Major Incident Plan
(abridged version)

Salisbury NHS Foundation Trust

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Role responsible for revisions - Emergency Planning Lead
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APPENDIX A - Emergency Department Chemical Incident Plan
version 1.1 (Abridged)

APPENDIX B – Antiobiotic Collection Centre Plan version 1.0
(Abridged)

APPENDIX C- Burns Escalation Incident Plan version 1.0 (Abridged)
Foreword by Trust Chief Executive

At Salisbury Foundation NHS Trust as with all NHS organisations we have a responsibility to provide planned and emergency services but also to respond to a Major Incident if one occurs.

Health Services and their provision are always important to local people. This is all the more true if a Major Incident occurs.

It is expected that the response to an incident will be appropriate and well co-ordinated within the hospital and with the emergency services, other health partners and local authorities. This does not happen by chance and well documented, well understood plans are vital in providing a framework which allows staff to perform at their best during periods that inevitably test systems and capacity.

Much of this plan (which is endorsed by the Trust board) is about communications internally and externally and getting this right is crucial to the effectiveness of an organisation during a significant Incident.

Recent events, well publicised in the media, tell us that nowhere is immune to the potential for incidents resulting in significant numbers of casualties and it is necessary that we as an organisation and all our staff prepare to provide a response to such an incident. That response must provide high quality care to patients and be sustainable over the duration and after an incident.

The Major Incident Plan has been produced to ensure that we are able to respond to the demands of an incident and that we are able to meet our responsibilities as a “category one” responder under the Civil Contingencies Act. (CCA) These include:

- Assessing the risk of emergencies occurring and use this to inform contingency planning;
- Putting in place emergency plans;
- Putting in place Business Continuity Management arrangements;
- Putting in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Sharing information with other local responders to enhance co-ordination;
- Co-operating with other local responders to enhance co-ordination and efficiency

Every member of Trust staff is responsible for ensuring that they are well prepared to take the necessary actions to enable the Trust to respond to a major incident. It is therefore your responsibility to read this Major Incident Plan carefully. Make sure that if a major incident happens, you know the following:

- What is expected of you
- What the role of the department in which you work is
- How your responsibilities integrate with those of your colleagues and other departments with whom you work

I therefore commend this plan to you and urge you to read it and to discuss it within your departments, service units, and directorates to help you and the organisation as a whole prepare to meet the challenge.

Caspar Ridley
Chief Executive
Introduction to the Plan

1. PURPOSE OF THE DOCUMENT

The aim of this plan is to enable Salisbury NHS Foundation Trust to respond effectively to a Major Incident. It provides guidance for staff in the assessment and subsequent management of both internal and external Major Incidents. The plan includes:

- Initial action in the event of a Major Incident and subsequent stages for future operational management
- Membership and key responsibilities for the main teams
- Key locations
- How the SDH site will operate during a Major Incident
- Confirmation of communication channels
- Management of mass casualty, biological or chemical Incidents
- Management of burn major incident patients and the Trust’s response to a national burns major incident
- Action Cards for key staff
- CRBN Plan

This local response to an Incident is part of a Health Economy wide response, the Wiltshire element of which is reflected in the Wiltshire-wide Major Incident response plan.

NB: Accident and Emergency (A&E) is called ED (Emergency Department) in this plan

2. STAKEHOLDER INVOLVEMENT AND PLAN CIRCULATION

This plan reflects collaboration within Salisbury NHS Foundation Trust and with partner organisations via the Local Resilience Forum Health Sub-Group, which includes representation from Acute Trusts, Primary Care, the Health Protection Agency, the Ambulance Service, Wiltshire Police, Mental health and the Military.

The plan has been widely circulated in its final form to partner organisations who are to be alerted to significant changes in the plan should they occur.

3. DEFINITION OF A MAJOR INCIDENT

A Major Incident is defined as: “any occurrence which presents a serious threat to the health of the community, disruption to operational services or causes such numbers of casualties as to require special arrangements to be implemented by the emergency services”. A Major Incident will normally be invoked by the Ambulance Service, Police or Fire Brigade, but the implementation of this plan may also be initiated by the ED Consultant or the Trust’s Duty Manager particularly where an Incident or Incidents
overwhelm local resources and routine capacity. The Local Authority or Primary Care Trusts may also invoke a Major Incident.

4. ENDORSEMENT

This plan is endorsed by:-
• Salisbury NHS Foundation Trust (SFT) CEO
• Emergency Department lead clinician
• Trust Emergency Planning Lead
• Emergency Planning lead at NHS Wiltshire

5. SUPPORTING PLANS

• This plan is supported by:-
• The Wiltshire & Swindon Health Services Major Incident Strategic Response
• SFT Pandemic Influenza Plan
• SFT Business Continuity Policy
• Facilities Directorate Major Incident Plan
• National Burns Major Incident Plan
• Great Western Ambulance Service Major Incident Plan

6. COMMAND & CONTROL

In the event of a Major Incident, command and control arrangements will be established by the emergency services. If there is a Major Incident scene, a Forward Control Point will be established on site called Bronze (or Operational) Control. A Silver (or Tactical) Control point may then be established just outside the scene to manage resources approaching the scene, and a Gold (or Strategic) Command Centre will be established at some considerable distance away from the Incident scene. Gold Command, if needed, is likely to be established at Police Headquarters in Devizes. The NHS may also establish Command & Control arrangements, and are likely to establish the NHS Silver Control Centre either at the Avon, Gloucestershire & Wiltshire Strategic Health Authority in Chippenham, or at the offices of the relevant Primary Care Trust. If such command control arrangements are established, Silver or Gold Command will inform the Trust Control room team which forms the link between these external command and control structures and the internal response.
7. INITIATING THE TRUST'S MAJOR INCIDENT RESPONSE

In flow diagram form the initiation looks like this:-

**Detail of initiation**
Upon receiving a call alerting the ED to a potential Major Incident the ED Nurse Co-ordinator (NCO) will contact the ED consultant (MCO). The MCO will decide if stand-by needs to be declared.

**7.1 Stand-by** This indicates that the hospital *may* need to respond to a Major Incident.

**STAND-BY** can only be called by the MCO, or, in the absence of an MCO and in the event of failure to contact one, by the NCO.

**7.1.2 Stand-by key Actions:**
a) If stand-by is declared the NCO will contact switchboard and request that the Control room team and Burns On-call consultant (if Burns Major Incident) are called out.

b) The NCO will contact the site co-ordinator and inform them that the hospital is on STAND-BY to receive patients.

c) Members of the Control room Team, including the MCO will make their way immediately to Major Incident Control Room 1, which is situated in the Orthopaedic outpatient department.

d) The Clinical Site Co-ordinator will be asked by the NCO to obtain accurate current and potential bed-states.

e) The Control room Team will assess the situation with the MCO and will decide whether to remain on STANDBY, or whether to proceed to LIVE Major Incident status. **Most staff will therefore only be informed of a Major Incident at the live phase.**

f) At Major Incident Standby, the ED Team will prepare to receive casualties. The NCO will make immediate arrangements for the admission or discharge of existing ED patients. Patients in the ED Waiting Area will be informed of the situation and advised to seek treatment from alternative health care providers including GP practices and NHS Walk-in Centres as appropriate. Orthopaedic outpatients and plastic outpatient departments will be asked to inform patients currently waiting of the STAND-BY phase.

7.2 Live - This means the hospital is actively involved in a Major Incident response and all staff must implement the Major Incident Plan immediately. The implementation of this plan will vary depending on the nature of the Incident. **LIVE can only be called by the MCO or the Duty Manager and will usually be called jointly following discussion.**

7.2.1 LIVE Key Actions

7.2.1 If the Major Incident is LIVE, the Duty Manager will instruct Switchboard to call in those staff on their prepared list. Those called by switchboard will implement their respective action cards including cascading to colleagues if indicated.

7.2.2 If the Major Incident is LIVE, the specialty receiving is **BURNS** and we are either the receiving ED or host burn service, then the National Burn Bed Bureau must be contacted immediately by the Duty Manager following discussion with the burns on-call consultant. Contact details can be found in Control Room 1 box file.

7.2.3 Once a Major Incident is LIVE, a broadcast message will be sent out by the Press Manager (Appendix 11) informing all staff to keep the use of computers to a minimum and to refrain from using the telephone system. Further broadcast messages will be sent out updating staff on current situation by the Press Officer. Messages
will also be displayed on the Plasma screens in waiting areas informing patients waiting for outpatient appointments.

7.2.4 If SDH is declaring the Major Incident the ‘Emergency Planner – Wiltshire’ should be paged by the duty manager – pager number as on the telephone list.

7.2.5 If anticipated casualty numbers are greater than can be accommodated in appropriate specialist beds the receiving ward will be Laverstock which should be alerted to implement its action cards and clear beds.

7.2.6 Throughout the Major Incident the Facilities Department will operate their own Major Incident plan which is available in a separate document but key points linked to this, a copy can be found in Control Room 1 box file.

7.2.7 Requests for staffing help should be directed via control room 3 and discussed with either the Medical Director or the Nursing Director.

Useful phone numbers are listed as an appendices to this document

7.2.9 Inform orthopaedic outpatients and plastic outpatients that their respective areas need to be used for Major Incident Patients.

7.3 Stand Down - This indicates that the hospital's response to the Major Incident is to be concluded. STAND DOWN can only be called by the Control room/Duty Manager.

8. MAJOR INCIDENT TEAMS

8.1 The ED Team
Responsible for making arrangements to ensure the initial reception and treatment of Major Incident patients. The ED Team consists of:
- ED Nurse Co-ordinator (NCO)
- Medical Co-ordinator - ED Department Senior Doctor (MCO)
- ED Duty Radiographer
- ED Receptionist
- On Call Anaesthetic Consultant
- Burns On-call Consultant – triage role (If Burns receiving speciality)
- Burns Senior Nurse – triage role (If Burns receiving speciality)
- Paediatric On-call consultant – triage role (If paediatric major incident)

8.2 The Control Room Team
Responsible for ensuring that the Trust is able to respond adequately to a Major Incident. The control room is the link between the internal response and external command and control structures – especially Gold Command. The Control room Team consists of:
- Duty Manager
- Chief Executive Officer
- Medical Director
- Nursing Director
• Facilities manager
• Hospital Ambulance Control Officer
• Police documentation team
• Loggists to ensure full documentation and to act as runners as required
• Site Co-ordinator

8.3 The Cascade Team
This is a virtual team that is responsible for initiating departmental plans to ensure the Trusts’ comprehensive response to the Major Incident. The Cascade Team are those people who are called by switchboard or a person nominated within the plan and whose individual action cards require them to call in colleagues.

8.4 Mobile Medical Team
The Mobile Medical Team (MMT) are responsible for undertaking clinical assessment and treatment at the scene of a Major Incident. The team is set up by the MCO following the departmental policy (see appendix 3). If SDH is designated as the main receiving Hospital for Major Incident patients, Salisbury NHS Foundation Trust will not normally be required to provide a MMT to the Major Incident scene.

8.5 The IT Department
The IT On-call Technician will be responsible for calling out a Senior IT manager. The Senior IT Manager will report to Control Room 1 and will take over as the IT contact. The department will then ensure that all affected areas have sufficient equipment to assist them both during and after the ‘Live Phase’.

8.6 Customer Care Department and Bereavement Support
The Customer Care and the Bereavement Team will be based in Hedgerows. The main contact number for this area will be 2743 or 2764. Relatives will be directed to Hedgerows coffee area with surrounding offices being used as required. The Bereavement team will liaise directly with the Mortuary staff, Coroners staff, Police, Pathologists, Chaplains and Undertakers.

9. KEY MAJOR INCIDENT ROLES

There are a number of key individual roles in relation to a Major Incident. These include:

9.1 Medical Director - Responsible for leading and co-ordinating the hospitals’ clinical response to a Major Incident. This role may be taken on by the Trust Medical Director or a deputy, who will be the duty surgical/medical consultant. Based in Control Room 3.

9.2 Hospital Ambulance Control Officer (HACO) - Responsible for liaising between the receiving hospital and the ambulance service, to ensure that effective arrangements are in place for the transfer of Major Incident casualties. The HACO will be based in Control Room 2.
9.3 **Duty Manager** - Responsible for the overall operational management of the Incident in liaison with the rest of the control room team. A particular focus of the role is managing capacity. If funding needs to be applied immediately the cost centre/code is 154750/749203. This is a specially allocated code held within the medical directorate exclusively for emergency planning usage. All funds expended should be allocated to this code to ensure that costs are readily identified/reclaimed. Based in Control Room 1.

9.4 **Trust On Call Executive** - Responsible for the management of the media with support from the Trust's Press Officer. Also responsible for ensuring effective collaboration with other health and non-health agencies and planning for the longer term impact of a Major Incident on the normal operational running of the Trust. Based in Control Room 1.

9.5 **Nursing Director** – Responsible for allocation of nursing resource, during and after the Major Incident. Based in Control Room 3.

9.6 **Clinical Site team** - Supplying bed states to the Duty manager and allocation of beds to patients requiring admission. They will be based in Control Room 1 and on the wards. They will be in contact via portable radio’s.

9.7 **Press Officer** - Responsible for managing the local media response to the Incident and for internal communications to staff not directly involved in the Incident, once the Media Centre and Press Support Office are ready they will be based in Trust Offices.

9.8 **Customer Care Team and Bereavement Team** – Based in Hedgerow’s Coffee Lounge and staffed by the Customer Care Team and Bereavement Team office staff along with Senior Helpdesk Managers, they will offer advice and support to patients, relatives and staff. The will also co-ordinate the Bereavement Service.

10. **KEY LOCATIONS**

10.1 **ED** - All patients involved in any Major Incident will initially be assessed and treated in ED.

10.2 **Major Incident Control Rooms 1-3** - These are located in the Orthopaedic Outpatient department on level 3. Equipment and documentation for the control room is kept in the ED Major Incident Cupboard, by the ED ramp/reception in a green storage box. Setting up the control rooms is the duty of the first arriving member of the control room team. In the event of this area being unavailable for use in an incident (for example if there were issues around contamination of security) the Trust Library in SDH central can be utilised as an alternative facility. Access and set up details are contained within the set up box.

10.3 **Laverstock** - In the event of casualty numbers exceeding the receiving specialty bed numbers this is where all Major Incident patients, requiring a bed will be admitted, excluding paediatrics
unless Sarum is full. The ward will be supported by the appropriate specialty medics i.e. the receiving specialty.

10.4 **Discharge Lounge** - This is the holding area for all patients (major incident and non-major incident patients) who are awaiting discharge. It is the responsibility of ward senior nurses to identify appropriate patients for the Discharge Lounge.

10.5 **Relatives Reception Centre – (Hedgerows)** In the event of a Major Incident it will be the responsibility of the Customer Care Department office or allocated DSN/Senior Nurse who is first on-site to set up this facility. All telephone calls from the public will be transferred to ext 2743.

10.6 **Media Centre** - The Boardroom will be used as the Major Incident Media Centre. It will be the responsibility of the Press Officer to set up this facility.

10.7 **Minor Injury over-spill – (Plastic Outpatients Department)** - In the event of large numbers of Major Incident trauma patients requiring minor treatment, the Plastic Outpatients department will be used for over-spill from the ED. It is probable that if running, clinics will have stopped as the medical staff respond to the Incident. A plan of the area and locations can be found in control room 1 and in the folder kept within the department. If the major incident is a CBRN event, then this area will be used for non-contaminated patients to report to and wait whilst ED is used for the major incident patients.

10.8 **Children’s Unit** - The children’s unit will be the holding area for all children ‘un-injured’ who have been separated from their guardian, during working hours only. All outpatient clinics will have been cancelled to allow this area to be used solely for Major Incident patients. The Customer Care Department and Bereavement team in hedgerows will need to be kept informed of children in this area.

10.9 **Sarum Ward** – Patients on the ward will be discharged where possible. Remaining patients will be moved to one area within the ward to continue to receive nursing care. The ward will then be used to take ‘minor injury’ patients identified in ED by the paediatric medical co-ordinator.

10.10 **Endoscopy Unit** – Holding area for patients discharged from wards who require additional facilities to those in the Discharge Lounge.

11. **CONTAMINATION INCIDENTS**

11.1 If ED is contaminated the ED team will implement the prepared contingency plan held in the ED.

11.2 In the event of a contamination Incident with any form of local decontamination – beit of people or other facilities, the Environmental Protection Agency should be contacted by the Duty Manager to invite them to attend.

12. **INCIDENT TYPES/RECEIVING SPECIALTIES**
Each potential receiving specialty has its own section in the plan.

12.1 **Trauma Major Incident**: In the event of a Trauma Major Incident, **Surgery** will be the receiving Specialty see Surgical Specialties action cards.

12.2 **Inhalation/Chemical/Biological Major Incident**: In the event of an Inhalation, Chemical or Biological Incident, **Medicine** will be the receiving specialty.

12.3 **Major Outbreak of Infection**: In the event of a Major Outbreak of Infection, **Medicine**, with support from Microbiology / infection control, will be the receiving specialty.

12.4 **Burns Major Incident**: In the event of a Burns Major Incident, **Burns** will be the receiving specialty.

12.5 **Paediatric Major Incident**: In the event of a Paediatric Major Incident, **Paediatrics** will be the receiving specialty.

13. **STAFFING**

13.1 Individual departments will be responsible for calling in additional staff as required in the event of a Major Incident. A full record of extra staff called should be kept by the individual department or ward including the time the staff commenced on duty. This record should be given to the relevant DSN after Incident stand-down, this will be used to identify staff to be thanked for their response and to identify the financial impact of the Incident, this can be reclaimed by the Trust if costs are over a determined level.

13.2 In the event of a Major Incident, it is likely that off duty staff will arrive at SDH to offer assistance. Such staff should report to the person in charge of their normal area of work and await further instructions.

13.3 It is important to ensure that wherever possible staff already scheduled to come on duty within the next 24 hours should not be called in to help in the event of a Major Incident. It is advisable to contact staff on annual leave or days off first. This helps to reduce the amount of time and effort spent arranging and re-arranging staffing.

13.4 Requests for additional staffing during the Major Incident should be made via the Medical Director or Nursing Director in control room 3.

14. **SIGNAGE/TRAFFIC MANAGEMENT/REFRESHMENTS**
Detailed information is reflected in the facilities Major Incident plan. Important key notes to be aware of:

**14.1 Signage** – Facilities staff will be responsible for placing signs around the site road perimeter for relatives, these can be found in the CCTV cupboard, situated near the porters lodge. Exact placement locations are indicated in the facilities major incident plan document.

**14.2 Traffic Management** – The site will adopt the following traffic system. Emergency vehicles only to access site via Entrance A, all other vehicles via Entrance B. Both entrances will be manned by facilities staff and signs warning traffic of the one-way system. **Car Park 10** will be solely for use by relatives.

**14.3 Refreshments** – Facilities staff will be responsible for opening up Hedgerow’s and Spring’s coffee lounge. For distributing refreshment trolleys to Control Room Area, Porter’s Lodge, Boardroom, Nunton and ED/X-ray.

**15. THE MEDIA**

**15.1** Consideration should be given to the use of local media to help call in additional staff to help the Trust to respond to a Major Incident. This is likely to be especially important in the event of a Mass Casualty Incident.

**15.2** No member of Trust staff should provide information to any members of the media without the prior explicit approval of the Trust Press Officer or On Call Executive.

**15.3** The Trust Press Officer and On Call Executive will take the lead on all media management issues. The Wiltshire-wide plan for the management of media issues will be available to the press officer.

**16. CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR (CBRN) INCIDENTS**

**16.1** In the event of a CBRN Major Incident, the ED NCO will be responsible for the allocation of appropriate Personal Protective Equipment (PPE) to trained nursing and medical staff, initiating the set up of the local decontamination facility (as defined in the department policy) and liaison with Wiltshire Fire Brigade in relation to decontamination support.

**16.2** If a patient requires decontamination at SDH prior to treatment (normally this will be for self presenting patients – patients delivered via the emergency services should be decontaminated at scene), it is expected this will be carried out in the decontamination area on the ED Ramp. The department decontamination plan protects the department from contamination as much as is possible.
Patients are to be held on the ramp prior to decontamination as per the plan.

16.3 If contamination occurs on the SDH site, the contaminated area must be immediately cordoned off to contain the contamination and prevent any further contamination. Staff movements should be reduced to a minimum or where possible stopped completely. Estates Technical Services (ETS) should be asked to shut down any ventilation of the contaminated and neighbouring areas. Police, Fire and Ambulance services should be contacted immediately and arrangements will be made to decontaminate any staff or patients affected / transfer them to appropriate specialist centres for treatment.

16.4 The ED CBRN plan and protocols are included as an attachment to the MI Plan. These have been updated following assessment and guidance conducted by the South West SHA in 2010.

16.5 Further advice on the management of chemical and biological Incidents can be found in The Wiltshire Hazardous Materials Incidents Guidance – copies available in ED and the control room. The Wiltshire Mass Casualty Plan also provides detailed information on the local multi-agency response to Major chemical Incidents.

17. NATIONAL BURN INJURY MAJOR INCIDENT

17.1 Declaration of a Major Burn Incident can occur by different levels of control. This may be the Ambulance Incident Commander (AIC) or by the Medical Incident Commander at the scene of the incident. The receiving departments may call a Burns Major Incident or it may be the local burn service when there is realisation that their resources are going to be overwhelmed.

17.2 In the event of a Major Burn Incident, the National Burns Bed Bureau (NBBB) must be informed on the initiation of the MI Plan, standby and live. National Burns Bed Bureau (NBBB) contact number 01384 215666.

17.3 Where burn injuries are part of a major incident, prompt involvement of the burn service is required for optimal patient care.

17.4 In the event of a Major Burn Incident, there may be a requirement to mobilise a Burn Assessment Team (BATS) to the referring emergency departments who will advise clinicians in the departments and assess the injured. BAT’s may come from the host service but also from burns and plastic surgery services within or outside the network.

17.5 If Salisbury is the Host Burn service, once the BAT has carried out a formal burn assessment of patients and fed this back to the hospital, the senior burn surgeon, in collaboration with the hospital control team will use information from the NBBB to decide on the
intended destination of each of the referred patients. This information will then be communicated to the referring emergency departments, the ambulance service and gold control. Gold control will decide whether the transfer will be done by the primary responding ambulance service or by mutual aid arrangements.

17.6 Repatriation to the local service should be considered as soon as clinically appropriate.

17.7 In the event of such an incident, there would inevitably be a profound reduction in the burns and plastic surgery service to deal with routine activity. The knock-on effect to other services on which burn care heavily depends will also be profoundly affected for a long time. These include critical care, pathology services.

17.8 Further information relating to the National Burns Major Incident can be found in the document entitled 'National Major Incident Plan for Burn Injury'. A copy can be found in the Control Room 1 Box File.

18. EMERGENCY EQUIPMENT AND DRUGS FOR MAJOR INCIDENTS/MASS CASUALTY INCIDENTS - UK RESERVE NATIONAL STOCK FOR MAJOR INCIDENTS

A. NHS Acute Trusts and Primary Care Trusts should access the following four items by contacting their local NHS Ambulance Service Trust Emergency Control Room:

1. **Equipment Pod**: respiratory support for 100 people (80 adults/20 children).

2. **Modesty Pod** for use after decontamination to dry and dress 100 people.

3. Nerve agent antidote pod containing atropine, saline, water and pralidoxime chloride injections to treat 90 people.

4. Dicobalt edetate pod containing dicobalt edetate injection and glucose 50% injection for treatment of cyanide poisoning in 90 people.

B. NHS Acute Trusts should access the following two items through their hospital blood bank. The blood bank must ring their local National Blood Service Issue Department to request:

1. **Obidoxime** to treat nerve agent poisoning in patients failing to respond to pralidoxime chloride.
2. **Botulinum antitoxin**

Supplies for treatment in usual situations should be obtained from the nearest designated centre. Please refer to the British National Formulary [BNF]. For major incidents, access is through the local blood bank.

C. **NHS Acute Trusts and Primary Care Trusts should access the following six items through the Department of Health Major Incident Coordination Centre 0845 000 5555:**

   Callers should clearly give the details of the incident, the number of pods requested and their contact details:

1. **Biological pods (oral ciprofloxacin)** to treat 100 or 250 adults, or 50 or 100 children, for 5 days, with post-exposure prophylaxis for anthrax, plague or tularemia.

2. **Further stocks of ciprofloxacin** to complete a treatment course, and stocks of doxycycline to change treatment if required.


5. **Potassium iodate tablets** to block the uptake of radioactive iodine, plus information leaflets for the public.

6. **Prussian blue for the treatment of thallium poisoning**

   **Decision making re the above**

The decision to request these medical supplies will normally be taken by the local CCDC, DPH, or Consultant in Public Health Medicine, who must inform the Regional Director of Public Health of their request.

The CEO in our Major Incident control room should contact Gold Command (see telephone directory linked to the Wiltshire wide Major Incident plan) to inform them of the need to access the above/that a request is to be made. In some circumstances, it is possible that Gold command will inform the Trust via the Control room of the need to make a request.

19. **BOMB THREATS**

   In the event that a bomb threat is made against Salisbury NHS Foundation Trust, the SDH site should not be evacuated unless this is advised by the Police or Fire Brigade. Staff should check their areas for suspicious packages, and if any are found, the police and the Duty Manager should be advised of this immediately. Staff and patients should be moved away from the package if possible, and further instructions should be awaited from the Police.

20. **MASS CASUALTY INCIDENTS**
In the event of an Incident occurring which results in excess of 50 seriously injured casualties, the Wiltshire Mass Casualty Plan will be invoked.

### 21. OUTBREAK OF INFECTION

In the event that a Major outbreak of infection results in a Major Incident, the Control room Team should refer to the Trust's Plan for Controlling Outbreaks of Infection.

### 22. SUSTAINABILITY

People who are acting in roles designated in the plan should consider handing over the role to a colleague of similar seniority and experience either at the time they have to leave the Trust due to other commitments or at the time when they have been acting in the role so long that they feel their effectiveness may become impaired if they continue in the role. Eight hours would generally be considered long enough.

### 23. ACCESS TO MILITARY, LOCAL AUTHORITY AND MUTUAL AID SUPPORT

To access these a request should be made by the Control room to Gold command.

### 24. STAND DOWN

The Stand-down order will be given by the control room and will be cascaded by the respective clinical managerial and departmental teams.

### 25. HUMAN RIGHTS ACT

The basic tenants of the act have been reflected and considered in the preparation of this plan.

### 26. EXERCISING

The Major Incident plan will be subjected to testing every year. Every two years that testing will be reflected in a ‘live’ exercise involving partner organizations and stakeholders. In a year when a live exercise does not take place the plan will in total or in part be subjected to internal testing via a tabletop exercise or ‘notional play’. Ensuring this takes place and that learning is reflected in revisions to the plan will be the responsibility of the Trusts’ Emergency planning lead (EPL).
27. TRAINING

The plan is written so that as much as possible all staff are acting within their normal roles or are at least doing jobs with which they are fully familiar. Notwithstanding this, some departments (ED in particular) will need training in some elements of the response, especially, where processes will be ‘outside’ normal working practices e.g. decontamination of casualties. It is the responsibility of those departments who have key roles within the plan to assess their state of readiness to implement those roles and to bridge any gaps in that state of readiness. This also applies to individuals who may find themselves in a key role in the plan e.g. consultant medical and surgical staff who may be asked to fulfill named roles within the plan and managers who may be required to take on a control room role. Self-assessment is critical and departments or individual staff should approach the EPL for support in bridging any gaps they identify.

28. VIP VISITS

The Chief Executive or their nominee will have a key role to play in managing and conducting VIP visits. Such visits will be conducted with the necessary protection of patients and relatives privacy and dignity. VIP’s will not normally be expected to visit ED when Major trauma or serious illness is being managed. Where necessary the CEO will call upon off-duty managers who are not actively involved in the Major Incident response to support VIP visits. The Public relations team will also provide advice and support.

29. LEGAL ISSUES

29.1 Preservation of Forensic Evidence

The primary purpose of the Trust is to provide health services. However, following a Major Incident there is likely to be an investigation into the event that caused the Incident. This will be true whatever the nature of the Incident. Patient’s property and belongings may be required after the event and nothing should be discarded or destroyed no matter what condition it is in. Preservation of life and limb should not be compromised by a reluctance to damage a patients clothing (e.g. cutting it off to gain access to the patient) or property (e.g. cutting off a ring or other jewelry) however, damage should be kept to what is necessary only. Property should be labeled accurately and kept with its owner where practicable or stored securely if not. In the event of a patient’s death (or DoA) the minimum possible should be done to the body prior to it being fully labeled and sent to the mortuary, no medical devices or foreign bodies should be removed.
29.2 Tracking of Patients During an Incident
In a major incident the Police Hospital Documentation Team will liaise with ED and the Control room regarding the whereabouts of patients. Primarily this is for the purpose of liaising with the casualty bureau who will be dealing with enquires from relatives etc. However, in the event of an incident with a suspect criminal element, the Police will also need to keep track of patients in order to obtain witness statements or question suspects.

29.3 Logging communications
All staff taking and making telephone calls and/or making decisions and committing resources (including staffing resources) are reminded of the importance of logging communications/decisions and actions. This is important for the following reasons:
- Ensuring that learning can take place after the Incident
- Generating a contemporaneous record
The Trust has a pool of trained loggists (see appendix 23) who will be called upon to ensure contemporaneous record of the Control Room Team’s decisions are maintained.

30. LOCAL RISKS

In order to encourage an integrated approach, the CCA places a responsibility on Category 1 responders to co-operate with each other in maintaining a Community Risk Register. The Trust works closely with partner agencies within the Wiltshire Local Resilience Forum (LRF) to assess the potential risks and hazards that may require the implementation of emergency plans. These risks are collated via the Community Risk Register.

Examples of high and very high risks from the Wiltshire Community Risk Register include Road accidents involving transport of fuel/explosives; Localised industrial accidents involving large toxic release (‘big bang’ incidents); Pandemic Influenza and Low temperatures and heavy snow (‘rising tide’ incidents).

The core catchment area of the Trust covers both urban and rural areas and there are a number of specific organisations in the locality reflected in the risk register, for example the military garrisons on Salisbury Plain, Boscombe Down Airfield and the HPA site and the Defence Science & Technology Laboratory at Porton Down.

31. BUSINESS CONTINUITY AND CONTINGENCY PLANNING

At Salisbury NHS Foundation Trust, business continuity and contingency planning is regarded as a separate process from Major Incident planning although it is recognized that there are potential overlaps. Business continuity and contingency planning is subject to a formalized structured process of risk assessment and response planning reflected in the Trusts’ ‘Continuity Policy’ and related documentation.
Contingency plans are held in readiness both in the relevant departments and in areas adjacent to those departments (so a copy is available if the response is to something that may have destroyed the copy in the department).

32. COMMUNICATIONS FAILURE

In the event of an internal communications failure the contingency plan held by switchboard will be implemented.

33. EXTERNAL CIRCULATION LIST

- HPA – AGW StHA
- NHS Wiltshire Emergency Planner – Southgate House
- Emergency Planner Great Western Ambulance Service
- Emergency Planner Wiltshire Fire Brigade
- Emergency planning lead Wiltshire Police – Police HQ Devizes
- CEO NHS Wiltshire
- Boscombe Down Airfield
- Emergency Planner Southampton University Trust
- Emergency Planner – Great Western Hospital (Swindon)

34. DEBRIEFING POST INCIDENT

Debriefing will be led by the Trust emergency planner and will take place on two levels:
- The control room team with senior Staff from key responding departments
- At individual responding department level

This double approach will ensure that local command and control issues are captured at a ‘high level’ whilst also giving the opportunity for low level local learning to take place.

Debriefing will take place within 14 days of an Incident and the Major Incident plan will be updated and re-circulated reflecting any learning within 12 weeks of the Incident.