedures to prevent an occurrence escalating into a major incident.
  - d. Having a comprehensive knowledge of both the HMIM and this Plan.
  - e. Having a working knowledge of the 'On-Call Directors Incident Operational Guide' and the Action Cards contained therein.
  - f. Maintaining a log of incidents, which must include information received and all actions taken.
  - g. Immediately responding to an alert, assimilate all available information and initiate an appropriate response. This may require:

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- i. An appropriate PCT On-Call Manager being alerted and briefed to initiate opening an Incident Control Centre (ICC). See Section 4 for an explanation of the role and function of an ICC.
  - ii. Placing a CE or nominated deputy on standby to attend Gold Control or, depending on the type of incident, being immediately deployed as the Health Gold to Gold Control.
  - iii. Depending on the type of incident, alerting other PCT On-Call Managers to open Incident Support Cells (ISC). See Section 4 for an explanation of the role and function of an ISC.
  - iv. Consider media implications and, if required, alert an appropriate Communications Lead.
  - v. Ensure that an appropriate Director/Senior Manager is alerted to become the ICC Co-ordinator.
  - vi. As required, deploy to an appropriate location to manage initial NHS response to the incident.
- h. Where practicable, ensure all relevant Action Cards are implemented.
  - i. Maintain a strategic overview of the incident.
  - j. Consider health and safety implications to staff providing support to an incident, especially those deploying to the scene. If required, obtain safety information from Ambulance Control and arrange for staff to receive a safety brief on arrival at the scene or place of work.
  - k. Maintain contact with Ambulance Control and provide them with a brief regarding the initial response taken by the PCT.
  - l. Once PCT Command and Control is fully operational, withdraw from any incident management and provide support as required.

### Senior On-Call Manager

- 6. Each PCT has a Senior Manager On-Call to provide operational support to the Health Community within the PCT area. General responsibilities are as follows:
  - a. Maintaining a 24/7 contactable presence within the PCT area during the duty period.
  - b. Representing the PCT within the Health Community and to external agencies.
  - c. Holding the appointment of responsible manager for out of hours incident management and available to provide required support during working hours.
  - d. Having the ability to act with initiative, responsibility and competence to handle any situation that may arise.
  - e. Immediately reporting any out of hours change of contact details to the Countywide On-Call Director and arrange for another Manager to cover any periods of absence.
  - f. Having a comprehensive knowledge of both the HMIM and this MIP.
  - g. Having a working knowledge of the 'On-Call Managers Incident Operational Guide' and the Action Cards contained therein.
  - h. Maintain a log of incidents, which must include information received and all actions taken.
  - i. When alerted, assimilate all available information and, in consultation with the Countywide On-Call Director open either an ICC/ISC or remain on standby to support a lead PCT.
  - j. If required, initiate an appropriate response to the incident. This may require:
    - i. Opening the PCT Control Centre and taking the role of the co-ordinator/manager until another manager/director takes over the role. See Section 4.
    - ii. During working hours, identify personnel to staff the PCT Control Centre.
    - iii. During out-of-hours, initiate the staff cascade callout system and recall required staff to duty. See 'Staff Cascade Callout Operational Guide' retained in the Control Centre Major Incident Cupboard.

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- iv. In consultation with the Countywide Director, identify and alert an appropriate Director or Senior Manager to take the Lead in the Control Centre.
- v. As required, deploy to an appropriate location to manage the initial NHS response to the incident.
- k. Consider health and safety implications to staff providing support to an incident, especially those deploying to the scene. If required, obtain safety information from Ambulance Control and arrange for staff to receive a safety brief on arrival at the scene or place of work.

### Control Centre Co-ordinator/Manager

7. The Control Centre Co-ordinator/Manager is to take the following actions:
  - a. Establishing a Control Centre as detailed in Section 4.
  - b. Initiating appropriate alerting procedures as outlined in Control Centre Operational Guides.
  - c. Deciding what level to declare the major incident. See guidance in Section 2.
  - d. Ensuring that the Control Centre operates in accordance with the requirements of the PCT Command and Control function outlined in Section 4.
  - e. Ensuring that an electronic and/or incident log is commenced and records maintained in accordance with Section 4.
  - f. Monitoring the 'Phases' of the incident as outlined at Section 2.
  - g. Implementing management procedures for dealing with a prolonged incident. See Section 2.
  - h. Ensuring appropriate support is provided to the Health Community and responding agencies as outlined in Section 5.
  - i. If established, maintaining close liaison with the Health Gold and provide regular briefings regarding incident developments. Immediately implement actions issued by the Health Gold and provide progress briefings.
  - j. Considering providing a brief to NHS Direct regarding health implications resulting from an incident. This information must only be provided with the agreement of a DPH and/or a Consultant in Communicable Disease Control (CCDC). The Communications Manager must also receive a copy of the brief.
  - k. Ensuring provision of Health Command and Control is commensurate with the incident and lines of communication are operating effectively.

### Staff Responsibilities

8. PCT Staff may be called upon to support either the PCT Control Centre or a Joint Health Advisory Cell (JHAC), (see Paragraph 14) and have the following responsibilities:
  - a. Being familiar with and having sufficient knowledge of this MIP and appropriate Incident Operational Guides to enable them to carry out their roles and responsibilities.
  - b. Providing their line Manager with contact details to enable the PCT to conduct an out-of-hours cascade call out of staff required for work to support the management function of a critical or major incident. Staff must inform their line manager of any change of address or contact details. Staff alerting procedures will be collated by the EPM.
9. It is the responsibility of line managers to ensure that all staff are familiar with the general outline of this plan and specific Sections relevant to individual roles and responsibilities. Staff must be aware of the location to which they should report when a critical or major incident occurs and their roles and responsibilities pertinent to their appointment as detailed in the Incident Operational Guides.
10. Staff will be provided with appropriate training to enable them to carry out their designated responsibilities as required by this MIP.

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11. Staff will be provided with appropriate training to enable them to carry out their designated responsibilities as required by this MIP. Staff training and exercising is outlined in the HMIM.

### Health Gold

12. If required an appropriate PCT Chief Executive, or nominated deputy, will go to Gold Control and assume the appointment of the Health Gold. The Health Gold will maintain the chain of command by only communicating with the Lead PCT ICC Co-ordinator.
13. The purpose of implementing a Health Gold is to establish a framework of policy within which the Health Community can tactically respond to an incident. The main Health Gold responsibilities are as follows:
- a. Establishing a strategic framework for the Health Community to manage the incident.
  - b. Identifying strategic objectives that should be recorded and subject to regular review.
  - c. Forming strategic management between Gold Control and the NHS response to an incident by ensuring there are clear lines of communication with the lead PCT and appropriate Health command and control structures are established.
  - d. Establishing appropriate liaison with strategic managers in other agencies.
  - e. Maintaining close links with the Ambulance Gold Commander.
  - f. Ensuring that the Ambulance Service is meeting NHS communications requirements.
  - g. Providing required administrative support staff at Gold Control.
  - h. In consultation with the Health Communications Lead, ensuring that the procedures outlined in the County Joint Agency Major Incident Media Plan are being implemented.
  - i. Liaising/briefing the SHA and, if required requesting their support.
  - j. Ensuring there is long-term Health resourcing and expertise for management and command resilience.
  - k. Giving consideration to the prioritisation of demands from the lead PCT or Ambulance Service tactical managers.
  - l. Deciding what resources or expertise can be made available for tactical response requirements.
  - m. Having the ability to provide additional resources to support medical operations at the scene and maintain a strategic overview of medical provision at the incident.
  - n. Maintaining a strategic overview of Public Health information and establishing public information help lines.
  - o. Considering the long-term implications for Public Health and the NHS.
  - p. Planning beyond the immediate response phase for recovering from the emergency and returning to a state of normality.

### Public Health

14. The Public Health Team (PHT) are on-call to the Department of Health and the County alerting procedures. The PHT will deploy in accordance with their local protocols as directed by the Director of PH (DPH). If required, the DPH will appoint an appropriate person to support the Control Centre.
15. If requested by the Police, a JHAC will be established to provide guidance to the Gold Commander on Public Health issues relating to an incident. A DPH/nominated deputy and or a Consultant in Communicable Disease Control (CCDC) will establish and chair the JHAC, which is usually established at Police Headquarters in Cheltenham. Procedures for establishing a JHAC are outlined in the Gloucestershire JHAC Plan, held by the DPH. See Section 7 for further details.

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16. The Public Health Link system is used where information needs to reach health professionals quickly and there is not sufficient time to organise a hard copy mailing. Categories describe the degree of urgency of the message and how quickly the information needs to be read by health professionals. Immediate cascades are within 6 hours, urgent 24 and non-urgent 48 hours. The initial alert is received from the DH by pager, which alerts the DPH to read the Public Health link web page. During working hours, appropriate alerting action will be taken by the PHT. Out of hours the initial alert will be received by the on-call practitioner for Public health who will contact Ambulance Control so that the out-of-hours cascade can be disseminated via a predetermined computerised fax system.
17. The role and function of the PHT are further outlined in Section 5 of the HMIM. The DPH will be supported by the HPA as required.

### Health Protection Agency

18. If required, the HPA will support the PCT with certain aspects of incident management e.g. impact of infectious diseases, poisons, chemical, biological, and radiation hazards. The Gloucestershire CCDC is located, with the Health Protection Team (HPT), at C&T PCT. operates from C&T PCT. An on-call CCDC is available via a paging system managed by Ambulance Control.
19. The Regional Health Emergency Planning Advisor (RHEPA) manages a HPA Regional Health Emergency Preparedness Team and will respond to support the PCT when requested. The RHEPA must be informed of critical incidents for information and major incidents may result in a formal request for support from the HPA.

### Strategic Health Authority

20. The SHA will provide the following support during a major incident:
  - a. Establishing an SHA Control Centre
  - b. Establishing robust communications with the PCT Control Centre and the Health Gold.
  - c. Guaranteeing strategic control of any incident that affects or seems likely to affect several hospitals or have a significant impact on primary care.
  - d. Forming links within the NHS, neighbouring SHAs, Regional Directors of Public Health, HPA, DH and if required the Regional Resilience Forum.
  - e. Responding to requests from the PCT Control Centre for the support of the Regional Resilience Team and/or DH.

### Regional Public Health Groups

21. Regional Public Health Groups, led by Regional Directors of Public Health (RDsPH), will ensure a 24/7 capability to support both the SHAs and the DH and where necessary to co-ordinate PH resources in responding to PH emergencies. The RDsPH will provide the health link to Regional Resilience mechanisms and act as the regional nominated co-ordinator in PH emergencies.

### Department of Health

22. The DH is responsible for national oversight and monitoring of all incidents that result in activation of a major incident plan. This does not mean it will necessarily always be involved in all of them, most will be handled by the SHA. However, when more than one SHA is substantially affected or when an incident has a 'national' characteristic, establish a national control room to support SHA management of incidents, to encourage mutual aid and to act as focal point for links across Government.

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**Regional Resilience Team at the Government Office of the South West**

23. The creation of Regional Resilience Teams (RRTs) is a Government initiative to improve the UK's resilience to emergencies and crises. Resilience is defined as the UK's ability to handle disruptive challenges that can lead to, or result in, crisis and have the following responsibilities:
- a. Improving emergency planning co-ordination at regional level
  - b. Improving co-ordination between the region and the local response capability, and harmonisation of plans
  - c. Supporting planning for a response capability
  - d. Co-ordinating Central Government resources in a disaster
  - e. Assisting with recovery
  - f. Building on existing emergency planning structures
  - g. Creating emergency planning partnerships, through consultation, throughout the South West.
24. Support from the RRT, at the Government Office of the South West in Bristol, can be sought from via the SHA Control Centre.

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## SECTION 4

### COMMAND AND CONTROL

1. The purpose of this Section is to outline the PCT command and control procedures relating to on-call arrangements, forming an appropriate incident management structure and opening a PCT Control Centre.

#### Alerting Procedures

2. There are clear lines of alerting procedures within the County and the PCT has an Incident Operational Guide for alerting staff to support either the Control Centre or JHAC. Procedures for alerting external agencies are identified in 'Action Cards' contained in relevant Incident Operational Guides. It is recognised that notification of an event requiring a generic major incident response may come from a number of different agencies. These include the following:
  - a. **Gloucestershire Ambulance Service Control** Has the ability to implement a multi contact group messaging system or individual alerting procedures and is central for Health communications within the County.
  - b. **Strategic Health Authority** Relating to information being disseminated from the Department of Health or in support of neighbouring SHA(s).
  - c. **Department of Health** In the case of a major incident requiring a co-ordinated national response.
  - d. **Public Health** Network (including NHS Trust staff, occupational health physicians, public utilities, local authority environmental health officers, etc.) to incidents affecting public health (e.g. outbreaks of infectious disease, drug/medical device problems, water contamination). See Section 5 of the HMIM.
  - e. **Gloucestershire Constabulary** In the case of public health issues stemming from CBRN terrorist incident or accident, however, it is more likely that the information will be disseminated by Ambulance Control.
  - f. **A&E Department or Minor Injuries Unit** May receive self reporting casualties before an incident has been reported to the emergency services.
3. Ambulance Control has the ability to initiate a single alerting cascade message to all on-call operational pagers and registered mobile phones. A protocol for this alerting procedure has been agreed and, in the majority of instances, is the usual way an initial alert will be received.

#### On-Call Arrangements

4. The PCTs maintain a rota for the provision of a Director On-Call for the County and each PCT has a Senior Manager On-Call to deal with local issues. When an alert has been received, the Countywide On-Call Director will consider the nature and location of the incident and decide which PCT should take the lead by opening an Incident Control Centre (ICC). However, for an incident involving a deliberate or accidental release of CBRN material C&T PCT will take the lead by opening an ICC, supported by the other two PCTs. See Section 7.
5. Depending upon the nature and location of the incident, one or both of the other PCTs may be required to establish an Incident Support Cell (ISC) to enable the management of local issues and support to the ICC. An ISC will be controlled by a nominated Manager, who must ensure that command and control of the incident remains with the ICC Co-ordinator. The location of the control centre facilities at each PCT are:
  - a. Cheltenham & Tewkesbury Primary Care Trust – The HPA Department, Unit 43, Central Way, Arle Road, Cheltenham.
  - b. Cotswold & Vale Primary Care Trust – The Board Room, Trust Headquarters, Corinium House, Cirencester Hospital, Cirencester.
  - c. West Gloucestershire Primary Care Trust – Heart Failure Nurse Area, Unit 14 Highnam Business Centre, Newent Road, Highnam, Gloucester.

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**Lead PCT**

6. As outlined at Paragraph 4, the lead PCT will open an IIC, managed by a Co-ordinator, with the following roles and responsibilities:
  - a. Implementing a Health command and control function.
  - b. As required, representing the Health Community within multi-agency incident management issues including liaison with Police, EMS and other external agencies.
  - c. Initiating/requesting cross border support arrangements.
  - d. Co-ordination of the NHS response and the provision of support to the Health Community.
  - e. If required, liaising with key agencies e.g. SHA and HPA.
  - f. If required, establishing direct communication links with the Health Gold.

**Supporting PCTs**

7. As outlined in Paragraph 5, one or both PCTs may be required to open an ISC with the following roles and responsibilities:
  - a. In accordance with local plans, supporting the Health Community within their PCT area.
  - b. As appropriate, liaising with local agencies e.g. Local Authorities.
  - c. Monitoring cross border support for local Health services.
  - d. Ensuring that Countywide tactical and strategic issues are referred/briefed to the ICC Co-ordinator and that the chain of command is maintained.

**Opening a Control Centre**

8. Once alerted to an incident, the Director On-Call must quickly assess the incident and decide which PCT should open the ICC and if other PCTs need to be alerted to open ISCs. The following should be considered:
  - a. Location of the incident e.g. which PCT is it in?
  - b. Could the location of the incident have an effect on the function of a PCT?
  - c. What type of incident is it? Regardless of location, if it is a CBRN incident C&T PCT will take the lead.
  - d. The possibility of Gold Control being formed and alerting an appropriate CE or Director.
  - e. Personnel required to staff the Control Centre e.g. will the incident be protracted.

**In Working Hours**

9. The following procedures are to be taken when opening an ICC or ISC.
  - a. Alert the CE and appropriate directors/staff.
  - b. Identify who will become the ICC Co-ordinator or ISC Manager.
  - c. With the assistance of the CCDC, clear the HPA office area and establish as a Control Centre. See Paragraph 13.
  - d. Identify a member of staff to initiate and maintain a computerised incident log.
  - e. Contact the Ambulance Control, obtain an incident update and inform them which PCT has taken the lead.
  - f. In consultation with a director and/or the DPH take appropriate alerting procedures.
  - g. Open a workstation and write a 'PCT Emergency Information Cascade' e-mail.
  - h. Agree initial actions required to manage incident.

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### Outside Working Hours

10. The following procedures are to be taken by the alerted director/manager when opening an ICC or ISC:
  - a. The alerted on-call director/manager is to evaluate the initial information received and decide whether a control function needs to be initiated.
  - b. If the incident requires PCT support, report to the Trust offices.
  - c. Use the entry information in the on-call pack to access the PCT building.
  - d. Alert appropriate personnel required to staff the ICC.
  - e. Quickly establish the ICC within the Heart Failure office. See Paragraph 19.
  - f. Obtain a brief from Ambulance Control.
  - g. In consultation with a director and/or the DPH take appropriate alerting procedures.
  - h. Open a workstation and write an initiating 'PCT Emergency Information Cascade' e-mail.
  - i. Agree initial actions required to manage incident.

### Staffing Requirements

11. The staffing requirements for the Control Centre to function are as follows:
  - a. A Director or Senior Manager to hold the appointment of ICC Co-ordinator or ISC Manager.
  - b. Trained A&C Grade to become the Log Keeper.
  - c. Representative from PH to staff the PHT desk.
  - d. The ADO or nominated deputy to support the Co-ordinator/Manager.
  - e. Suitable member of staff to provide support.
12. Depending on the type of incident, this establishment may be reduced.

### Communications

13. The following communications are available:
  - a. The main line of communication within the Control Centre will be by internal and external landline telephones located on each Control Centre workstation.
  - b. There are three permanent computers within the Control Centre, with the capability of additional computers being moved onto the spare desks.
  - c. One fax machines readily available.
  - d. Most staff have mobile telephones but this would depend on availability and cannot form part of a communications strategy for the ICC.
14. A comprehensive list of emergency telephone numbers is contained in the Emergency Telephone Directory held in relevant Incident Operational Guides.

### Information Technology Support

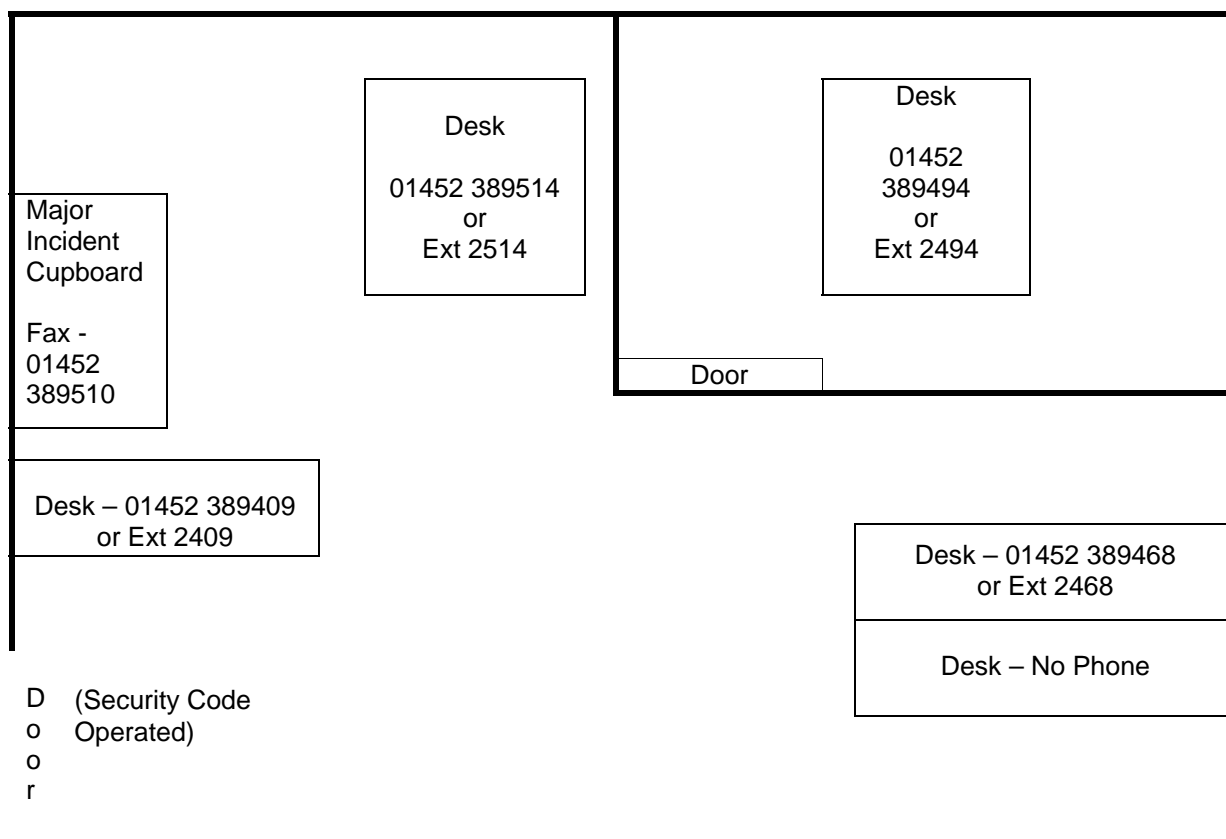
15. Upon opening a Control Centre, the IT Shared Services are to be notified through the IT Help Desk during normal working hours. In the case of a critical or major incident, the IT Operations Manager can be contacted during out-of-hours. Contact details are in the Emergency Contact Telephone Directory.
16. It cannot be assumed that all IT services will function out-of-hours. It will be the responsibility of the PCT's IM&T Leads to liaise with the IT Department in order to monitor progress to ensure incident resolution meets Business Continuity Management requirements wherever possible.

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17. In the event of a systems failure the IM&T Leads from the PCT will be required to communicate directly through the Help Desk or IT Operations Manager, to enable the IT Disaster Recovery Plan to be initiated from Rikenel to support the PCT.
18. The PCT must inform the IT Operations Manager when the incident has been terminated and the Control Centre is managing a return to normality.

**Control Centre Layout**

19. The Control Centre will be configured within the Heart Failure Nurse area in Unit 14G as follows:



**Stationery**

20. A 'Control Centre Administration Pack' is contained in a cardboard storage box in the Major Incident Cupboard. The pack contains sufficient stationery to enable staff to establish a Control Centre. A contents list is available in the box, which is maintained by the ADO.
21. Relevant Major Incident Plans, Incident Operational Guides and documents required to support the Control Centre are held in the Major Incident Cupboard. A JHAC Administration Pack is also retained in the cupboard for issue to a DPH.

**Records and Log Keeping**

22. It is most important that all staff working in the Control Centre or in an incident management role maintain an incident log and/or record of actions taken and decisions made. The accuracy of these records is very important as they may be required as evidence in any of the following post incident enquiries:
  - a. Coroner's inquest.
  - b. Public inquiry.
  - c. Criminal proceedings.
  - d. Internal inquiry or disciplinary procedure.
  - e. Civil litigation.

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- f. As guidance for post incident debriefs.
23. All records appertaining to an incident must be retained 'Preserved and Protected' and only destroyed with the written permission of the CE, or nominated deputy. Depending on the type of incident, records may be kept for many years or indefinitely. Records may include very rough contemporaneous written notes, a computer generated log, video footage, photographs or any other item that acts as a diary of events e.g. cassette tape from a hand held tape recorder. The following must be considered:

#### **During an Incident:**

- a. Suspend any procedures for destroying both archived files and current documents. Only lift suspension when procedures are in place to ensure incident records are not accidentally destroyed.
- b. Keep an accurate log of information received, decisions made (within reason) and actions taken.
- c. Ensure that records are maintained of media management issues.

#### **After the Incident:**

- a. The ADO will collect and collate all documents relating to the incident and identify a suitable custodian, ensure records are secure and access is restricted.
- b. Some staff may require professional advice regarding making written statements.
- c. Consider witness training.
- d. Consider legal representation.

#### **Prolonged Incident**

##### **Shift System**

24. The Control Centre Co-ordinator/Manager must establish the length of time an incident may be expected to last and consider implementing a shift system.
25. A Public Health incident may only be declared a major incident for the NHS and initially the ICC may be formed by a single outbreak control team which may expand to encompass epidemiology, microbiology and environment sub groups. Depending on the type of incident an Infection Outbreak Control Team may be formed at C&T PCT.
26. A prolonged incident may require an appropriate person to be identified to manage personnel required to staff operational facilities and assistance may be requested from other Trusts and external organisations.

##### **Catering**

27. The Control Centre Co-ordinator/Manager must ensure that adequate catering facilities are available throughout the incident.

##### **Logistical Support**

28. Any equipment required to maintain the function of the Control Centre is to be requested via the Corporate Services Officer or nominated deputy, who will endeavour to obtain the item(s) as expediently as possible.

##### **Briefing and Debriefing**

29. Successfully dealing with an incident can depend on the type and quality of briefings provided to staff. A well structured system for debriefing will greatly contribute to improving procedures and systems for dealing with similar future incidents. Section 12 of the HMIM outlines procedures for planning and delivering pre and post event briefings. See the Control Centre Co-ordinators Action Card for procedures.

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### Post Traumatic Stress Disorder

30. Post Traumatic Stress Disorder (PTSD) is a very real illness, which can affect any person exposed to a traumatic incident. Procedures for managing and dealing with PTSD are detailed at Section 12 of the HMIM and requirements detailed in the ICC Co-ordinators Action Card. Procedures for obtaining counselling support are outlined in Section 5.

### Alternative Control Centre

31. In the event of the Control Centre being unavailable e.g. electrical failure or the building is close to the incident, arrangements have been made with Gloucestershire Ambulance Service to use facilities in the TriService Headquarters at Waterwells in Quedgeley. Directions to the TriService Headquarters are contained in the On-Call Packs. If this is impractical, appropriate staff may have to be deployed to another PCT to support their Control Centre.

### Activation of Alternative Control Centre

32. The alternative Control Centre can be activated by contacting Ambulance Control. This will alert the Duty Control Officer that WGPCT are moving to the TriService HQ and access arrangements will be put into place. An Ambulance Officer will be identified to act as liaison to ensure that the deployment runs smoothly.

### Admission Procedures

33. The TriService Emergency Centre has strict control of entry and an appropriate member of staff must be identified to remain at and support the TriService Reception staff with controlling entry.

### Location

34. The alternative control will be located in Conference Room No 1 and has the following facilities:
- a. Space/desks to accommodate sufficient staff.
  - b. Telephone points
  - c. 2 electrical power sockets per desk
  - d. Photocopying and fax facilities will be identified by Ambulance support staff.

### Equipment

35. The ICC Co-ordinator must ensure that any required equipment is taken to the alternative ICC. However, this will depend if access is available to the WGPCT building. Equipment to be considered is:
- a. Laptop computers.
  - b. Control Centre admin pack.
  - c. Relevant orders and instructions.
36. In the event of access not being available to the Trust Building, consideration must be given to contacting C&V or C&T PCTs for support equipment to open an alternative ICC. The Corporate Services Officer will respond to any requests for equipment.
37. In the event of a power failure, it may be necessary to retain a contact person at the WGPCT, with a means of communication, to facilitate access to information and equipment.

Any deployment to the alternative Control Centre will require a flexible management approach regarding the type of incident, personnel and equipment required

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## SECTION 5

### INCIDENT MANAGEMENT AND SUPPORT

1. The purpose of this Section is to outline the support that the PCT may be expected to provide to the Health Community and other responding agencies during a major incident. The following paragraphs outline key operational issues.

#### Primary Care

##### GPs

2. GPs have a professional responsibility to take what action they can in contributing to the emergency response whilst continuing to provide general medical care to the community within the limits imposed by the nature of the incident.
3. The Local Medical Committee has been consulted and is aware that GPs may be required to respond outside of their normal working environment to provide medical support during a major incident. This support may be required at County Council Rest Centres, Place of Safety or supporting the Health Community.

#### Alerting GPs

4. In the event of GPs being required to provide support during a major incident, a PCT Primary Care Manager will be briefed and tasked with co-ordinating alerting appropriated Doctors as required. A sealed envelope, containing GP home telephone numbers, is held in the Control Centre Major Incident Cupboard to facilitate out-of-hours call-out procedures.

#### Deployment

5. Before deploying GPs, a comprehensive brief should be obtained from an appropriate source regarding issues like role and function and any Health and Safety issues to be considered.

#### Community Nurses

6. Depending on the location and type of incident, Community Nurses may be called upon to provide additional staff or the provision of medical support to the following:
  - a. Local Authority Rest Centre(s). See Section 6.
  - b. Community Hospitals accepting in-patients from the Acute Hospitals.
  - c. Provide medical teams for facilities that have been commandeered to provide medical services in response to a Level 3 incident e.g. Wotton Lawn Hospital having been cleared to admit casualties with minor injuries.
7. It is recognised that Community Nurses may be asked to support the Health Community in varying clinical functions and their response will need to be flexible and well managed.

#### Alerting Community Nurses

8. The Community Nursing Manager will be briefed and tasked with co-ordinating alerting appropriate Nurses as required. A sealed envelope, containing Community Nurse home telephone numbers, is held in the Control Centre Major Incident Cupboard to facilitate out-of-hours call-out procedures.

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## Deployment

9. Before deploying Community Nurses to operate outside of their normal working environment the Community Nursing Manager, or nominated deputy, will need to consider:
  - a. The request for support and decide whether it would be better to use GPs and Practice Nurses and hold the Community Nurses for other duties. This decision may require to be made in close liaison with a Primary Care Manager.
  - b. Which health service providers or services may be affected by the deployment of Community Nurses and assess availability of staff to ensure Health Services are maintained.
  - c. Communication issues e.g. mobile phone numbers, to enable management issues to be maintained and a reporting link to be established.
  - d. Health and safety issues and, if required, provide an appropriate briefing to staff being deployed.

## Rest Centres

10. As an immediate response there may be a requirement to deploy GPs and Community Nurses to County Council Rest Centres, which may be activated by the Local Authority. The primary roles of the deployed Community Nurses will be to:
  - a. Provide some medical screening to ensure evacuees who have or develop medical problems receive necessary health care.
  - b. Assess health needs of evacuated people.
  - c. Provide medical care for those with minor injuries at a Place of Safety (Rest Centre) near an incident.
  - d. Arrange for the replacement of lost prescribed medicines, which may require support from the PCT Control Centre.
  - e. As directed by the Public Health Team, provide medical advice and information on the consequences of the incident.
  - f. Provide a Health contribution to the welfare support of evacuees.
11. Additional information relating to Rest Centres is provided at Section 6 of this Plan and a detailed explanation of the different types of Centre is provided at Section 2 of the HMIM.

## Community Hospitals

12. Depending on the number of casualties, the Community Hospitals may be required to accept in-patients from the Acute Hospitals to free beds. Both the Acute and Community Hospitals major incident plans have bed management strategies that outline agreed procedures for the decanting of in-patients. The Ambulance Trust has plans in place to call on cross border support for the provision of patient transport from the Acute to Community Hospitals and to co-ordinate patient movement. The Community Hospitals will manage transport requirements for patient being discharged home however, depending on the type of incident, may require support from the PCT with this issue.
13. When it becomes apparent that a Community Hospital will receive decanted in-patients the PCT may send an appropriate manager to the hospital to provide support and a point of contact for the Control Centre.
14. The PCT may be required to assist the Community Hospitals with discharging patients and has plans in place for:
  - a. Obtaining community equipment from Gloucestershire Industrial Services.
  - b. Liaising with Social Services.
  - c. Providing support regarding patient transport issues.

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- d. Providing additional clinical staff.
  - e. Providing additional pharmaceutical supplies.
15. If the incident is close to a Community Hospital, the Ambulance Service may decide to take certain casualties to the Minor Injuries Unit and some of those injured may self report to the hospital. In this eventuality, the PCT may be required to provide clinical and non clinical staff to support the duty personnel.
  16. During a Level 3 incident the Community Hospitals may use their standby arrangements and open local non medical facilities e.g. village halls to hold/triage self reporting casualties. This will require off duty staff to return to duty and the PCT to arrange immediate support.
  17. CHs do not have individual major incident plans. Generic procedures have been agreed across the Health Community and are outlined in Section 8. Each CH has Incident Operational Guides identifying uniform procedures to follow applying to their own requirements.

### Pharmaceutical Support

18. Procedures for gaining access to emergency pharmaceutical support are outlined in the 'Community Pharmacy Major Incident Contingency Plan' held in the Major Incident Cupboard. Countywide Pharmacy telephone numbers and alerting details are contained in the plan. This document is produced by the Local Pharmaceutical Committee and will be reviewed annually.

### Social Services

19. There are two distinct areas to be considered relating to the provision of Social Services: the service provided to patients being discharged from hospital and existing care in the community.
20. In the event of a major incident, the County Council may establish an Emergency Welfare Team to manage Social Service response and initiate plans for dealing with an escalating incident. Emergency procedures for the provision of Social Services are as follows:
  - a. **Hospital Discharges** will be arranged by the Acute or Community Hospitals and Social Services. This may involve formal links being established with the Welfare Team to deal with emergency discharges.
  - b. **Emergency Social Service Support to the Community** during a major incident will be co-ordinated by the Welfare Team. Business continuity management plans for maintaining services to existing people will be implemented.
21. It is unlikely that the PCT will be asked to co-ordinate additional Social Service support as the Hospitals, Social Services and the Welfare Team have robust alerting procedures and plans for dealing with an escalating incident. However, any requests for additional Social Service support should be directed through EMS.

### Linen

22. Emergency supplies of linen can be obtained 24/7 from Sunlight Laundry. Both the normal and emergency contact telephone numbers are provided in the Emergency Telephone Directory.
23. The provision of additional linen during an emergency is outlined in both the Hospitals Trust and Community Hospitals Business Continuity Management Plans. However during a Level 3 incident the PCT may need to seek the support of the SHA for emergency supply of linen.

### Gloucestershire Industrial Services

24. Gloucestershire Industrial Services (GIS) are responsible for the provision of Community Equipment. Procedures for obtaining an emergency supply of equipment are outlined in the GIS Contingency Plan held in the Major Incident Cupboard.

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## Security

25. A major incident may cause security issues within the Health Community e.g. casualties self reporting to Acute and Community Hospitals. In this eventuality, any requests for security to be provided at NHS premises should be referred to the Health Gold via the PCT Control Centre. However, it is acknowledged that during a Level 3 incident the Police will probably be unable to provide/arrange security at affected hospitals and 'Lockdown' procedures will need to be invoked. The Local Security Management Specialist will review NHS facilities and provide guidance on security issues.

## Lockdown

26. In the event of a Level 3 or CBRN incident, Ambulance Control will alert possible affected hospitals to implement 'Lockdown' procedures. Each hospital has plans in place to secure access to prevent the facility be overridden or contaminated and relevant staff are aware that they will need to provide their own security management for some hours before assistance can be provided by the Police or Military. Hospitals which receive self reporting casualties may implement their own 'Lockdown' plan. See Section 6.

## Domestic Services

27. After a Level 3 incident those hospitals that received high numbers or contaminated casualties may require heavy industrial cleaning contractors to assist in returning the building to normality and the PCT has plans in place to provide such a cleansing support.

## Counselling Services

28. Requests for counselling services should be directed to the Health Gold for consideration by the Gold County Council representative. Long term counselling support can be arranged from the Partnership Trust. Long term counselling support can be obtained from the NHS Critical Incident Staff Support Service via the Partnership or Acute Trusts. The team of trained and experienced staff provide a private discussion for individuals or groups of staff who have experienced disturbing or distressing incidents in the workplace and is a confidential service. Individual or groups of staff may independently contact this Counselling Service.

## Media Management

29. Managing the media forms an integral part of the County emergency planning systems. A Gloucestershire Joint Agency Major Incident Media Plan incorporates the procedures and responsibilities of NHS personnel responsible for liaising with and managing the media. Section 6 of the HMIM provides information about news gatherers and the systems in place for managing the media during an incident. The C&T PCT Communications Manager is responsible for ensuring that the Trust is capable of responding 24/7 and appropriately dealing with media management. This includes informing the public about health issues and co-ordination between media information and advice being given through public health lines e.g. NHS Direct.
30. It is most important that all requests from media representatives are referred to the PCT Communications Manager, in order that correct, accurate and timely information is given. It is better to say nothing than make an inaccurate statement which adds confusion to the public information process.

## Dealing with Children, Vulnerable People and Persons with Special Needs

31. Both the Ambulance and Hospitals Trusts MIPs outline procedures for dealing with children and with mental health and learning disabilities. Section 7 of the HMIM outlines procedures required to manage incidents involving vulnerable people.

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### Religious and Ethnic Groups

32. A major incident may involve members of religious and ethnic minorities who may not speak English and/or have particular religious requirements. Arrangements to deal with these issues are contained in Local Authority Plans and any requests for support from religious or ethnic groups should be referred to the Health Gold for an appropriate request to be submitted to the Gold County Council representative.

### Voluntary Agencies

33. Most of the County voluntary agencies have service level agreements with organisations e.g. St John Ambulance will support the Ambulance Service and the British Red Cross will provide assistance to EMS. However, if required the PCT may request voluntary agency support via the Health Gold.

### Military Involvement

34. The military may have the capability to support the civil community with the provision of personnel and equipment. Any request of military assistance must be made via the Health Gold, who will submit the request to the Police Gold Commander. Additional information regarding military support is outlined at Section 8 of the HMIM.
35. In the event of the military being involved in an overseas conflict, specific plans will be put in place for the repatriation of injured service personnel to the UK and acceptance into the NHS. The PCT will support these plans as required.

### Civil Disorder and Civil Disaster

36. The NHS must plan for both incidents of civil disorder and civil disaster. A description of both types of incident is provided at Section 9 of the HMIM.

### Escalation

37. An escalating incident, which may produce large numbers of casualties, will require the PCT to provide considerable support to the Health Community. Appropriate response may require the support of the SHA or, in the event of a catastrophic incident, the DH. Procedures for dealing with an escalating incident are detailed in Section 10 of the HMIM.

### Communications

38. The PCT must ensure that the Health Communication strategy is maintained during an incident and agreed lines of command and control are maintained. Section 15 of the HMIM details communication procedures to be adopted during incident management.

### General

39. During any level of major incident, the PCT Control Centre may be required to provide varying types of incident management and support to the Health Community. This can only be achieved by maintaining proper lines of command and control and a flexible approach to management and service provision issues.

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## SECTION 6

### EMERGENCY MANAGEMENT SERVICE - REST CENTRES

1. The County Council's Emergency Management Service (EMS) produces a number of documents and plans that are kept in the Major Incident Cupboard. Along with the emergency services, the PCT will work closely with EMS regarding incident management. Section 5 outlines the function of EMS Rest Centres and the Health support that may need to be arranged by the PCT.

#### Rest Centres

2. During or following an incident, it may be necessary for the Gloucestershire County Council Emergency Management Service (EMS) to provide care to members of the public who have been evacuated from their homes and require temporary accommodation, or to uninjured survivors of an incident.
3. Experience of disasters has shown that if people believe their friends and relatives may have been involved, they will wish to travel from within the UK or abroad to the scene of a disaster. If required, there may be a need to establish a Friends and Relatives Reception Centre.
4. Recent events have also signalled the need for Local Authorities to set up and manage a 'place of safety' in support of the health authorities, should decontamination and prophylactic treatment of the public be required, following a chemical-biological incident.

#### Types of Rest/Reception Centres

5. EMS have plans for four different types of Rest Centre as follows:
  - a. **A Rest Centre** is a building designated for the temporary accommodation of evacuees. It will be managed by local authority staff from the affected District Council or from staff of another District as agreed, assisted by members of the County Council Welfare Team and members of voluntary groups. Under certain circumstances the Police may also assist at a Rest Centre.
  - b. **A Survivor Reception Centre** is a secure area to which uninjured survivors can be taken for shelter, first aid, interview and documentation. It will be managed by Local Authority staff from the affected District Council or from staff of another District as agreed, assisted by members of the County Council Welfare Team. The Police may also be involved in collecting evidence in relation to the incident. A Survivors Reception Centre will be organised, staffed and administered in the same way as a Rest Centre.
  - c. **A Friends and Relatives Reception Centre** is a secure area set aside for the use and interview of friends and relatives of victims arriving at the scene. A plan is being prepared for such a facility involving a multi agency response.
  - d. **A 'Place of Safety'** is a centre primarily for Health to treat the public, and gather information following an incident involving CBRN. It is envisaged that this should be set up for a short term only, as people who have gone through the decontamination process will be anxious to return to their homes as soon as possible. A place of safety will be identified by the EMS Duty Officer and will be staffed by a Rest Centre Management Team only. By agreement, a Place of Safety may be established for incidents other than CBRN.

#### Scenarios Requiring Rest Centres

6. When a Rest Centre is being established it will be helpful to consider the various types of incident which may dictate the structure of the service provided:

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- a. **A Short-Term Evacuation** can be evaluated as being precautionary rather than necessary e.g. chemical spillage, unsafe building structure, unexploded bomb. In terms of duration, short term could be assessed as being up to 24 hours.
- b. **Medium-Term Evacuation** A major incident may have occurred which could involve fatalities and the potential for further loss of life or injuries e.g. air crash, rail crash, maritime incident, crowd disturbance. The Centre may need to adopt a far longer plan to cope with the aftermath and provide for the survivors, as well as the needs of the friends and relatives of the affected persons. In this instance the duration of the provision could well be unknown.
- c. **Long-Term Evacuation** may be required in the case of flooding, earthquake or terrorism. Survivors may be unable to return to their homes for weeks or perhaps months. It could be necessary to provide a long-term service, not only to survivors but also their communities. This could develop into a two-phase approach using the Rest Centre building firstly for the immediate response and then in the long-term as an information centre.

### Location

7. Depending on the type and location of the incident, EMS, in consultation with the Police and/or Fire Service may decide to open a planned location or use a suitable building to accommodate the number of people involved. The PCT will be informed of the Rest Centre location and appropriate support requested.

### NHS Support to a Rest Centre

8. It is acknowledged that Health response will vary for the different types of Rest Centre, however PCTs have plans in place to provide support to these facilities and procedures are outlined in their individual MIPs.
  - a. Maintain close links with the Ambulance Service.
  - b. Provide some medical screening to ensure evacuees who have, or develop, medical problems receive necessary health care.
  - c. Assessing health needs of the evacuated people.
  - d. Arrange for the replacement of lost prescribed medicines.
  - e. Provide medical advice and information on the consequence of the incident.
  - f. Provide a health contribution to the welfare support of evacuees.

See Section 5 for the deployment of GPs and Community Nurses.

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## SECTION 7

### CHEMICAL BIOLOGICAL RADIOLOGICAL AND NUCLEAR INCIDENTS

#### Introduction

1. In the event of an accidental or deliberate release of a chemical, biological, radiological or nuclear (CBRN) agent C&T PCT will automatically take the lead and will be supported by C&V and West Glos PCTs.
2. The consequences of a deliberate release of CBRN agents are potentially enormous. It is likely that the number of casualties would far exceed that resulting from any previous major incident in the UK and all agencies would be required, at short notice, to find solutions to exceptional problems. As with other first responders, Health should adopt the dictum of 'doing the greatest good for the greatest number.'
3. Many of the people involved, sources of advice and organisational structures for dealing with a deliberate release will be the same as those that already exist for dealing with a major chemical incident or an infectious disease outbreak. However, the involvement of terrorists does mean that there are some important differences e.g. the Police will have absolute primacy in directing response to the incident and immediately invoke national mutual aid. The PCT, whilst not relinquishing its own responsibilities, will have a key part to play a key part in the overall response led by the Police Gold Commander.

#### PCT Response

4. The PCT is responsible for protecting the health of the population it serves and the Director of Public Health (DPH) will have a key role in responding to a CBRN incident. The Public Health Team (PHT) will be supported by the Consultant in Communicable Disease Control (CCDC) and the Health Protection Team (HPT).
5. Depending on the type of incident, both the PHT and HPT have comprehensive plans in place for the provision of initial advice, dealing with CBRN incidents and implementing procedures for managing long-term health issues resulting from an incident.
6. If required, the Police Gold Commander may request the PCT to establish a Joint Health Advisory Cell (JHAC) at the Police Headquarters or a Police Strategic Co-ordinating Centre. The JHAC is a strategic group, chaired by a DPH, nominated deputy or CCDC, which provides advice on the PH consequences of an incident and formulates advice for the Gold Commander, Health Community, other agencies and the public. The composition, deployment and management of the JHAC will be commensurate with the incident and formed as outline in the Gloucestershire JHAC Plan.
7. The pressure on the JHAC, and in particular the chair, may be intense and last for several days. The JHAC will be supported by the ICC at C&T PCT and additional personnel may need to be provided by the supporting PCTs to staff the Cell during a prolonged incident.
8. If the incident is more widespread than one PCT, then the Chair may be either a Director of Public Health who will take the lead on behalf of all PCTs in the affected area, the Regional Director of Public Health or the Regional Epidemiologist.
9. Close liaison between the JHAC, the Gold Command and the ICC will be essential.
10. The PCT will monitor those affected and implement measures to ensure that the public are kept informed and as safe as possible.
11. In consultation with the Police, JHAC, HPA and other appropriate agencies, the PCT may co-ordinate the issue of information to relevant organisations e.g. NHS Direct, to enable them to establish and maintain help line facilities to keep the public informed and reduce concern.

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12. A CBRN incident may result in large numbers of people being displaced, requiring Local Authority Rest Centres or Place of Safety being established requiring the PCT to provide appropriate medical assistance. Sections 5 and 6 outline PCT response to Rest Centres.
13. It is highly likely that a CBRN incident will be declared a Level 3 incident, resulting in Trusts implementing their mass casualty plans. This response may require:
  - a. Some normal clinical practises to be relaxed or dispensed with.
  - b. Areas/buildings not usually used to treat patients being opened to receive casualties. These may be holding areas with a triage facility and provision for dealing with minor injuries.
  - c. Medical staff may need to be transported from their normal working environment to support other health service providers.

Further information relating to dealing with mass casualties is outlined in Section 10 of the HMIM.

### **PCT, Regional and National Level Response**

14. The main response will be at the local level. However, CBRN incidents are acts of terrorism and the DH, Regional Office and Central Government will be involved. The following paragraphs set out the role and responsibilities of organisations that are likely to be involved in the response.

### **Health Protection Agency**

15. If required, the CCDC will call upon the support of the Health Protection Agency (HPA). The HPA have immediate access to their own specialists and external organisations including:
  - a. Specialists in communicable disease control – who will provide advice regarding tackling outbreaks of infectious diseases and methods to prevent the spread of disease through vaccination and other measures
  - b. Public Health specialists to support the PHT.
  - c. Infection control nurses.
  - d. Emergency planning advisers, who maintain a 24/7 callout to provide advice to the PCT.
  - e. Microbiologists – who study the organisms that cause infectious diseases.
  - f. Epidemiologists – who monitor the spread of disease.
  - g. Toxicologists – who study the effects of chemicals and poisons on the body.
  - h. Laboratory scientists and technicians.
  - i. Information specialists.
  - j. Scientists.
16. A CCDC will co-ordinate support from the HPA and ensure appropriate links are maintained with the Control Centre.

### **CBRN Plans**

17. This plan is based on the concept of 'Integrated Emergency Management' and builds on existing generic major incident procedures and plans held by the Local Authorities, emergency services and other responding agencies. The emergency services respond in accordance with established joint procedures, which are subject to continuous review. All Trusts have plans for dealing with and supporting the Health Community during a mass casualty incident. The following Trusts have specific comprehensive plans for dealing with a release of CBRN:
  - a. Ambulance Trust – Working within protocols agreed with the Fire Service, provide decontamination, triaging and providing medical services to casualties and transporting

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- patients to identified receiving hospitals. If required, deploying decontamination units to CHs, affected by the incident. The ICC may be required to co-ordinated this issue.
- b. Hospitals Trust – Decontaminating self reporting patients and procedures for triaging/admitting casualties from a CBRN incident.
  - c. Community Hospitals – have ‘lockdown’ plans in place for preventing self reporting casualties from contaminating hospitals and procedures for receiving decanted in-patients from the Acute Hospitals to free beds. (See section 8)
  - d. The Partnership Trust – if required, may provide transport, personnel and estates.
  - e. This Trust and C&V PCT have plans in place to open ISCs to support C&T PCT in responding to and managing a CBRN incident. This may also include dealing with the long-term health of any population affected by the incident.
18. The local level of response and roles and responsibilities of these agencies responding to a CBRN incident are detailed in the ‘MICG Joint Major Incident Procedures Manual’, held in the Major Incident Cupboard.

### ACCIDENTAL OR DELIBERATE RELEASE

19. Some of the major differences between dealing with a terrorist incident and a naturally occurring disease outbreak or chemical accident are:
- a. The numbers of actual or potential casualties. Normal Health resources could rapidly be overwhelmed. Abnormal solutions to exceptional problems will have to be considered.
  - b. The scale of public concern. The Police will be looking to the JHAC for advice on public statements.
  - c. There will be central government and national political interest. Special arrangements for co-ordination and control will be established at the Cabinet Office.
  - d. There may be advance warning of the location and type of release.

### Potential Scenarios

20. There are 5 potential scenarios:
- a. A warning of release but intervention prevents an actual release.
  - b. Warning of release followed by release.
  - c. Covert release without prior warning.
  - d. An overt deliberate act of terrorism.
  - e. A hoax.
21. The organisational arrangements described in the rest of this Section refer primarily to an incident for which there is some prior warning. As soon as the Police decide there is a credible risk of a terrorist attack, special arrangements, led by the Home Office nationally and Gloucestershire Constabulary, will be put into place. The Police are required to notify Health as soon as they become aware that there is a significant threat to public health.
22. The organisation of the response to a covert release is in the first instance likely to be the same as for an accident or naturally occurring disease outbreak. Casualties of a chemical release will require an immediate response by the emergency services. Detection of a covert release of biological agents, or some chemical agents, especially if introduced to the water supply or food, will depend upon astute clinicians detecting abnormal disease presentations and communicating their findings to clinical and public health colleagues. Current routine surveillance systems may be slow to detect cases that could follow a deliberate release of a biological agent. Following a completely covert biological release it is likely that the health services first suspect a deliberate release.
23. The Police must be informed immediately if **any** deliberate release is suspected.

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## Chemical

24. Knowledge of the nature of the site affected by an accidental chemical release, (perhaps based on regulatory requirements), makes it likely that some information will be available at an early stage about which chemicals or groups of chemicals are involved. This information would not be available following a deliberate release and there may even be deception.
25. The symptoms and signs shown by those who have been exposed may make it possible to speculate about the nature of the chemical involved but definitive identification may depend on urgent chemical analysis of soil and other materials from the site of release. Blood or urine samples may also have to be taken from victims with symptoms or with evidence of exposure to estimate the degree of exposure, aid clinical management, assist epidemiological follow up and for forensic purposes.
26. It is important that there should be plans for the collection of appropriate samples from the exposed or potentially exposed. The PHT or HPT will arrange for these samples to be taken, not only at the incident site, but also at remote sites where there are victims, emergency services personnel, hospital staff, and possibly even 'unexposed' members of the public. The purpose of sampling may be to:
  - a. Assess the extent of the exposure.
  - b. Prove lack of exposure.
  - c. Aid clinical management.

## Biological

27. Biological agents, especially those with a capacity for person to person spread are potentially even more devastating for a civilian population than chemicals. It is known that the Aum Shinrikyo sect (which was responsible for the Sarin attack in Tokyo) had a large facility for the manufacture of chemical and biological agents. It is also possible that terrorists could obtain biological agents from the governments of countries sympathetic to their cause.
28. Biological agents used as weapons can be produced easily and cheaply, they can inflict large numbers of casualties over a wide area with minimum logistical requirements, and there are very serious difficulties of detection, protection and treatment. Very small quantities can produce devastating effects thus making them very easy to transport and conceal.
29. The release of a biological agent may be overt or covert. If announced, details given may be vague, inaccurate or deliberately misleading.
30. The NHS has well established procedures for dealing with outbreaks of infectious diseases. These procedures will be used in the event of a deliberate release. However, a deliberate release may present special difficulties. For example, the agents used, the concentrations of infectious material and the methods of dispersal may be unfamiliar to those responsible for preparing plans or responding to incidents. Moreover, surveillance systems are not well tuned to detecting a deliberate covert release, resulting in unusual disease presentations.
31. Unlike a chemical release where the effects are immediate, the effects of a biological release are likely to be delayed and prolonged for the following reasons:
  - a. People exposed are unlikely to know immediately that they have been affected.
  - b. Incubation periods between infection and development of symptoms may vary from 1 day to 2 weeks and exceptionally longer.
  - c. A single aerosol release may continue to be effective for sometime after it is discharged.
  - d. Material dispersed will be deposited on clothing, equipment, the ground and surfaces. When these surfaces are subsequently disturbed secondary dispersal may occur.
  - e. Slower methods of dispersal could be used in the first instance e.g. contamination of the food chain.

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- f. Secondary infection of contacts may lead to epidemics. This is only considered at all likely for plague and smallpox.
32. There are currently no effective monitoring devices giving a rapid indication of the presence of biological agents. Response should ensure that sampling arrangements take account of the biological hazards.

### **Radiological and Nuclear Incidents**

33. NHS response to a radiological or biological incident will depend on the type of incident. It is highly likely that considerable support will be provided by the PHT and HPA.

### **NHS Response**

34. Trusts already have plans for the control of naturally occurring outbreaks of infectious disease. The following points are either unique to a deliberate release or will need greater consideration than for a naturally occurring outbreak:
- a. Confirmation of scale and nature of threat.
  - b. Restriction of access to potentially contaminated areas.
  - c. Immunisation, desirability and availability.
  - d. Public information.
  - e. Guidance for health professionals.
  - f. Availability of suitable laboratory facilities to deal with very large numbers of specimens.
  - g. Ability of the NHS to deal with large numbers of patients with infectious disease.

### **'White Powder' Incidents**

35. The MICG has agreed a joint agency response for dealing with 'White Powder' incidents. Procedures are outlined in the 'MICG Joint Major Incident Procedures Manual', held in the Major Incident Cupboard.

### **Preventing Exposure - Shelter or Evacuation**

36. The PCT has a responsibility to protect the health of the population and will be consulted by the Police at the earliest opportunity after they become aware of any threat to health. During or following a terrorist incident the Police have powers to control the movement of the population from within a cordoned area.
37. Sheltering or evacuation is an issue which may arise during the initial response phase and the ICC Co-ordinator may become involved in the decision making process at a very early stage. Although, in consultation with appropriate agencies, the Police will lead and have final responsibility for shelter or evacuation, the PCT must make every effort to provide the Police with accurate and timely information to enable them to make the most appropriate decision.
38. A decision to evacuate or continue with shelter could be contentious and subject to hindsight. It may well be that such decisions are challenged in litigation or other process. It will therefore be essential to ensure that decisions taken, or not, and the supporting considerations are comprehensively documented. In all cases the overall priority must be the safety of the public and emergency responders. This must be the focus of the decision making process and other factors e.g. commercial considerations must not be permitted to interfere in achieving this objective.
39. In the event of a deliberate or threatened release of a toxic agent, it is for the Police to decide whether to advise people to take shelter or to evacuate. In reaching their decision, they will receive scientific advice from the Chemical and Biological Defence Agency, Porton Down and will also consult with the NHS, which may require an expedient response.

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## Shelter

40. National guidelines suggest that the public should be encouraged to shelter, **unless there is a clear and obvious danger to life** and the agreed national warning should be used:
- Go In** (go and stay indoors, go upstairs where possible, do not collect children from school they will be properly cared for).
  - Stay In** (close all doors and window, extinguish all fires, keep away from windows).
  - Tune In** (to local radio for further details, do not use the phone, keep lines free for emergency use only).
41. Any changes in the situation may require a decision to evacuate which will then be taken by the Police Incident Commander with advice from other agencies including the Fire Service. This may be a decision that is taken by the Silver Commander, having consulted the PCT.
42. As further information becomes available, this will need to be applied to the decision-making process which will need to be re-evaluated and may modify the NHS response. Decisions will have to be made in the face of considerable uncertainty and the decision process will be a continuous process.
43. The identity of the material may not be known for some time, if at all, during the incident. There may be deliberate mis-information about the nature, quantity and point of release. It is important, where possible, to obtain best information, including estimates of the amounts of the material(s) involved, as well as access to the proper interpretation of the data.

## Evacuation

44. Whether or not to evacuate populations depends ultimately on an evaluation of the health benefit in doing so. Assessment of the health risks to the general population requires the skills of the PHT and HPT supported by appropriate specialist advice. Mass evacuations may only add to the public risk. Research shows that, in most cases, evacuation may expose the public to greater danger than other measures, but must be considered.
45. In general, the Police have no statutory power to enforce an evacuation, except the provision under Section 34 Terrorism Act 2000 to designate a cordoned area and instruct all persons to leave that area. Whilst police officers have a common law duty to take all reasonable steps to save/preserve life, they have no authority to remove persons from their property against their will.
46. Evacuation of all those within the possible downwind hazard to a safe place by a safe route would be one approach. This presupposes that:
- There is time to achieve evacuation before the hazard arrives.
  - Evacuation is practically possible.
  - The public will readily comply with the Police order to evacuate.
  - The risk of evacuating potentially large numbers of individuals is outweighed by the likely harm from exposure.
47. Factors (many of which are interdependent) affecting the decision to evacuate include:
- The nature and quantity of the material(s) involved or identified.
  - The means of dissemination of the material.
  - The size of the area involved and the numbers to be evacuated.
  - The likely duration of the hazard.
  - The existing and forecast meteorological conditions.
  - The availability of suitable routes for evacuees, and whether those routes can be adequately controlled.

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48. Additional information regarding evacuation and shelter can be found in the MICG Joint Major Incident Procedures Manual.

### Decontamination

49. The Ambulance Service will, in conjunction with the Police and Fire and Rescue Service, respond in accordance with established joint procedures, which are subject to continuous review. This will require all casualties to be decontaminated prior to any resuscitation, treatment or transport. Focusing the main effort of decontamination at the incident site minimises the risk of secondary contamination, particularly of vehicles transporting casualties and hospitals. However, the large numbers of people likely to be exposed in a non-accidental release may make the ideal of rapid forward decontamination impossible. Although further work needs to be done on this subject, a general principle is that liquid chemical contamination must be removed as soon as possible and is very unlikely to be present beyond the immediate point of release.

### Modesty and Equipment Pods

50. There is a 'UK Reserve National Stock for Major Incidents', particularly resuscitation equipment, drugs and clothing/towels which may be needed when dealing with the casualties of CBRN or mass casualty incident. These supplies are in pre-packed Pods (containers) and are designed to enhance and support the capability of hospitals and the Ambulance Service airway management, antidotes and clothing casualties following decontamination. Pods are held on a regional basis and mobilisation is in accordance with a national plan, co-ordinated by the Ambulance Service.

## NATIONAL RESPONSE

### Central Government Response

51. The fundamental principle in dealing with any major incident is that the first response is at the local level. However, a terrorist incident is of such political significance and of such media and public interest that Central Government will be involved as soon as the nature of the incident becomes apparent.
52. The lead Government Department in a terrorist related incident is the Home Office. If necessary a special Cabinet Committee will be chaired by the Home Secretary or a senior Home Office official to determine Government policy.
53. The DH is responsible for advising the Government on public health matters and on the operational response of the NHS. Health Ministers or senior officials will represent the DH on the Cabinet Office Committee. The Chief Medical Officer may be required to provide appropriate advice to the public at a national level.
54. The Emergency Planning Co-ordination Unit, which is part of the DH, will, in the first instance at least, act as the focal point, co-ordinating the Department's involvement with Central Government response.

### Co-ordination of Multi Agency Response

55. The arrangements for responding to the credible threat of a release of chemicals or biological material are unusual because the response may be initiated by the Strategic level, it involves Central Government as a key player and the military are likely to be involved. It is critical therefore that the response is genuinely multi-agency and communication between all agencies is of the highest order. Ministers and senior officials representing the appropriate departments lead the Central Government involvement from the Cabinet Office Briefing Room, known as COBR.

### Notification and Confirmation

56. Any terrorist incident is a crime and the Police Incident Commander remains in operational command. As soon as it appears that a terrorist threat or action has taken place, the Police

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will notify Central Government and the national plan will be brought into operation to augment local resources. This will involve a range of national assets, some of which focus on the management of the crisis (preventing or mitigating the incident itself), whilst others concentrate on consequence management. A Government Liaison Officer from the Home Office leads a Government Liaison Team based at the Police Strategic Co-ordinating Centre, which will include a member of the Cabinet Management Liaison Officer.

## OTHER ISSUES

### Deceased

57. There could be a substantial number of fatalities and bodies are likely to be contaminated or infected. No bodies are to be removed without Police approval. Responsibility for the dead rests with the Coroner and the County Council is responsible for establishing temporary mortuaries. Guidelines for disposing of contaminated bodies will be provided by the PHT or HPT.

### Media Management

58. A deliberate release or threatened release will attract intense media interest and will be managed by the Police in accordance with the Gloucestershire Joint Agency Major Incident Media Plan.
59. As with any major incident, it is important to keep the media accurately and regularly informed and, when appropriate, to harness their resources to help manage the incident. In particular, they could have an important role in the public dissemination of information on sheltering and the potential hazards of self-evacuation. **Press releases on the public health aspects of a CBRN incident must be agreed by JHAC and the Police Gold Commander's Co-ordinating Group.** They may also need to be agreed by the Cabinet Office Co-ordinating Group.

### Training

60. The rarity of major releases of hazardous materials (intentional or otherwise) means that most individuals, even those in the emergency services, will have little personal experience of a situation where rapid response times are essential, and where hazardous materials pose a real risk to all health care providers. All staff, from managers to those delivering acute care require appropriate training if incidents are to be managed effectively and safely. This training will involve an integrated approach between all responding agencies.

### Long-Term Health Issues

61. Though the emergency response may be over at this stage, the public health consequences acute, delayed and/or chronic may persist for several hours, days or longer, depending on the nature of the material, duration of human exposure and the level of environmental contamination or persistence in environmental media. The PCT will need to take advice on long-term follow-up of exposed individuals. The National Focus will assist or direct in this respect.
62. The incident itself may have disrupted Ambulance Services through their being diverted or temporarily appropriated, or where crews and emergency response vehicles have been contaminated or affected by the hazardous substances. Similar considerations may apply to health service providers and the PCT must support a return to normality, which may require the support of the SHA and other organisations.

### Recovery

63. The PCT will have a lead role in the recovery phase, restoring normality and considering the medium and longer-term Public Health issues. This may include the immediate and ongoing Public Health issues of the affected area and the provision of information and advice for the restoration of public confidence.

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- 64. A special planning group for reoccupation and recovery of the community may be set up early in the incident to prepare advice and proposals for the Gold Commander. On request of the Gold Commander and the County Council Chief Executive will decide who should lead such a group and Health will be consulted on the composition of the group.
- 65. The core of the group should include representatives from relevant Local Authority departments and other agencies. It is expected that Gold will hand over control to the Local Authority at the end of the incident, and that the group will continue to meet and co-opt other representatives required, until normality is restored.

**Decontamination of Premises**

- 66. Some Health establishments may have been contaminated and require specialist advice regarding decontamination. If required, the PCT will liaise with the Local Authority, Environment Agency and HPA regarding building decontamination.

**General**

- 67. A deliberate release of any CBRN agent will place extraordinary pressures on the NHS and the PCT will take a flexible approach to providing support to health service providers. Plans will enable an appropriate command and control structure to be quickly put in place and provide support to the Gold Commander. Central Government and DH involvement will require the PCT to support decision makers e.g. Health Gold and the DPH Chairing JHAC, make well informed decisions.

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## SECTION 8

### COMMUNITY HOSPITALS

#### Introduction

1. This Section deals with the emergency planning issues relating to the PCT Community Hospitals and relate to the following CHs:
  - a. Lydney Hospital, Grove Road, Lydney, Gloucestershire GL15 5JF
  - b. Dilke Memorial Hospital, Cinderford, Gloucestershire GL14 3HX

#### Purpose

2. The purpose of this plan is to enable the CHs to respond to and support the Health Community during major incident. The objectives are as follows:
  - a. To provide clear and concise guidelines for Community Hospital staff in responding to a critical or major incident.
  - b. To ensure that procedures are linked with the PCT, Gloucestershire Hospitals Foundation Trust (GHFT), Social Services, Ambulance Service Major Incident Plans and the Gloucestershire Health Community Joint Critical & Major Incident Manual (HMIM).
  - c. To provide guidance regarding the assessment and management of incidents, regardless of their nature.
  - d. To ensure an integrated response.
  - e. To provide links with external agency plans and procedures.
  - f. To ensure Business Continuity Management Plans (BCM) are in place to ensure continuation of service delivery during a major incident.
3. This Section provides guidance regarding incident management, regardless of the size and complexity of a CH. Each CH will produce Incident Operational Guides for key appointments, outlining individual roles and responsibilities. The Guides provide clear and concise guidelines and contain:
  - a. Brief regarding roles and responsibilities.
  - b. Action Card.
  - c. If required, an Emergency Contacts Directory.
  - d. Relevant quick reference information to enable the user to carry out the required actions.
4. The guides will be raised and maintained by an appointed person and issued to key staff with a role in dealing with or managing response to an incident.
5. Emergency planning procedures outlined in other Sections of this document also apply to the CHs e.g. dealing with children and people with special needs.

#### Alerting Categorisation of 'Major Incident'

6. The objective of categorising a 'Major Incident' is to ensure immediate economical response of required resources best suited to deal with a particular type of occurrence. The system will allow the CH to quickly establish an appropriate management structure in accordance with the procedures outlined in Section 4. There are three categories of major incident and three levels of response, which are also outlined in Section 4.

#### Alerting Procedures

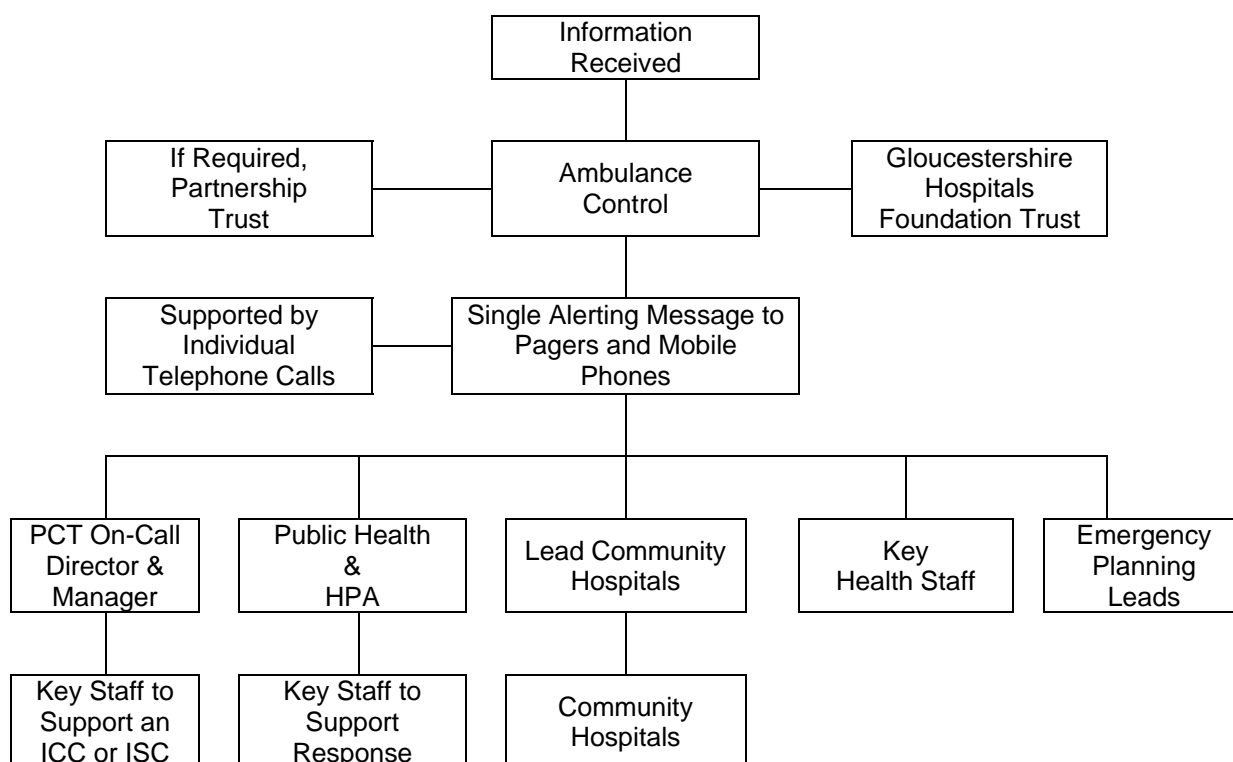
7. In addition to individual alerting procedures, Ambulance Control has the ability to transmit a single message to on-call pagers and key staff mobile phones to quickly disseminate alerting messages and initial information.

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8. Each PCT has identified a lead CH for receiving incident alerting messages and initiating response, as outlined in the following paragraphs. The Lead CH are:
- a. Cheltenham and Tewkesbury PCT: **Tewkesbury Hospital**
  - b. Cotswold and Vale PCT: **Cirencester Hospital**
  - c. West Gloucestershire PCT: **Lydney Hospital**

When alerted, the Lead CH will cascade the information to the other CHs within their PCT area and, if required, take predetermined actions.

9. Major incident lines of alerting for Health are as follows:



### Command and Control

10. Once alerted the PCT On-Call Director will decide which PCT should open an Incident Control Centre (ICC) and if the other PCTs are required to establish Incident Support Cells (ISC). Section 4 outlines the Health command and control function.

### PCT Support

11. In the event of an incident occurring, the CH may quickly require the support of the PCT and the CH Incident Manager should establish a CH Control Room and communications with the PCT Control Centre.

### Community Hospitals Response

12. There may be an occasion when the CH is the first to receive casualties from an accident e.g. self reporting casualties or information relating an incident. Should this occur, Ambulance Control must be immediately contacted via the '999' system and alerted to the incident.
13. If the casualties have come from a chemical incident or are contaminated with an unknown substance, staff may wish to immediately 'lockdown' the Hospital to prevent contamination. See Section 7. Contaminated casualties and staff already in the Hospital are to be immediately isolated from staff and patients. See Section 7 for guidance regarding response to a CBRN incident.

14. The following paragraphs detail issues that may need to be considered by a CH regarding accepting casualties from an incident or in-patients decanted from GHFT.

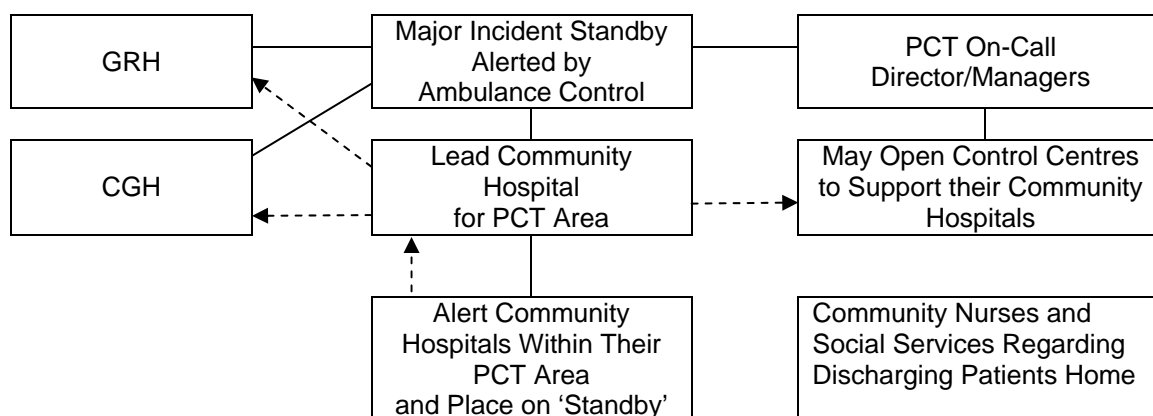
### Escalation

15. Procedures for dealing with an escalating incident are outlined at Section 5 and further details are provided in the HMIM. In addition to treating/admitting casualties for an incident, the CH will also have plans in place to accept in-patients from GHFT to increase bed capacity within the Acute Hospitals.

### Decanting Operation

#### Major Incident Standby

16. The Lead CH will receive the initial message from Ambulance Control and will alert CHs within their area, provide them with a brief about the incident and ask them to consider the following:
- Implementing 'Action Cards' relating to a Major Incident 'Standby'.
  - Assess current in-patient status.
  - Establish which patients could be discharged.
  - Consider cancelling planned admissions and the associated implications.
  - Completing a 'Bed Availability Form' to be faxed to the Lead CH on the identified number.
  - Consider staffing levels
  - Alert key staff and, depending on the type of incident, instruct them to return to their place of work.
17. Upon receipt of the 'Bed Availability Form' the Lead CH will fax the information to both Acute Hospitals and the PCT Control Centre.
18. Placing CHs on 'Standby' provides time for staff to come to a state of readiness in preparation for a co-ordinated response should a Major Incident be 'Declared' and decanting required. It is far better to be ready to respond to an incident than initiate procedures after a major incident has been declared.
19. The Lead CHs will brief their PCTs regarding progress and, if established, form links with their PCT Control Centres.
20. The following flow chart shows the lines of communication relating to a Major Incident 'Standby'.



Flow of 'Bed Availability Form' ----->

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**Major Incident Declared**

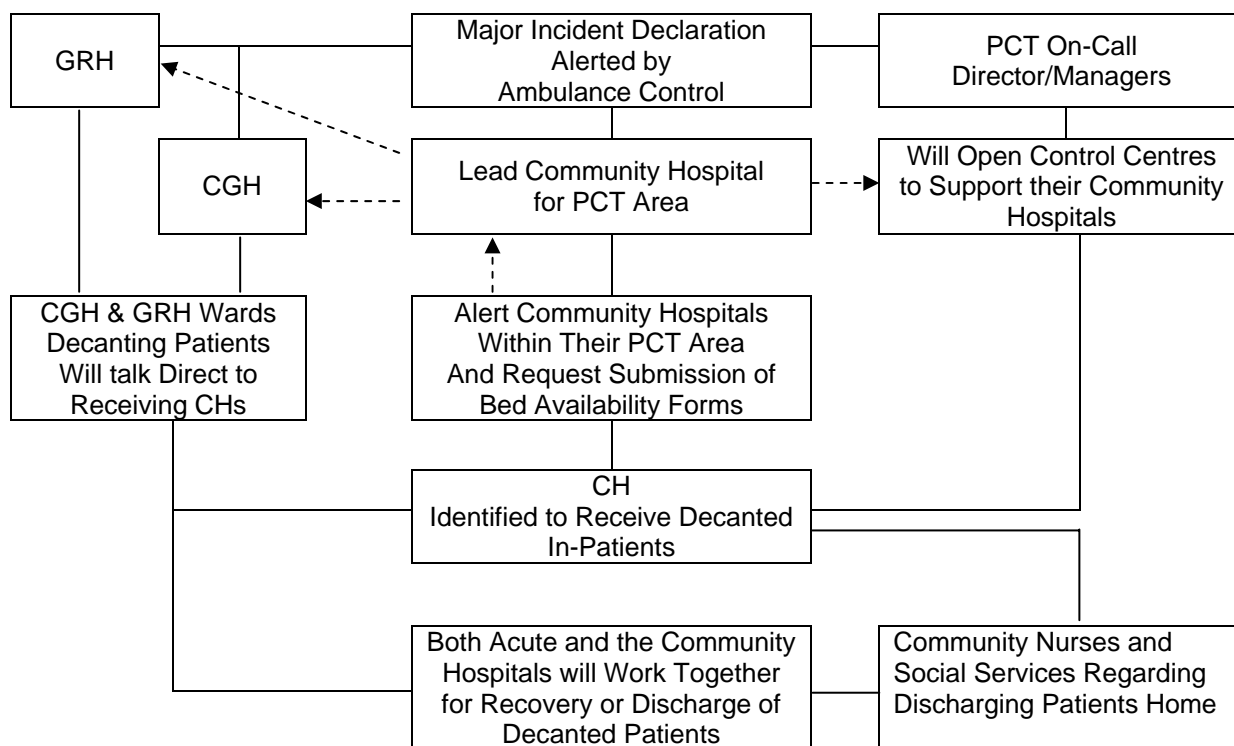
21. The Lead CH will alert the CHs in their area and request the following:
  - a. Implementing 'Action Cards' relating to a Major Incident 'Declared'.
  - b. Senior Nurse to assess current inpatient status.
  - c. Establish which patients can be discharged early
  - d. Complete a 'Bed Availability Form' and fax to the Lead CH on the identified number.
  - e. Implement staff cascade call out procedure and recall to their place of work.
  - f. Dependent upon the type of incident, consider expansion of existing capacity to cope with large numbers of patients. Any further capacity must be relayed to the Lead CH.
22. In certain circumstances CHs may not be placed on 'Standby' but Major Incident 'Declared' may be the first alert received.
23. The Lead CH will collate the 'Bed Availability Forms' and fax to the Bed Management Offices at both the Acute Hospitals and the PCT Control centre.

**Decanting**

24. When it becomes apparent that in-patients will be decanted, the GHFT Ward staff will contact identified receiving CH direct and the following protocols have been agreed:
  - a. Full use will be made of available resources within each hospital in the Trust before outside assistance is requested.
  - b. It will be the responsibility of all CH wards across the County to free up as much space as possible based on sound clinical assessments.
  - c. Clinical decisions will be made in conjunction with the CH capacity to care for the decanted patients.
  - d. Sound clinical decisions on patient stability and suitability for internal transfer or discharge will be paramount, but in exceptional circumstances a lower threshold for suitability for internal transfer may need to be made where the dictum '*doing the greatest good for the greatest number*' may need to be applied.
  - e. Wherever possible, patients will be transferred to a CH in their locality; however this will not preclude transfers of patients to a CH in a different area if circumstances dictate.
  - f. When patients are decanted they will be transferred with the necessary specialist equipment, dressings and drugs if these are not available at the receiving hospital.
  - g. Transport for patients to be decanted to other hospitals will be co-ordinated by Ambulance Control via Ambulance Liaison Officers at each Acute Hospital.
  - h. At the conclusion of a major incident, the Acute Discharge Assessment Teams will liaise with those CHs which received patients to discuss any problematic placements and/or discharge issues.

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25. The following chart shows the lines of communication relating to alerting and the management of decanting in-patients from an Acute Hospital to the CHs:



Flow of 'Bed Availability Form' ----->

### Major Incident Cancelled

26. A Major Incident 'Standby' or 'Declared' will be formally terminated by a Major Incident 'Cancelled' message from Ambulance Control or the PCT Control Centre.
27. It is incumbent on the Senior Nurse (Incident Manager) to implement stand down procedures as quickly as possible. Procedures must ensure that staffing levels and NHS procedures return to normal as quickly and efficiently as possible. The following will need to be considered:
- Commencing 'hot' debrief, see Section 4.
  - Standing down additional staff no longer required
  - Assessing decant patients and, if required, liaise with GHFT Wards regarding discharging or retention issues.
  - If required, contacting PCT to request assistance to enable Hospital to return to normality i.e. contract cleaning or an emergency resupply of clinical equipment.
  - Considering staff involved for possible Post Traumatic Distress Disorder, see Section 4.
  - Collating and securing all information/paperwork relating to the incident, see Section 4.
28. PCTs will have an important role in ensuring a well managed return to normality and the provision of appropriate support to their CHs.

**PCT Support**

29. If required the CH Incident Co-ordinator can request support for their PCT Control Centre. The following paragraphs outline some of the issues that may need to be considered:

**CCSD Supplies**

30. As outlined in the Acute Hospitals 'Bed Management Strategy', decant patients should arrive at CHs with a supply of dressings, drugs etc from dispatching hospital.

**Equipment**

31. Gloucester Industrial Services (GIS) has plans in place for the emergency provision of community equipment to enable CH to discharge patients as required.

**Bed Linen**

32. Local company has an agreement (i.e. Sunlight) that they can be called out in an emergency as outlined in Hospital BCM Plans. If, due to the incident, problems are encountered, the PCT will arrange for additional supplies to be made available.

**Pharmaceutical**

33. The Local Pharmaceutical Committee has produced a contingency plan to facilitate access to pharmaceutical items and access to Pharmacists within the County. PCT has copies of the plan and the procedures to be followed.

**Catering**

34. Dependent upon location, individual CH will utilise local services as outlined in their BCM Plans. Under certain circumstances they may require assistance from PCT.

**Transport**

35. Local arrangements should be in place for the movement of patients from the Community Hospital to home. It cannot be assumed that the Ambulance Patient Transport Services will be available. The Community Hospital may need to call upon the assistance of the PCT to arrange transport.

**Medical Gases**

36. An emergency supply of medical gases can be sourced via a 24/7 callout service. Contact details are known by each CH and are identified in the Hospital BCM Plan.

**Security**

37. A Local Security Management Specialist will regularly conduct a security review of all CHs and this will include actions to be taken during a major incident.

**Media**

38. Managing the media forms an integral part of emergency planning systems. A Gloucestershire Joint Agency Major Incident Media Plan incorporates the procedures and responsibilities of NHS personnel responsible for liaising with and managing the media. See Section 5 of this plan and Section 6 of the HMIM outline procedures for dealing with the media. The PCT is to be immediately informed of any media interest at a CH and media management handed over to a Communications Lead.

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### Religious and Ethnic Needs

39. If the event generates a number of casualties self reporting with religious or ethnic needs, the PCT Control Centre have procedures in place for accessing Local Authority support. Depending upon the type and location of the incident, which may result in a centralised service, accredited volunteers may be deployed to support the CH. See Section 5.

### Business Continuity Management

40. BCM is a statutory obligation and each CH has a comprehensive BCM plan detailing procedures to be adopted in response to an incident that threatens service provision. Staff are familiar with these plans and procedures to be followed.

### Dealing with People/Children with Special Needs

41. Dealing with children and people with special needs require special considerations. Section 5 of this plan and Section 7 of the HMIM outlines procedures to be adopted and staff should be familiar with appropriate NHS protocols.

### Risk Management

42. Risk management is an important part of major incident planning. Section 11 HMIM details key points for risk management process, conducting both a formal and visual risk assessment and general Countywide risks.

### Training and Exercising

#### Staff Training Requirements

43. Both PCT and CH staff, with key responsibilities linked with major incident management, will be trained in their roles and responsibilities. Appropriate staff will be identified to conduct the training and local training strategies identified and implemented. Training records are to be maintained.

#### Exercising and Testing

44. Local procedures will be regularly tested and, when appropriate, CHs will become involved with both PCT and Countywide exercises. Exercise and testing records will be maintained.
45. Section 1 of the HMIM outlines training and exercise requirements.

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## SECTION 9

## DISTRIBUTION

Organisation - Internal NHS:	Designation	Doc	PDF
West Gloucestershire PCT	CE		
	Dir Ops		✓
	EP Lead		✓
	DPH		✓
	HPA		✓
	Communications Lead		✓
	Lydney Hospital		✓
	Dilke Memorial Hospital		✓
Cotswold & Vale PCT	CE		✓
	Dir Ops		✓
	EP Lead		✓
	DPH		✓
	County Communications Lead		✓
Cheltenham & Tewkesbury PCT	CE		✓
	Dir Ops		✓
	Asst Dir (E&CP)	1	
	DPH		✓
	HPA (CCDC)		✓
	Communications Lead		✓
	Local Security Management Specialist		✓
Acute Hospitals Trust	CE		✓
	Dir Ops		✓
	EP Lead		✓
	CBRN Lead		✓
	GRH		✓
	CGH		✓
Partnership Trust	CE		✓
	EP Lead		✓
Gloucester Ambulance Service	CE		✓
	Dir Ops		✓
	Dep Dir Ops		✓
	EP Lead		✓
	CBRN Lead		✓
AGW Strategic Health Authority	Lead Director		✓
	EP Lead		✓
HPA	RHEPA		✓
	CCDC		✓
NHS Direct	General Manager		✓
<b>External Agencies:</b>			
Emergency Management Service	Senior Emergency Planning Officer		✓
Environment Agency	Emergency Planning Lead		✓
Gloucestershire Constabulary	Contingency Planning		✓
Gloucestershire Fire and Rescue Service	Head of Risk Management		✓
Military (HQ 43 (Wessex) Brigade)	Deputy Liaison Officer		✓