

If you are using this plan to respond to an incident, turn to page 12 now

Warning - if you are using the paper version of this plan in a Control Room check via The Vocare Resilience Page [link](#) that it is the most up-to-date plan against the version control below.



**VOCARE/Urgent Care Division
EMERGENCY PLANNING, RESILIENCE AND RESPONSE (EPRR) PLAN
January 2019**

This Vocare document is applicable to

All Vocare

X

**Version: 2.1a
Date Published: January 2019
Review Date: 1 December 2021**

**Vocare
Vocare House
Balliol Business Park
Benton Lane
Gosforth
Newcastle upon Tyne
NE12 8EW**

The Department of Health defines emergency situations as “incidents and emergency situations which could affect the provision of normal services”. This plan focusses on internal incidents and maintaining service continuity: and incorporates the Major Incident Plan, which deals with external “big bang” events. It also is subject to Vocare’s EPRR Policy.

THE ELECTRONIC COPY OF THIS DOCUMENT IS TO BE CONSIDERED AS THE CURRENT VERSION. PRINTED COPIES MAY BE OBSOLETE - SEE ABOVE.

The term “Vocare” is used throughout this document to refer to Vocare and the Urgent Care Division

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1. Document Control

1.1 Document History

Version	Release Date	Author	Notes
1.0	July 2017	[REDACTED]	Created post EPRR meeting 16.6.2017 - final version signed off at Board July 2017
2.0	August 2018 Board meeting	[REDACTED]	Initial draft from "Vocare EPRR Review July 2018" document. Draft based on organizational and national EPRR learning 2017-8, agreed at August 2018 board meeting Changes/flags in respect of: <ul style="list-style-type: none"> On-call provision Flu vaccination % compliance Evacuation and shelter guidance Badging of CBRN/HAZMAT advice for remote use
2.1	January 2019	[REDACTED]	<ul style="list-style-type: none"> Updates to Wave 1 & Wave 2 Personnel Alert lists to reflect revised regional structures and job titles. Phone contact details added to Wave 2 Minor update to Critical Activities in Scope. Minor Update to Document Review Process 111 action card for major incidents
2.1a	August 2019	[REDACTED]	<ul style="list-style-type: none"> Appendix 1 added - Local Risk Registers Severe Weather Plans updated including hyperlinks to NHSE "Follow Me" number for Vocare Digital Service updated. Hyperlink to Smart Incident Command System Updated Update to Loggist Action Card in reflection of remote access. NHS Supply Chain Numbers Updated Adastra Emergency Contact Number Updated
2.1a	June 2020	[REDACTED]	<ul style="list-style-type: none"> No changes to document. Review date agreed to April 2021 in light of COVID-19 and against principles of assurance given by EPRR Lead.
2.1a	13 May 2021	[REDACTED]	<ul style="list-style-type: none"> No changes to document. Review date rolled forward to 1 October 2021 by UCD Exec in light of COVID-19 and against principles of assurance given by EPRR Lead.

2.1b	30.8.21	<div style="background-color: black; width: 100px; height: 15px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 150px; height: 15px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 50px; height: 15px;"></div>	<ul style="list-style-type: none"> • Updated links to locality Risk Registers. • Review date rolled forward to 1 December 2021 by UCD Exec in light of COVID-19 and against principles of assurance given by EPRR Lead. • AEO and DONQ details updated. • Head of Group Resilience details updated. • Totally plc/UCD logos added and clarity of use of the term "Vocare" • Telephone contact lists updated.
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1.2 Document Approval

Urgent Care Division / Vocare Authorisation	
Name & Title	Authorisation
Andy Gregory Managing Director	Version 2.1a Via August 2018 board meeting & Accountable Officer Jan 2019. Review date agreed to April 2021 by Vocare Exec 25/6/20. Sept 2021: Review date extended to Dec 2021 by UCD Exec.
<div style="background-color: black; width: 100px; height: 15px; margin-bottom: 5px;"></div> Urgent Care Division, Director of Operations, Accountable Emergency Officer	
<div style="background-color: black; width: 80px; height: 15px; display: inline-block;"></div> Urgent Care Division, Director of Nursing, Senior lead EPRR professional	

1.3 Distribution

Applicable to whole organization: This document will be made available on Vocare's Intranet. Controlled copies will be produced, distributed and maintained in accordance with Vocare's Quality Manual. **Paper copies of this plan will be required in all Vocare VC rooms.**

1.4 Master Copy

The master electronic copy of this document is held by

Name	Role	Contact
<div style="background-color: black; width: 60px; height: 15px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 90px; height: 15px;"></div>	Head of Group Resilience	<div style="background-color: black; width: 200px; height: 15px;"></div>

2. Introduction/Background

- 2.1 The Department of Health defines emergency situations as “incidents and emergency situations which could affect the provision of normal services”. This plan focusses on internal incidents and maintaining service continuity: and incorporates the Major Incident Plan, which deals with external “big bang” events. It also is subject to Vocare’s EPRR Policy.
- 2.2 Many problems are dealt with on a day-to-day basis but a disruption to service for Vocare could come from different sources, any of which could damage the organisation. As well as managing disruptions to ensure the impact on patient care is minimal, it is also necessary to consider financial and reputation consequences for Vocare on public expectations and on achieving targets, standards and guidelines as set by the Department of Health, NHS England, CQC, NHS Improvement, service commissioners and other stakeholders.
- 2.3 This template should be used as an example for creating or amending a policy, procedure or guideline which is applicable to the whole organisation of Vocare.
- 2.4 This Vocare procedure requires documented approval by:
 - Managing Director
 - Director of Operations
 - Director of Nursing.
- 2.5 This document is an operational procedure. It is also subject to Vocare’s EPRR Policy. For definitions of policy, procedures and guidelines, this document should be read in conjunction with:
 - Vocare EPRR Policy
 - V-P80 Policies, Procedures and Guidelines.

3. Scope of Plan

- 3.1 This plan applies to all Vocare staff and applies to the premises and locations from which the service is delivered within the areas covered by Vocare.
- 3.2 The critical activities and services in scope include, but are not limited to:
- The provision of contracted 111 services and associated infrastructure;
 - The provision of Out-of-Hours services and associated infrastructure;
 - The provision of Urgent Care Centre Services and associated infrastructure

4. Plan Framework

As described in the Vocare EPRR Policy, this plan is for use in the most difficult of circumstances and incidents only. It is not an alternative means of circumscribing normal management arrangements during business as usual.

The overall framework is very closely related to the Escalation Plan in that:

- if a problem can be dealt with at local level, it should be. If not, it should be escalated:
- if a problem can be dealt with at regional level, it should be. If not, it should be escalated:
- and dealt with at a corporate level before damage to patient care or the organisation happens: i.e. this plan, requiring an incident declaration.

At the time of writing a review of on-call is in train and it is anticipated that the change will be for the 3 regions to have regional on call within these (Silver) and a national on call framework that includes the Executive and other SMT members (Gold).

5. Procedure & Review Process

5.1 This plan is under constant review and is formally reviewed as a minimum on a quarterly basis by each Vocare Regional Board to identify any local influences to be escalated to the National Executive Board. This plan is reviewed as a minimum on an annual basis by the Vocare Executive Board. The plan and the various components of its delivery are maintained by the Head of Resilience, supported by The Resilience Manager and the EPRR Regional Leads. Staff are under an obligation to notify for consideration any change which may affect its contents, and requests to consider this should be addressed to the Accountable Emergency Officer, the Director of Operations.

EPRR Assurance, Infrastructure Chart



5.2 The focus of the plan is to provide a framework for coping with incidents which have to be escalated to executive level. These may be caused by clinical demand and which by nature are:

- **Business Continuity Incident**

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

- **Critical Incident**

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

- **Major Incident**

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

5.3 As discussed in the Vocare EPRR Policy and 4 above, difficult events falling short of events described in 5.2 will be dealt with by day-to-day managerial frameworks and the Vocare Escalation Plan.

5.4 The planning for such events will be guided by risk analysis of past and likely internal events. Additionally, the Chartered Management Institute has conducted retrospective surveys over the previous few years from both the public and private sector concerning continuity disruptions. From this work the

potential commonly occurring disruptions that could happen within an organisation were derived, and these are also taken account of in the Resources to the Plan:

- Loss of equipment / IT / telecommunications either by accident or deliberate attack
- Loss of staff and key skills, either temporarily or permanently (e.g. flu, weather, health and safety incidents, industrial action)
- Loss of utility (power, water, medical gas, steam)
- Denial of site (e.g. lifts, stairwells, corridors etc.) or structural damage (e.g. fire, natural disaster)
- Supply chain disruption.

Of course, NHS England policy requirements are also of consideration in choosing the portfolio of possible planned responses. This plan also gives a generic problem-solving model, a resource on extreme weather conditions, VIP receipt, pandemics and associated infectious disease work and major incidents. The managerial roles and principles in the plan will be usable for a variety of events, with the Operations Room protocols, and interact with UK-wide systems - links to these plans are made via the Vocare Resilience Webpage.

5.5 This plan will be available:

- Electronically, via quality organisational filing-controlled systems
- Electronically, via the Vocare Emergency Planning Resilience and response intranet page (V-Central, accessed under Clinical Guidelines off the front page)
- In paper, in all Vocare VC rooms.

6. Equality & Diversity Statement

- 6.1 The management of Vocare are committed to providing equality of opportunity, not only in its employment practices but also in the services for this plan which it is responsible. The Equality Impact Assessment of the plan is neutral.
- 6.3 Vocare also value and respect the diversity of their respective employees and the communities they service. In applying this plan, they will have due regard for the need to:
- Eliminate unlawful discrimination
 - Promote equality of opportunity
 - Provide for good relations between people of diverse groups

IN AN INCIDENT, START HERE

7. When should this plan be used? Who declares it? How is it started?

This plan should be used if major disruption to internal patient activity is foreseen, or when external influences or requests for internal action which affecting patient activity are experienced or made.

The overall framework is:

- if a problem can be dealt with at local level, it should be. If not, it should be escalated:
- if a problem can be dealt with at regional level, it should be. If not, it should be escalated:
- and dealt with at a corporate level before damage to patient care or the organisation happens: i.e. this plan, requiring an incident declaration.

It follows, then, that if an issue can be dealt with via the Vocare Escalation Plan or by normal day-to-day management arrangements, it should be.

It is up to the following staff to declare and control an internal incident, **and record the reasons for doing so:**

- In hours; **Director of Operations or Executive on-call**
 - The Duty Director of Operations will discuss the situation with the Executive Director of Operations or Executive on-call who will then decide whether to declare an internal incident
- Out of hours: **Executive On-Call**
 - The local affected lead will contact the Executive On-Call who will then decide whether to declare an internal incident.

The lead Operations on-call is the Incident Commander.

If an INTERNAL INCIDENT or MAJOR INCIDENT is declared (see pages 6-7, paragraph 5.2), next call:

Wave 1 - Management on Call Smart Numbers & Contacts		
Director of Operations / National Manager On-call	██████████	
Medical Director	██████████	
Director of Nursing	██████████	
Digital Services	██████████	

“INTERNAL INCIDENT or MAJOR INCIDENT declared: report or dial in to the VC Room, Vocare House, Newcastle upon Tyne (or insert location as determined by the Commander, reserve is VC Room, Regional HQ Stockton)”

Who else needs to be involved?

The severity, nature and location of the incident will dictate who gets called. The following options are open to the Incident Commander, depending on the apparent severity of the incident, but can be built up as more information on the situation is known.

“Internal incident declared: report or dial in to the VC Room Longbenton (or insert location as determined by the silver leader, reserve is VC Room, Regional HQ Stockton)”

Wave 2 – Senior Team Members	Contact Number
Managing Director	██████████
Medical Director	██████████
Director of Nursing and Quality	██████████
Director of IT and Digital Strategy (or appointed deputy)	██████████
Operations Director: North Region	██████████
Medical Director: North Region	██████████
Clinical Director, North Region	██████████
Operations Director: South Region	██████████
Medical Director: 111	██████████
Clinical Director, 111	██████████
Operations Director: 111	██████████ (Head of Contact Centres 111)
Medical Director: South Region	██████████
Clinical Director, South Region	██████████
Head of Group Resilience	██████████
Communications Manager	██████████

Details of the above in the form of a communications cascade, which will be practiced twice a year as per the NHS core standards, will be held in encrypted form on V-Central.

Location of Incident Management Team: Command will normally operate, unless decided otherwise by Command and communicated to other senior managers, at:

**Vocare HQ VC Room, Vocare House
Balliol Business Park, Benton Lane
Gosforth, Newcastle upon Tyne NE12 8EW**

The Reserve location for the Incident Management Team is at the

**Vocare Regional HQ VC Room, Crutes Building
Fudan Way, Thornaby, Stockton on Tees, Cleveland TS17
6EN**

The standard telephone conferring number for incidents will be:

**[REDACTED]
[REDACTED]
[REDACTED]**

8. Incidents which affect sites and services other than Vocare

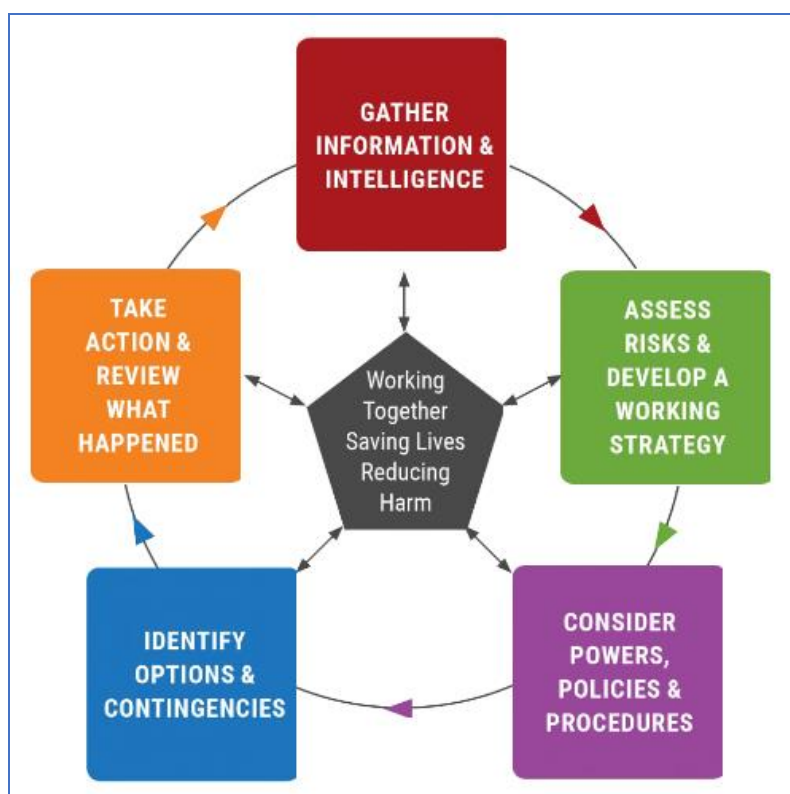
Major issues on sites other than Vocare sites will be dealt with as follows:

- For immediate site issues the host site's lead Trust Business Continuity or Major Incident Plan (eg NHS Trust or CCG) and command structures will apply to those organisations e.g. Major Incident Plan fire, site denial, water quality
- **For NHS Trusts declaring major incidents with Vocare UCC on-site, go to the UCC Major Incident Plan (page 86)**
- For recovery, business and staff issues the lead site practitioner will report back to the local Vocare operations lead for that activity

Keep a record of what you do... If it isn't written down, it didn't happen!

- The Vocare operations lead will determine, in conjunction with the lead local practitioner and Regional support whether further escalation of the Vocare EPRR will apply, or whether further management actions are necessary.

9. The Joint Decision-Making Framework



10. Applying the Joint Decision-Making Framework

The Incident Commander should use the Joint Decision Model to help bring together the available information, reconcile objectives and make effective decisions - as other agencies are doing the same way, this should allow you to communicate better and to understand complex multi-agency situations. Like most decision models it centres around three primary considerations:

Situation	Direction	Action
What is happening?	What do you want/need to achieve in the first hour (the desired outcomes)?	What do you need to do to resolve the situation and achieve your desired outcomes?
What are the impacts?	What are the aims and objectives of the emergency response?	What assets (plans or staff, see page 41-97) should be deployed to solve the problem?
What are the risks?	What overarching values and priorities will inform and guide this?	
What might happen and what is being done about it?		

¹ <http://www.jesip.org.uk/joint-decision-model>

Gather information and intelligence

The first stage of the process helps the commander gather all known information - or situational awareness - about the emergency. Commanders should ask:

- What is happening?
 - This is often the most difficult stage: simple means of gathering information on an event is to consider the 5 W's and H: Who? What? Where? When? Why? and How?
- What are the impacts?
- What are the risks?
- What might happen?
- What is being done about it?

To help all those involved in emergency response the UK has accepted the use of a common model to help with the consistent and effective way of sharing incident information - see the Information Action Card and METHANE Action Card.

Assess risks & develop a working strategy

The second stage prompts commanders to ensure they have reviewed and understood all risks so that appropriate control measures can be put in place. Understanding risk is central to emergency response. One of the major challenges in successful joint emergency response is for responders to build and maintain a common understanding of the full range of risks, and the way that those risks may be increased or controlled by decisions made and actions taken by the emergency responders.

Consider powers, policies, and procedures

The third stage of the model aims to ensure commanders have considered the following when planning their joint response:

- What relevant laws, Vocare standard operating procedures, Vocare EPRR plan assets (see pages 41-97) and policies apply?
- How do these influence joint decisions?
- How do they constrain joint decisions?

In the context of a joint response, a common understanding of any relevant powers, policies, and procedures is essential in order that the activities of one service complement, and do not compromise, the approach of the other

services. This will help people to decide what help from other agencies is required.

Identify options and contingencies

The fourth step reminds commanders to stop and assess all potential options for response. For every potential option or contingency commanders should consider:

- Suitability
- Feasibility
- Acceptability

There will almost always be more than one option to achieve the desired end state, and it is good practice that a range of options are identified and rigorously evaluated by commanders. The best option should be identified clearly. Where the best option is time-critical, there should be clearly agreed procedures for communicating any decision to defer, abort or initiate a specific tactic.

Take action and review what happened

The fifth step is about reviewing what has taken place and, if required, re-evaluating and amending plans. This is also a check on what you have asked to happen as a commander has actually happened.

As the incident management process is a continuous loop, it is essential that the results of agreed actions are fed back into the first box - Gather and share information and intelligence - which establishes shared situational awareness. This will, in turn, shape any further revision to the direction and risk assessment, and the cycle continues.

The process is designed to be used in fast moving, dynamic situations but can equally be applied to pre-planning activity or more slowly evolving situations. Other agencies use it too: police, fire, ambulance, local authorities, and NHS, so you can talk to other organisations more easily.

11. Longer term incidents: e.g. “rising tide”

Longer term incidents are managed by the same framework. However, long-scale incidents, including pandemic and other large-scale infectious disease activity, increased death rates, will demand the answer to large-scale management questions:

- “can we keep all activities going?”,
- “have we got the resources?”,
- “are we in charge or is another agency?”,
- “how soon can we get back to normal?”

The distinguishing characteristics of short and longer-term problems are illustrated in the table below². Any given situation may require both types of responses - a less flexible and more rehearsed mode for those elements which are more fixed and predictable, and a more flexible approach for less predictable or novel elements. Put more simply, longer term incidents require a response less dependent on set plays, and more dependent on judgement, and a battle rhythm counted in days, not hours or minutes. This will have a knock-on effect to the level of time this plan is in operation, and make demands on command staff, although the intensity of action will be lesser, generally, the longer a plan is in place.

Difference between excellence in routine and crisis emergencies		
Characteristic	Response mode for: Routine emergencies	Response mode for: Crisis emergencies
Situational awareness	High	Low
Decision-making	Recognition-primed	Cognitively driven, analytic
Scripts	Comprehensive	No playbook
Skills required	Well-defined, highly developed	Incompletely specified
Leadership	Trained, practised, selected for prior training and performance	Adaptive, comfortable sharing authority, skilled in eliciting ideas from the team, innovative
Command presence	Authority-based	Muted, oriented towards collaboration in developing solutions, more hierarchical in execution
Organisational structure	Hierarchical	Flattened for solution development, more hierarchical in design, hierarchical for execution
Execution	Aims for precision	Must be fault-tolerant

² from Crisis Response Vol 4 issue 3

12. Action Cards Index

Action Card	Role	Page
Action Card 1	Incident Commander Card	
Action Card 2	Information Officer Card	
Action Card 3	Briefings Officer Card	
Action Card 4	Response team members - operational	
Action Card 5	Response team members - professional/clinical	
Action Card 6	IT/telephony specialist Card	
Action Card 7	Executives Card	
Action Card 8	Loggist	
Action Card 9	REGIONAL DIRECTOR	
Action Card 10	LOCAL SERVICE MANAGER	
UCC ACTION CARD	MAJOR INCIDENTS AND HAZMAT/CBRN	

ACTION CARD 1 Incident Commander

INCIDENT COMMANDER

Who is this? – a senior operational manager delegated by the EXECUTIVE

Accountable to – EXECUTIVE

Purpose –

- Operational management of the incident
- Decides on the operational response
- Defines the solutions agreed by the INCIDENT Command Group
- Directs briefings for partners and staff

1. Act as SILVER COMMANDER. Check the cascade has happened.

Wave 1 - Management on Call Smart Numbers & Contacts		
Director of Operations / National Manager On-call	██████████	
Medical Director	██████████	
Director of Nursing	██████████	
Digital Services	██████████	

2. Discuss with the Gold Commander to determine whether or not the incident warrants the declaration of an internal incident:
 - **NO:** then an appropriate management plan must be agreed and relayed to those implementing it.
 - **YES:** inform the manager/s for the affected area that an internal incident will be declared

Wave 2 – Senior Team Members	Contact Number
Managing Director	██████████
Medical Director	██████████
Director of Nursing and Quality	██████████
Director of IT and Digital Strategy (or appointed deputy)	██████████
Operations Director: North Region	██████████
Medical Director: North Region	██████████
Clinical Director, North Region	██████████
Operations Director: South Region	██████████
Medical Director: 111	██████████
Clinical Director, 111	██████████
Operations Director: 111	██████████ Head of Contact Centres 111)
Medical Director: South Region	██████████
Clinical Director, South Region	██████████
Head of Group Resilience	██████████
Communications Manager	██████████

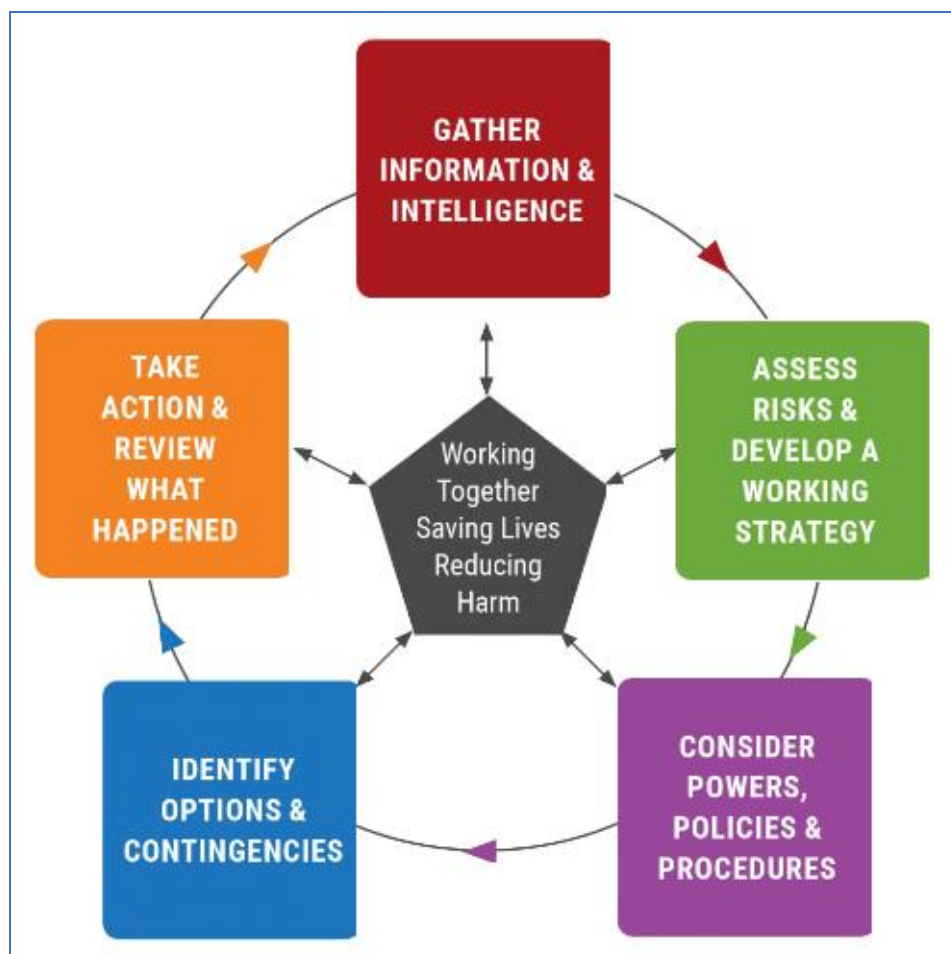
3. Designate staff to the following roles and brief them via their action cards in this plan: note action cards 2 and 3 are information roles which can be carried out by other members of the team: the Intelligence Officer finds out about the event, the Briefings Officer creates briefings for staff and external players ready.

Action Card	Role	Who nominated
Action Card 1	Incident Commander	
Action Card 2	Intelligence Officer	
Action Card 3	Briefings Officer	
Action Card 4	Response team members - operational	
Action Card 5	Response team members - professional/clinical	
Action Card 6	IT/telephony specialist card	
Action Card 7	Executives Card	

Action Card 8	Loggist	
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NB: there are also action cards 9 Regional Director and 10 - Local Service Manager.

4. Report to the Gold Commander and confirm objectives for the incident once sufficient intelligence on the incident exists. These will normally be:
 - the saving of life
 - maintenance of safe clinical practice and critical service provision
 - the protection of Vocare staff, assets, and finances
 - co-operation with other responders under the Civil Contingencies Act
 - warning and informing the public.
5. Work towards a solution using the Joint Decision Model, using guidance from pages 14 to 16 in this plan:



6. Establish via the Operational Team Card a line of reporting to places affected by the incident regular operational updates from the Site Management team

The standard telephone conferring number for incidents will be:



7. Consider spare capacity as appropriate.
8. Liaise with NHS Ambulance control or use information from them to identify any key stand-by hospitals and ascertain bed availability / triggers for transfer
9. Facilitate accelerated discharge and social care support
10. Agree an action plan for the suspension or cancellation of services and review at regular intervals with clinical/professional team member
11. If it is necessary to consider the closure of services, or if services are not operational, discuss with Gold Commander for discussion with commissioners
12. Determine any necessary cordons for services using Lockdown policy if necessary
13. Ensure the cause of the incident is being investigated further by senior managers from the appropriate area, co-opting as appropriate (e.g. clinical leads, IT, facilities managers)
14. Allocate a senior manager to liaise with the principal external agencies where these have on-site command functions if no contact made
15. Establish the impact of the incident using the Incident Impact Analysis on page 98 of this plan - ask appropriate clinicians to risk assess patient groups in the affected areas and act on it
16. Consider recovery issues: see recovery checklist page 40. If the incident is large scale, advise the Gold Commander that a separate recovery team responsible to the Gold Commander will need to be set up.
17. Delegate an operational team member to establish any alternative communication needed.
18. Attend meetings with Gold Commander as required, designating a deputy to manage the Silver Team during his or her absence.

Keep a record of what you do... If it isn't written down, it didn't happen!

19. At the end of the incident, confirm the decision to stand down with the Gold Commander and the issue the “stand down” order clearly and unambiguously, and adequate circulation of that information internally and externally.
20. Conduct a hot debrief and record briefly the main findings in 24 hours (on-call managers if out-of-hours): submit main findings to the Emergency Planning lead or other officer conducting a full debrief - see Section 15 of this plan for a simple guide on how to do that.

ACTION CARD 2 Intelligence Officer

INTELLIGENCE OFFICER CARD

Who is this? – a senior manager delegated by the INCIDENT COMMANDER

Accountable to – INCIDENT COMMANDER

Purpose –

- Gathers the information below about the incident
- Reports information gained to the INCIDENT COMMANDER
- Defines the problem
- By defining the problem, suggests solutions
- Acts in other ways to help the INCIDENT COMMANDER

The standard telephone conferring number for incidents will be:

██████████

██████████

██████████

1 Gather information and intelligence: the 5 'W's' and H - who, what, why, where, when and how.	
Assess locally the extent of the impact of disruption has had on:	
Crucial clinical systems required for patient care	
Is public access affected?	
Crucial non-clinical systems?	
Non-critical systems requiring longer term re-provision	
2 Establish the quantity of staff affected	
Ascertain the skill-mix of those staff members who are not available	
Establish whether additional members of suitably skilled employees exist locally who can be	

redeployed, say from training on the day	
Consider if HR can assist? - could additional short-term staff help - are call-out lists of any use? - Liaise with alternative providers for the provision of temporary staffing including approved agencies	
Consider deployment of staff to assist in secondary issues arising as a result of the disruption (e.g. lift trap-ins, flooding on site, moving gas cylinders).	
3. Ascertain & implement alternative systems for replicating the workload locally (e.g. written systems or requests, IT, telephones, use of hand-held radios, runners, audible or visual signals). If appropriate, reassign work tasks accordingly or redeploy temporarily	
Consider the ability of the Organisation to provide patient care safely and a safe workplace	
Paper routines?	
Access technical back-up systems?	
Think - who needs to know about the disruption - communicate it - which patient areas have priority - 111, GP filter, GP out-of-hours, other?	
Can non-affected areas have a re-designated function for essential patient functions?	
Consider whether the disruption to services has affected other local NHS services?	
Could other local NHS services help? Could other non-NHS services help? E.g. local authority, police, fire and rescue	
How soon could suppliers (e.g. gas suppliers, BT) help? How much stock	

is affected and how long can the organisation survive without it? Are there alternative suppliers?	
4. Ascertain & implement alternative systems for coping with increased demand	
Capacity Management	
Ascertain the cause of the increase in care demands (e.g. infection outbreak, heatwave conditions, etc.)	
Is there a specific plan for this eventuality linked to the Major Incident Plan?	
Is there a specific plan for this eventuality linked to capacity plans?	
Establish whether the increase in care demands is localised to the service.	
If increase in care demands is as a result of infection outbreak, liaise with the Infection Control Team to minimise spread of infection cross-organisation via the outbreak policy	
Assess current increase in care demands; urgent vs. non-urgent	
Establish whether the increase in care demands for patients is limited to Vocare or whether other organisations are experiencing similar problems	
Consider requesting additional staffing to aid in the response on site	
If possible, consider diverting patients not affected by the disruption to alternative organisations - this will require the co-operation of the Sector	

Keep a record of what you do... If it isn't written down, it didn't happen!

Transferring patients; 'First movers' identified: not transferred if already transferred, if likely to be suffering from an infection, or if likely to be confused.	
---	--

ACTION CARD 3 Briefing Officer

BRIEFING OFFICER

Who is this? – a senior manager delegated by the INCIDENT COMMANDER

Accountable to – INCIDENT COMMANDER

Purpose –

- Completes the information below with the INCIDENT COMMANDER
- Reports on decisions made by the INCIDENT COMMANDER
- Defines the solutions received by the INCIDENT Command Group
- Prepares and delivers briefings for partners and staff

The standard telephone conferring number for incidents will be:



1. Complete this form with the INCIDENT COMMANDER

Decision Log Number	Decision - Date and Time of Decision
1. Identify situation & gather information What is your understanding of what has happened? What do we know so far? What might happen?	
2. Assess threats & risks Do I need to take action immediately? Do I need to seek more information? Where can I get it from? What could go wrong?	
3. Policies & Procedure	

Which ones have I taken into account	
4. Options & Considerations What options are open to me? Consider immediacy of any risk/threat, limits of information etc.?	
5. Decision & Rationale Decision controls- why are we doing this? What do we think will happen? Do we have a common understanding and position on; <ul style="list-style-type: none"> • Situation • Available information • Terminology • Working practices • Conclusions Is the benefit proportional to the risk?	
6. Review of Decision - Time and result	
Names of People Making Decision	

Name of Person Recording Decision	
--	--

2. Prepare these briefs for the organisation and partner organisations below with the Incident Commander and use flexibly in communications out from the Control Centre.

METHANE MESSAGE

Major Incident Declared or Standby:.....

Exact location of Incident:.....

Type of Incident:

Hazards involved:

Access (time to arrive at Vocare sites):

Number of patients:

Emergency services involved.....

	SBAR report
S ituation	describe situation/incident that has occurred
B ackground	explain history and impact of incident on services / patient safety
A ssessment	confirm your understanding of the issues involved
R ecommendation	explain what you need, clarify expectations and what you would like to happen
	Ask receiver to repeat information to ensure understanding

See over for Single Situation Report Template

NHS England Single Situation Report Template

This may be supplemented with other situation-specific requests by NHS England at time of incident.

NATIONAL SITUATION REPORT TEMPLATE

NHS England Major Incident Situation Report – SITREP

Use this template to collect and report data when managing major incidents to ensure a consistent methodology and commonly recognised picture across the health community.

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

Organisation:		Date:	
Name (completed by):		Time:	
Telephone number:			
Email address:			
Authorised for release by (name & title):			

Type of Incident (Name)	
Organisations reporting <u>serious</u> operational difficulties	
Impact/potential impact of incident on services / critical functions and patients	
Impact on other service providers	
Mitigating actions for the above impacts	

Keep a record of what you do... If it isn't written down, it didn't happen!

Impact of business continuity arrangements	
Media interest expected/received	
Mutual Aid Request Made (Y/N) and agreed with?	
Additional comments	
Other issues	
NHS England local office Incident Coordination Centre contact details: Name: Telephone number: Email:	

ACTION CARD 4 Command team member: operational

COMMAND TEAM MEMBER - Operational

Who these are – Wave 2 staff member as nominated by any member of the Incident Control Team – clinical background required

Report to – Incident Commander

Purpose – Flexible and proportionate support to incident management.

The standard telephone conferring number for incidents will be:

██████████
██████████
██████████

1. Nominate local operational leaders in the affected areas and brief them as to the nature and extent of the incident. The areas affected by the incident will determine who those local leaders should be, and some local leaders may be required to support colleagues outside of their normal working area
2. Find out what local plans local operational leaders have in place to deal with the problem - See 14. Plan resources Section C for a sample local plan.
3. Quickly run through the plan and advise the Silver Commander what resources in the plan are available to manage the incident
4. The operational leaders will request SitReps from Bronze leaders to a specification agreed by the Silver Commander
5. The Incident Commander will direct operational incident team members.

Duties may include but are not limited to - and may be added to from the scenario specific information in the plan Appendices and direction from the incident commander:

- Analysis of Plan Resources to ensure action appropriate to the event takes place
- Implementation of alternative communication means eg WhatsApp
- Co-opting staff and nomination of runners
- Evacuation and cordon control (if applicable)

- Cordon Officer relief
- Liaising with the emergency services (if applicable)
- Liaison with Risk & Safety for HSE/RIDDOR considerations
- Catering arrangements
- Record keeping/decision documentation

Some Silver team members may form part of a Recovery Group

The roles of the Recovery Team may include

Establishing Priorities

- People - patient, staff and visitors' safety and welfare
- Operations - maintaining what is critical
- Protecting the organisation's reputation
- Conforming or varying the recovery time objectives in the

Achieving Priorities

- What will a good outcome look like? What needs to be maintained (as determined by Gold)?
- How do you achieve that?
- What is required to achieve this? (Staff, premises, equipment, supplies, IT, etc.)
- Who needs to be involved?
- Effect on other stakeholders and talking to them to get agreement (Contractors, other healthcare organisations, local authority, etc.)

Programme Management

- Finance
 - Charging for short-notice requests made by commissioners during the incident
 - Insurance claims
 - Potential legal claims
- Contracts
 - Contact and negotiation with commissioners under Section 30 of the NHS Standard Contract
 - Lists of affected patients during service suspensions to commissioners

Communications management

- Staff information management
- Consider contacting doctors' deputising services and other commissioned services.

See page 47 for a fuller recovery checklist.

ACTION CARD 5 Command team member; professional/clinical

COMMAND TEAM MEMBER – Professional/Clinical

Who these are – Wave 2 staff member as nominated by any member of the Incident Control Team – clinical/professional background required

Report to – Incident Commander

Role:

- Advise Incident Commander on any clinical or professional aspect of the incident
- Advise on triage where required
- Advise on the return to normal of any clinical service

The **standard telephone conferring number for incidents** will be:



1. Advise Incident Commander on any clinical or professional aspect of the incident
2. Consider the need to re-deploy staff to increase staffing numbers in any affected clinical areas if required by the incident
3. Advise or assist in any temporary redesign of a clinical service to meet incident needs
4. Advise on triage - see overleaf
5. Lead the team on the consideration of vulnerable patients - either those people who are inherently vulnerable, or those made vulnerable by the circumstances of the incident
6. Make a note of key professional clinical and professional decisions and actions for subsequent reporting and debriefing of the incident.
7. Call professional/clinical assistance of outside agencies as agreed by the Incident Commander
8. Assist the Incident Commander as requested.

In the [UK](#), the commonly used triage system is the [Smart Incident Command System](#), taught on the MIMMS (Major Incident Medical Management (and) Support) training program.^[25] The [UK Armed Forces](#) are also using this system on operations worldwide. This grades casualties from Priority 1 (most urgent) to Priority 4 (expectant, i.e. likely to die).^[26]

- *Dead* - patients who have a trauma score of 0 to 2 and are beyond help
- *Immediate* - patients who have a trauma score of 3 to 10 (RTS) and need immediate attention
- *Urgent* - patients who have a trauma score of 10 or 11 and can wait for a short time before transport to definitive medical attention
- *Delayed* - patients who have a trauma score of 12 (maximum score) and can be delayed before transport from the scene

ACTION CARD 6 IT/Telephony member

IT/Telephony member

Who this is - on-call IT manager - technical background required

Report to - Incident Commander

Role:

- Advise Incident Commander on any IT or technical communication aspect of the incident
- Be the technical sorter for IT and technical communications
- Advise on the return to normal of any technical service

The standard telephone conferring number for incidents will be:



1. Advise Incident Commander on any IT or technical communication aspect of the incident
2. Consider the need to re-deploy staff to increase staffing numbers in any affected technical areas if required by the incident
3. Advise or assist in any temporary redesign of a clinical service to meet incident needs
4. Implementation of IT BCP arrangements including PO6 Adastra Plan and 111 National Business Continuity Plan
5. Lead the team on the consideration of vulnerable patients - either those people who are inherently vulnerable, or those made vulnerable by the circumstances of the incident
6. Make a note of key professional IT or technical communication decisions and actions for subsequent reporting and debriefing of the incident.
7. Call professional/clinical assistance of outside agencies as agreed by the Incident Commander
8. Assist the Incident Commander as requested.

ACTION CARD 7 Gold Commander

GOLD COMMANDER, VOCARE

This is – Chief Executive

Deputy - Executive on-call

Supported by – Communications lead

Responsible to – Vocare Executive Board

Purpose – Overall responsibility for executive and strategic decisions and external accountability

The standard telephone conferring number for incidents will be:

[REDACTED]
[REDACTED]
[REDACTED]

1. Seek a briefing from Silver Commander as soon as possible, and determine whether a declaration of *internal or major incident* is warranted. The key criteria for this is if the situation cannot be managed by day-to-day arrangements or the Vocare Escalation Plan. Reputation is also key, as is acting with NHS during national escalations: see the NHS England escalation regime attached
2. Be advised by the Silver Commander on the operability of services. Any closure or non-operability will require commissioner notification and involvement.
3. Identify the next Incident Commander shift and forward programme for relief - 4 hours is the absolute maximum
4. Inform the Chief Executive if not already appraised of issues.
5. Be accountable for Silver Commander and prompt any command shift arrangements in conjunction with the Silver Commander
6. Liaise as guided by scenario notes with
 - Commissioners
 - Press
 - Ambulance Service
 - Public Health England if necessary (i.e. involving dangerous substances)
 - Police if terrorism
 - Organisation solicitors if the situation dictates

Health and Safety Executive and other external agencies as required.

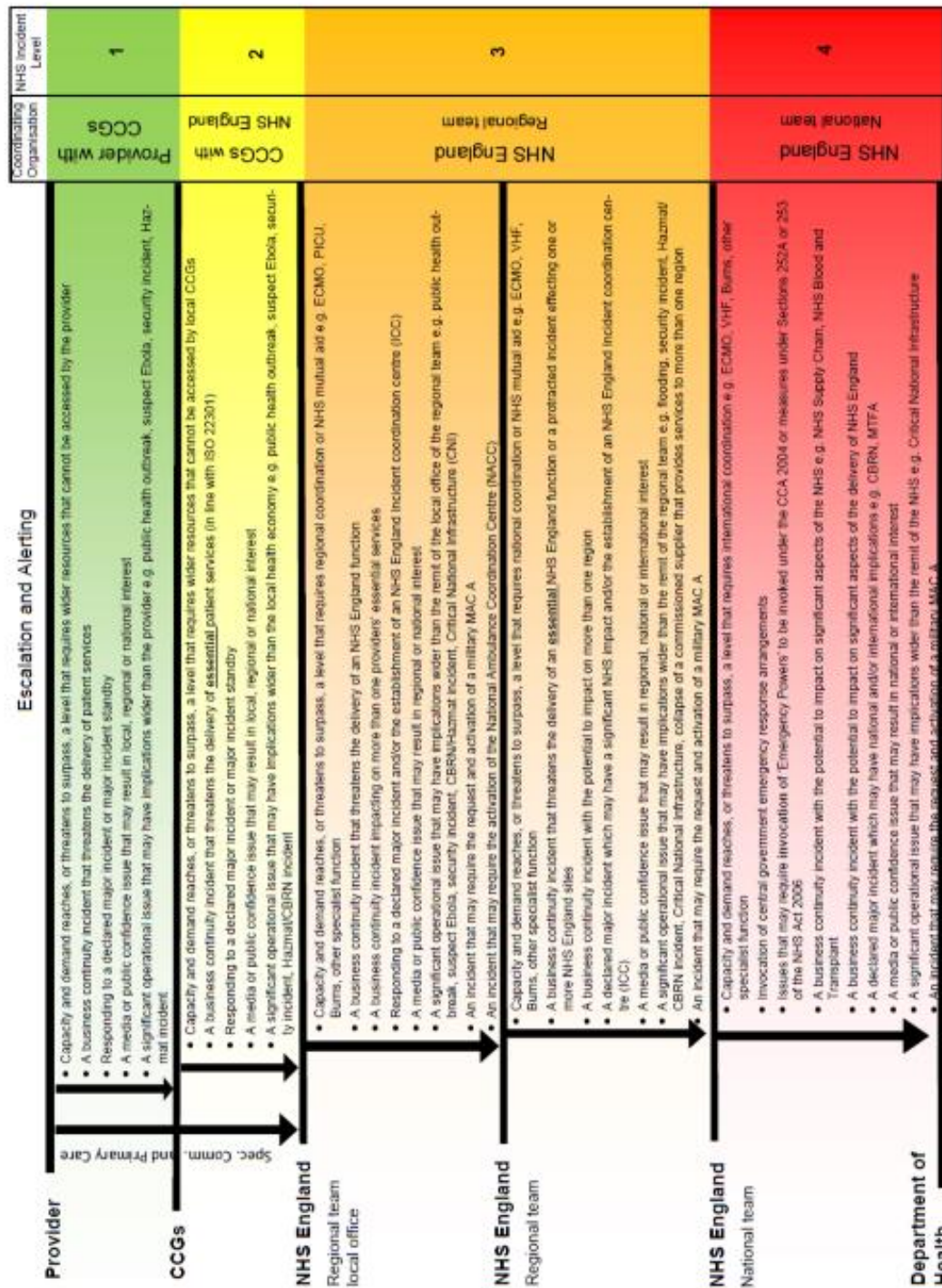
7. Formulate view with Incident Commander of the need for a separate recovery team and if so establish them as a sub-group of the Silver Team using the Recovery checklist page 37 to programme manage recovery
8. Authorise 'urgent and extreme situation measures' in extremis only e.g. fast communications and military-style triage: see Incident Team Member - clinical and professional card.
9. The Gold Commander will confirm the stand down at the end of the incident
10. Commission from the EPRR director/Accountable Emergency Officer a debrief from analysis of the incident log and other evidence to be completed within 72 hours of incident on basis of what worked well and what needs changing.
11. Note the NHS England escalation regime (overleaf)

Strategic advice

- Designate incident management aims and communicate them, especially to the Incident Commander - these will normally be, but may be altered or require additional goals depending on the situation:
 - the saving of life
 - maintenance of safe clinical practice and critical service provision
 - the protection of Vocare staff, assets and finances
 - co-operation with other responders under the Civil Contingencies Act
 - warning and informing the public.

Role review/role relief

- Think of the next shift
- Where do you expect Vocare to be in +4 hours, +8 hours, +24 hours, +3 days, + 1 week
- Remember how tiring the control role is. Identify who is next on shift with the Incident Commander.



ACTION CARD 8 Loggist

ACTION CARD 8	
LOGGIST	
Responsible to:	INCIDENT COMMANDER
Location:	VC Room in operation as control centre or dial in
Role:	Logging for your decision maker

- 1 Go to the Incident Room and report to the Incident Officer or dial into the incident number.

The **standard telephone conferring number for incidents** will be:



- 2 You are Logging for your decision maker not for the meeting
- 3 Locate the Emergency Log Book (Green CWC)
- 4 Note date, time, place in front cover
- 5 Find out the names of those present, their job titles and the organization / department that they represent
- 6 Draw a diagram of the room/table and note where the people are seated. Make a list of names with initials. Where people have the same initials i.e. DT then it will be necessary to take all three initials. i.e. DET and DIT. List
- 7 Make entries as follows: have two pages open: use the left-hand page to note key events: use the right-hand page to note the action and responses arising out of those events. Ensure that all entries are timed, recorded sequentially.
- 8 Note the relevant facts
- 9 Don't make any assumptions/comment/opinion unless based on confirmed facts
- 10 Entries must be chronological
- 11 Do not remove pages - Vocare could be called to account for what might have happened
- 12 Don't leave blank spaces
- 13 Don't overwrite, instead put a single line through the mistake and initial
- 14 Don't use correction fluid
- 15 Don't write in the margins unless it's the date and time and initials
- 16 Sign and date the log when you have finished

Keep a record of what you do... If it isn't written down, it didn't happen!

- 17 Begin each entry on a new line but ensure there are no complete line gaps between entries. The log may be submitted as evidence a future public inquiry.
- 18 At the end of your shift, you may handover to someone else, please make sure you hand this action card to them. Ensure they know what arrangements are in place for the storage and retention of all incident records, emails etc
- 19 You may be working on a rota to cover 24-hour period. Given the intensity of the work you must ensure that regular breaks are taken to relieve stress and clear the mind.

Post incident action:

- 1 Collate ALL documentation, drawings, maps, trigger notes, and A/V material pertaining to the incident for hot debrief/lessons to be learnt and future enquiries.

Take time to debrief with your Decision Maker. Agree any amendments and annotate correctly in the Emergency Log Book.

ACTION CARD 9 Regional Director

<p style="text-align: center;">Action Card 9</p> <p style="text-align: center;">Regional Director</p> <p>Deputy - Clinical Services Manager</p> <p>Responsible to - Incident Commander</p> <p>Purpose -</p> <ul style="list-style-type: none">• supervision of local response within the region• provides information on incident and response to Group level

The standard telephone conferring number for incidents will be:

██████████
██████████
██████████

1. Be briefed by the Incident Commander on the nature of the incident
2. Take an overview of all aspects of Vocare response within the region:
 - a. GP out-of-hours
 - b. 111 - there will be key measurable indicators
 - c. Urgent Care Services
 - d. Other
3. Advise on whether the incident is containable within day-to-day management arrangements or the Vocare Escalation Plan; and be clear in your advice: if not, why not
4. Represent the view of Vocare services within the context of emergency response: noting the Civil Contingencies Act responsibilities to co-operate with other responders
5. Alert commissioners locally as to suspension or restriction of services signed off by the Incident Commander. Note that this is not merely a business continuity issue - it is a reputational and contractual issue
6. Communicate any Incident requirements to local staff
7. Advise the Incident Commander on the actions needed to return to business as usual and take a regional lead in any recovery arrangements
8. Hold a Regional debrief on the "what went well/what when less well" model: see Section 15.

ACTION CARD 10 - Local service manager

Action Card 10

Local Service Manager

Responsible to - Regional Manager or Clinical Services Manager

Purpose -

- supervision of local response
- provides information on incident and response to Group level

1. Make contact with the Regional or Clinical Services lead
2. Receive briefings and carry out any functions allocated within the incident
3. If this is a Major Incident, and you are a UCC matched with an A&E, be briefed by the A&E lead clinical and follow the UCC Major Incident Action Card (pages 87)
4. Team Leaders to inform service commissioner in case of 111 service failure: see also guidance in problems section pages 46-50
5. Ensure welfare of staff within the area of responsibility including Security
6. Brief your manager on any requests made to you by external and NHS bodies including the Police: follow all Police instructions
7. Identify any child protection issues with your manager and act on them including unaccompanied children
8. Provide increased capacity to assess and meet early discharges from hospital if required
9. Provide assessment and treatment of evacuated patients including meeting chronic health care needs and arranging medication stocks, or mass treatment/vaccination as guided by national requirement
10. Identify to your manager any issues to get back to normal after the incident
11. Identify any areas of learning from the incident and report to your manager on them.

13. Recovery Phase - Recovery Team

As soon as the incident is under immediate control, and at a point to be determined by the Gold Commander as advised by the Incident Commander, a recovery team should be put in place.

Membership will be determined by the agenda which is:

- Reduction of risks to acceptable tolerances
- The creation of a recovery programme plan including finance
- How capacity will be managed so that, as far as possible, normal clinical activity can be maintained
- The outcome of the incident debrief and immediate and longer-term remedial action
- Management of the Serious Untoward Incident protocol
- Physical recovery of systems: managerial, estates, IT, telecommunications
- Repatriation of 'outlier' patients
- Accommodation requirements including identification of alternate temporary business sites
- Replacement and investment priorities.
- Securing temporary replacement equipment
- Financial issues including cost recovery from response.
- Recovery of records
- Recovery of shift patterns if these are disturbed
- Recovery of records: placing manually kept records in normal IT systems
- Multi-agency aspects of recovery including contribution to those bodies set up by the National Recovery Guidance including economic recovery
- Take into account the long-term effects of the event e.g. staff fatigue, health and work issues
- What will the plan be for return to normal working following the adaptation of normal standards of care?
- Legal issues including formal inquiry arrangements
- Communications issues: information for the public on the scope of service, management of reputation
- Arrangements for receiving VIPs e.g. Ministers, MPs etc
- The setting up of memorial etc appeals, services etc.

The Team will continue to function until a point defined by the Gold Commander advised by the EPRR lead or other suitable senior manager. Work should be project, and programme, managed.

This list, derived from National Recovery Guidance³, is not exhaustive but a guide to action required.

³ <https://www.gov.uk/guidance/national-recovery-guidance>

14. Plan resources

Section A: Brief plans for key risks: all scenario based risks are subject to the overall command arrangements given above.

- Loss of equipment / IT / telecommunications- **A.1.i-iii**
- Loss of staff and key skills, either temporarily or permanently (e.g. flu, weather, health and safety incidents, industrial action) - **A.2**
- Loss of utility (power, water, medical gas) - **A.3.1-iv**
- Denial of site (e.g. lifts, stairwells, corridors, entire site etc.) including Structural damage (e.g. fire, natural disaster) - **A.4** (A4i Flooding, A4ii Total Evacuation)
- Supply chain disruption- **A.5**
- Extreme Weather - **A.6**
- Service escalations - how to deal with surges in demand - **A.7**
- Major incidents including terrorism and CBRN - **A.8**
- Pandemic Flu and other outbreaks - **A.9**
- Dealing with VIPs - **A.10**

Section A.1.i

Problem: Loss of equipment		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none">the saving of lifemaintenance of safe clinical practice and critical service provision (see Section B)the protection of Vocare staff, assets, and financesco-operation with other responders under the Civil Contingencies Actwarning and informing the public - Comms Team. <p>These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Incident Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none">access local information on the affected equipmenttry to ascertain the potential length of disruption in hoursassess how crucial the equipment is and the services provided by the equipmentconsider if portable items of equipment could be deployed or if similar equipment exists locally - inter division, inter site, and across organisations.are alternative suppliers or short-term acquisition appropriate?what workload needs to be cancelled or relocated? What's the effect on the relocated area?consider diverting workload to alternative areas locally, dependent on capacity and priority of work.	
Actioned by:		
Key Contacts:	Contact Details:	What action will happen/what plan invoked
Local managers	Via internal ext or via local switchboard	Local inventory of equipment: location of manuals: specific diversion of work or mutual aid agreements: local prioritisation of work: contracts where local Medical Electronics expertise not held
Security	Local host site security contact	Security Policy:

Manager		initiation of recovery of lost equipment																								
Medical Electronics	Via internal ext or via switchboard	Maintenance and repair of Medical Equipment Policy; fixing																								
Supplies	<p>Normal internal arrangements</p> <p>NHS Supply Chain contacts</p> <table> <tr> <th>Area</th><th></th><th>Telephone</th></tr> <tr> <td>North West England</td><td>Runcorn</td><td>01928 858575</td></tr> <tr> <td>North East England</td><td>Normanton</td><td>01924 328722</td></tr> <tr> <td>North Midlands</td><td>Alfreton</td><td>01623 587173</td></tr> <tr> <td>East of England</td><td>Bury</td><td>01622 402691</td></tr> <tr> <td>Central England</td><td>Rugby</td><td>01623 587092</td></tr> <tr> <td>Southern England</td><td>Maidstone</td><td>01622 402669</td></tr> <tr> <td>South West England</td><td>Bridgwater</td><td>01623 587165</td></tr> </table>	Area		Telephone	North West England	Runcorn	01928 858575	North East England	Normanton	01924 328722	North Midlands	Alfreton	01623 587173	East of England	Bury	01622 402691	Central England	Rugby	01623 587092	Southern England	Maidstone	01622 402669	South West England	Bridgwater	01623 587165	<p>Evaluation and procurement of alternative supplies - consideration of short-term replacement</p> <p>NHS Supply Chain has a proven emergency service that is available to NHS organisations 365 days per year, 24 hours per day and is committed to delivery of a stocked product within five hours of any emergency request being received.</p>
Area		Telephone																								
North West England	Runcorn	01928 858575																								
North East England	Normanton	01924 328722																								
North Midlands	Alfreton	01623 587173																								
East of England	Bury	01622 402691																								
Central England	Rugby	01623 587092																								
Southern England	Maidstone	01622 402669																								
South West England	Bridgwater	01623 587165																								
Gold Commander	Via start routine	Declaration of Internal Incident?																								
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Cost of urgent delivery • Cost of repair/replacement • Insurance • Commissioning • Associated services provision • Avoiding future “single point of failure” loss. 																										

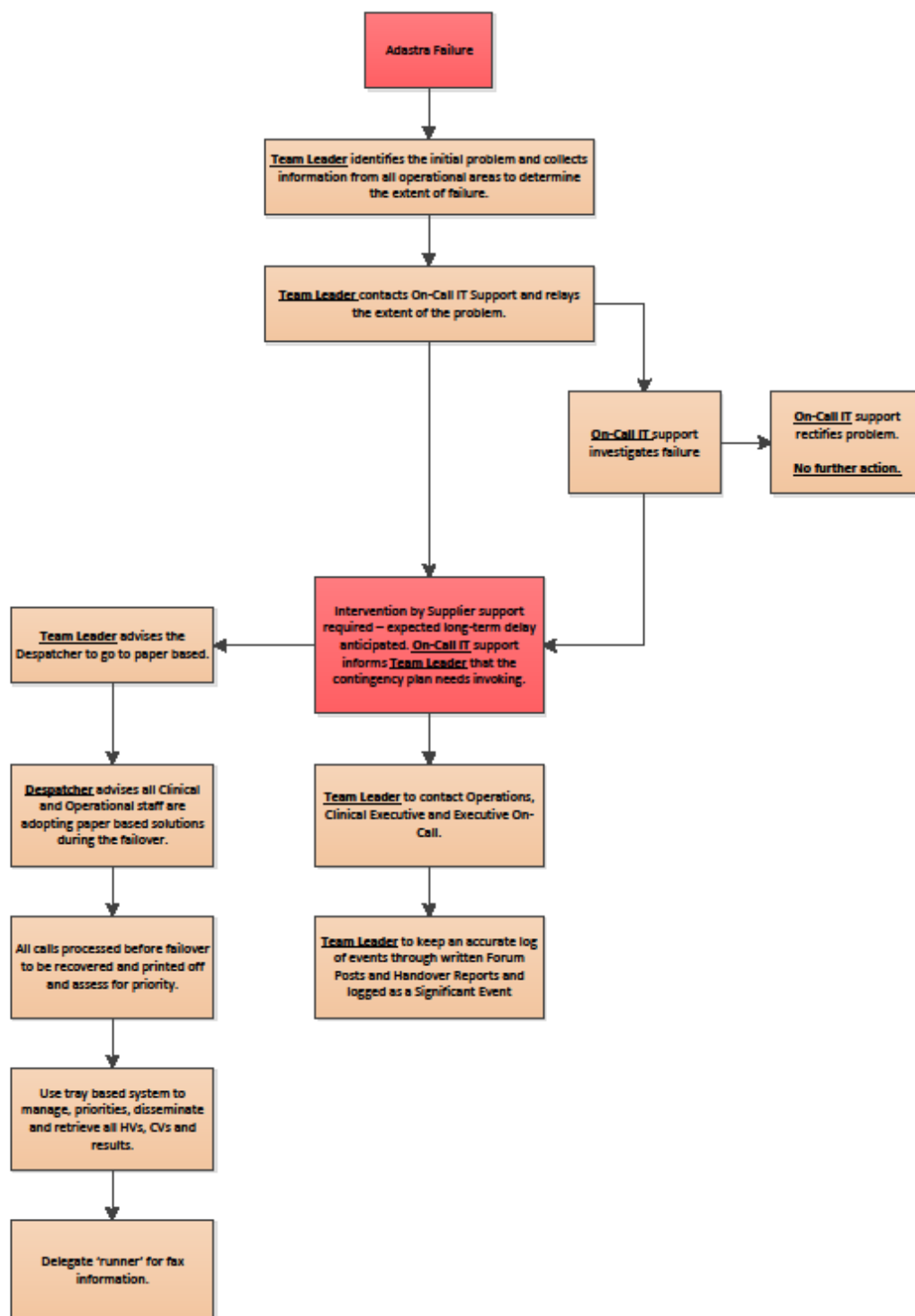
Section A.1.ii

Problem: Loss or failure of IT		
<i>Operating risk and information requirements appropriate for each level of decision maker</i>		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> • the saving of life • maintenance of safe clinical practice and critical service provision (see Section B) • the protection of Vocare staff, assets and finances • co-operation with other responders under the Civil Contingencies Act • warning and informing the public: Comms Team. <p>These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Incident Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none"> ○ is disruption located on a stand-alone service or localised part of a Vocare-wide service? ○ assess locally extent of: <ul style="list-style-type: none"> ○ crucial clinical systems required for patient care ○ crucial non-clinical systems ○ non-critical systems requiring medium to long term re-provision ○ ascertain alternative systems for replicating the workload locally (e.g. written requests) reassign work tasks accordingly ○ establish if the disruption needs local hardware repair / replacement, and for how long ○ is disruption outside Vocare but affecting Vocare operations severely? ○ Sanction use of paper and manual systems ○ Sanction recovery from paper etc to digital systems ○ Be aware of local plans referenced below ○ Review Section B critical service priorities 	
Key Contacts:	Contact Details:	What action will happen/what plan invoked
Digital Department	IT escalation and repair	IT Business Continuity Plan and fixing - plan V-GP66
Adastra	01233 722700	Out-of-hours escalation Contingency Contact
Local mitigation plans	Include paper operation	Local action to move to paper and manual systems: :Plan PO6 Adastra Contingency Plan; Local protocols for escalation: see below for indicative

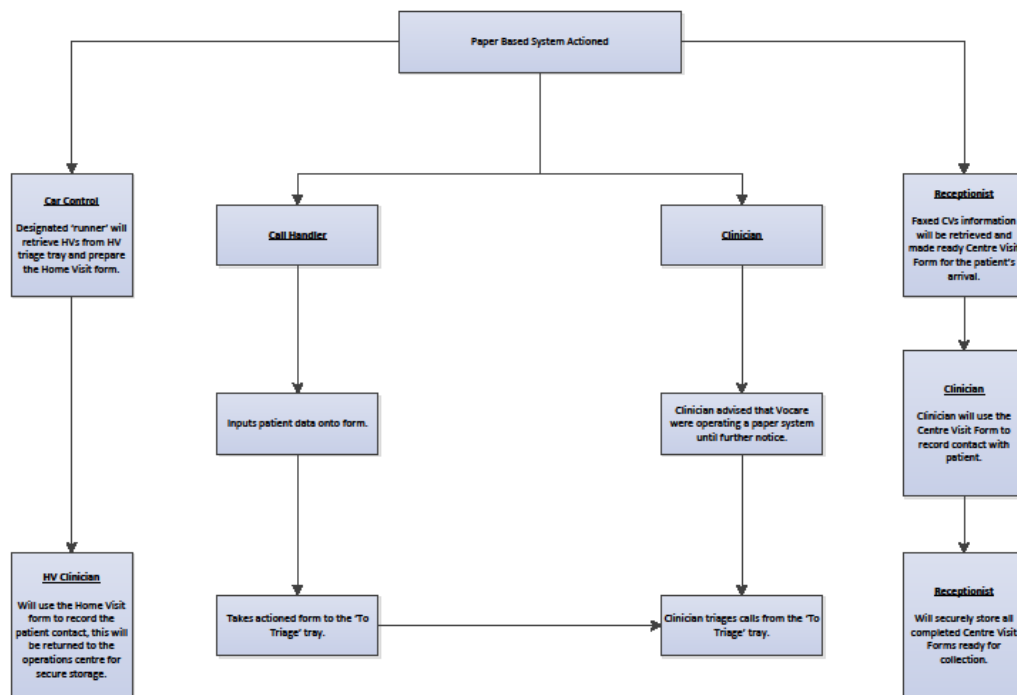
	<p>Include alternative pathways</p> <p>Inform service commissioner</p>	<p>action</p> <p>Use of Pathways Solo to support call handlers: eg V-OM-543 NHS111 use of pathways in the event of a system failure</p> <p>Team Leaders to inform service commissioner in case of 111 service failure: see also Action Card 10</p>		
Silver Commander and other NHS resouces	<p>Via escalation routine</p> <p>Escalate to 111 National Contingency Plan if not resolvable within 20 minutes</p> <p>111 NCC: https://www.england.nhs.uk/wp-content/uploads/2014/02/nhs11-escl-pol.pdf</p>	<p>Declaration of internal incident</p>		
<p><i>Specific recovery issues:</i></p> <table><tr><td><p>Debrief</p><p>Cost of urgent delivery</p><p>Cost of repair/replacement</p><p>Verify that systems expected to be “automatic” actually are: back up, data mirroring.</p></td><td><p>Insurance</p><p>Commissioning</p><p>Maintenance routines eg back up</p><p>Associated services provision</p><p>Avoid future “single point of failure” loss</p></td></tr></table>			<p>Debrief</p> <p>Cost of urgent delivery</p> <p>Cost of repair/replacement</p> <p>Verify that systems expected to be “automatic” actually are: back up, data mirroring.</p>	<p>Insurance</p> <p>Commissioning</p> <p>Maintenance routines eg back up</p> <p>Associated services provision</p> <p>Avoid future “single point of failure” loss</p>
<p>Debrief</p> <p>Cost of urgent delivery</p> <p>Cost of repair/replacement</p> <p>Verify that systems expected to be “automatic” actually are: back up, data mirroring.</p>	<p>Insurance</p> <p>Commissioning</p> <p>Maintenance routines eg back up</p> <p>Associated services provision</p> <p>Avoid future “single point of failure” loss</p>			

Local Adastra failure-specific routines - examples and see overleaf graphics from Plan PO6

Appendix 5 to P06: Adastra Contingency Instigation Flow Chart



Appendix 6 to PO6: Paper-Based System Flow Chart



Section A.1.iii

Problem: Telecommunications failure		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Command	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> • the saving of life • maintenance of safe clinical practice and critical service provision (see Section B) • the protection of Vocare staff, assets, and finances • co-operation with other responders under the Civil Contingencies Act • warning and informing the public <p>These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Incident Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none"> • assess the extent of the impact of telecoms failure: <ul style="list-style-type: none"> ▪ 111, Adastra ▪ crucial non-clinical systems ▪ non-critical systems • implement alternative systems for replicating the workload - see Adastra Plan PO6 and summaries in Appendix A.1.ii • establish whether the disruption requires localised hardware repair / replacement • how long will the problem take to fix? <ul style="list-style-type: none"> ○ Does fixing the problem pose more risks? • sanction use of alternatives: WhatsApp, Microsoft Messenger etc - for minimum time to avoid information governance risks • be aware of local plans referenced below • review Section B critical service priorities 	
<i>Key Contacts:</i>	<i>Contact Details/information:</i>	<i>What action will happen/what plan invoked</i>
Digital Department	IT escalation and repair	IT Business Continuity Plan and fixing - plan V-GP66 Out-of-hours escalation
Telecoms contractor	Shore Tel Unified Communications System 01344 208800 Call for P1 priority	https://support.shoretel.com/kb/view.php?id=kA6C000000LCLS KA4
BT Linkline	BT Emergency Linkline 08457 555999	Emergency public

emergency line	BT is a Category 2 responder under the Civil Contingencies Act 2004 and as such obliged to co-operate with other local responders such as Vocare. If BT will not stand up for Vocare, the lead CCG involved may need to call into this service to activate it.	service helpline under CCA2004
Use of WhatsApp or alternatives	Sanctioned by Incident Commander for a set period.	Communication to alert organisation
Silver Commander	Via escalation	Setting up of Incident Command?
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Debrief • Cost of urgent deliveries • Cost of repair/replacement • Insurance • Use of mobile phones off-main system • Commissioning • Associated services provision • Avoiding future “single point of failure” loss. 		

Section A.2

Problem: Loss of staff		
Operating risk and information requirements appropriate for each level of decision maker		
Executive		Incident Commander
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none">the saving of lifemaintenance of safe clinical practice and critical service provision (see Section B)the protection of Vocare staff, assets and financesco-operation with other responders under the Civil Contingencies Actwarning and informing the public Comms Team. <p>These may be amended by the Gold Commander according to circumstances prevailing:</p> <ul style="list-style-type: none">can non-essential services be closed to create additional staff capacity for deployment to essential services? may require agreement with commissionersconsider availability of staff from other NHS Trusts in agreement <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary- see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>		<ul style="list-style-type: none">find out proportion of staff affected.do commonalities exist in loss of staff?, i.e. is there a pattern?can staff from non-essential areas be redeployed to essential services given skill profile?is there anyone else who has experience of working in the affected area (e.g. staff members who have recently left the department)can non-clinical staff be deployed to clinical support duties?can non-essential services be closed to create additional staff capacity for deployment to essential services?use of staff accommodation options - call accommodation team or site managersapply escalation routines derived from Business Continuity Analysis Section B
See overleaf		
Key Contacts:	Contact Details:	What action will happen/what plan

		<i>invoked</i>
Departmental managers	Via this plan and cascades page 10	Maintain lists of staff for urgent call-out
HR	Nursing Medical Administrative Advice on industrial relations issues General enquiries	Access to approved staff agency working HR Protocols
Nursing		Escalation/resolution of nursing shortages
Gold Commander	Via cascade	Setting up of Incident Command?
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Debrief • Cost of additional staff • Causes of staff loss • Accommodation for overnight stays • HR and Occupational Health issues 		

Section A.3.i

Problem: Loss of power		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> the saving of life maintenance of safe clinical practice and critical service provision (see Section B) the protection of Vocare staff, assets and finances co-operation with other responders under the Civil Contingencies warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing:</p> <ul style="list-style-type: none"> if the power supply is provided from emergency generator supply only, activity needs to be altered accordingly: may require agreement with commissioners <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none"> establish the extent and the nature of the loss of power. check whether all emergency backup generator systems are operating normally and are resilient supply. if the power supply is provided from emergency generator supply only, inform the affected location and discuss with Gold can essential/non-essential working across be implemented? consider the impact the loss of power has had on support services which are required for Business Continuity in crucial functions - see Appendix B priority list should staff be deployed to assist in secondary issues arising as a result of the power loss (e.g. lift trap-ins, assisting members of the public) is service relocation required? See Denial of site scenario is the electricity outage part of a blackstart scenario? If so, how wide is the outage, and how long will the supply be affected for as a minimum? If the outage is part of industrial action, speak to the relevant local authority regarding protection from rota'ed cuts - in practice, this may be extremely difficult. 	
<u>overleaf</u>		
Key Contacts:	Contact Details:	What action will happen/what plan invoked

Systems	Generators for essential areas kick in automatically upon suspension of service. If this is not the case due to scheduled works on an NHS site this should be approved by the NHS organisation permit to work and operational resilience arrangements	Cut in of emergency generators and uninterruptible power supplies; all sites are covered by emergency generation covering high risk areas
Estates/Facilities of local site	Via local switchboard to the on-call estates manager bleep	Estates Emergency On-Call Manual
EDF	<p>1. Unexpected power cuts (e.g. accidental line cut)</p> <p>Power supply companies are a Category 2 responders under the Civil Contingencies Act 2004 and as such obliged to co-operate with other local responders such as the Trust</p> <p>2. V list exemption for rota'ed cuts (e.g. 1973 conditions of national shortage)</p>	<p>Service standards and main emergency numbers defined by local company website eg EDF at http://www.edfenergy.com/products-services/networks/customer-services/standards-of-service.shtml</p> <p>Vocare does not have V list status - discuss with relevant local authority.</p>
IT Department	IT escalation	<p>IT Business Continuity Plan and fixing - plan V-GP66</p> <p>Out-of-hours escalation</p>
Gold Commander	Via cascade	Setting up of Incident Command?
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Debrief • Adequacy of alternative power supplies • Cost of permanent damage to plant and equipment • Establish the reason for the loss of power • Remedial action. 		

Section A.3.ii

Problem: Loss of water supply		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> the saving of life maintenance of safe clinical practice and critical service provision (see Section B) the protection of Vocare staff, assets, and finances co-operation with other responders under the Civil Contingencies Act warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing:</p> <ul style="list-style-type: none"> if the power supply is provided from emergency generator supply only, activity needs to be altered accordingly: may require agreement with commissioners <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none"> what is the extent and the nature of the loss of water supply? a resilient and safe supply? quantity of water currently stored on site and estimated length of time before supplies exhausted without conservation measures in place? should supplies be switched off? are appropriate onsite water storage options operating normally? relocate essential services in areas currently occupied by non-essential services? use of a secondary supply (tanker-how long to implement?)? (hydrant water have the Fire Brigade been informed and when?) conservation of reserve stock of stored water by reducing demand suspending supply of water to non-critical areas consider Fire and Rescue Service option (999) if conventional resources do not resolve water issue for non-drinking isolation options available? contamination issues (if any)? review Section B critical service priorities 	
overleaf		
Key Contacts:	Contact Details:	What action will happen/what plan invoked

Estates and facilities	Normal organizational arrangements	Local site Estates Emergency On-Call Manual Assessment of internal or external problem Assessment of quantity of water supply left
Infection control advice	Normal organizational arrangements	Assessment of water supply quality and alternatives
Water	Service standard defined as per local website. Eg Main number Thames Water 0845 9200 800 if water - also see steam supply p.41 For example, Thames Water is a Category 1 responder under the Civil Contingencies act 2004 and as such obliged to co-operate with other local responders such as Vocare.	Service standard defined as per local website: for example http://www.thameswater.co.uk/cps/rde/xchg/corp/hs.xsl/3018.htm <ul style="list-style-type: none"> • “If there is an unplanned interruption, for example when a water main bursts, water supply back on within 12 hours of knowing about this problem. • If a larger “strategic” main bursts, we guarantee to fix it within 48 hours.” See Information section below
Other NHS sites	Via contact list	NHS sites
Gold Commander	Via cascade page 10	Setting up of Incident Command?
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Debrief • Adequacy of alternative water supplies • Establish the reason for the loss of water supplies • Remedial action. 		

Section A.3.iii

Problem: Loss of medical gas		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> • the saving of life • maintenance of safe clinical practice and critical service provision (see Section B) • the protection of Vocare staff, assets and finances • co-operation with other responders under the Civil Contingencies Act • warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none"> • establish the extent and the nature of the loss of medical gas. • ensure areas requiring emergency supply are receiving appropriate resilient and safe supply. • are appropriate backup systems are operating normally? (e.g. reserve tank supply / bottled gas). • Consider if other areas of Vocare have been affected locally by the disruption. If not relocate essential services in areas currently occupied by non-essential services? • review Section B critical service priorities 	
Key Contacts:	Contact Details:	What action will happen/what plan invoked
Local host estates departments	<p>Automatic reading in place</p> <p>via local switchboard to the on call estates manager: or out of hours via bleep</p>	<p>Estates Emergency On-Call Manual, local contact details for BOC and suppliers</p> <p>Assessment of bottled, tank or pipeline problem; quantity of supply left</p>

		Accessing bottled supplies through nearby health facilities and use of transport
BOC	http://www.boconline.co.uk/contact/in_an_emergency.asp Customer Service Centre - 0800 111 333 - For emergencies relating to industrial gases, industrial products, safety products, healthcare, medical gases or related services offered by BOC.	BOC 24 hour helpline - "we can guarantee emergency deliveries within four hours"
Gold Commander	Via escalation	Setting up of Silver Command?
<p><i>Technical Briefing:</i></p> <ul style="list-style-type: none"> • BOC monitor on site oxygen using telemetry • There are usually a number of days' supply held on site • Local host estates departments will have information on supply and usage. 		
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Debrief • Adequacy of alternative supplies • Establish the reason for the loss of supplies • Remedial action. 		

Section A.3.iv

Problem: Denial of site/access, including fuel, and structural damage		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> the saving of life maintenance of safe clinical practice and critical service provision (see Section B) the protection of Vocare staff, assets, and finances co-operation with other responders under the Civil Contingencies Act warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing:</p> <ul style="list-style-type: none"> sanction partial or total evacuation with commissioner assess the risks associated with patients remaining within clinical areas affected by the loss of access. Consider temporary evacuation where necessary, bearing in mind the risks associated with this to patient care strategic management of fuel restrictions: extent of service changes re fuel rationing with NHS England/ commissioner and multi-agency emergency planning structures (see relevant local authority) - this will be an extended incident <p>These may be amended by the Gold Commander according to circumstances prevailing.</p>	<ul style="list-style-type: none"> There are many local health and safety and fire plans - these are referenced below consider alternative points of access to the service locally. use specific plans if available for the problem. can the service to continue with limited options for access (e.g. loss of lifts etc). can essential functions be relocated in an accessible area locally that is unaffected by the disruption look at and apply local business continuity plans for fuel rationing on National Emergency Plan-Fuel review Section B critical service priorities <p>.....over</p>	

Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40. If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.																								
Key Contacts:	Contact Details:	What action will happen/what plan invoked																						
Local centre staff	<div>Via local managers</div> <table><tr><td>HSP 1</td><td>Fire Emergency Procedures Vocare House</td></tr><tr><td>S-HS P3</td><td>Staffordshire House Fire Emergency Procedures</td></tr><tr><td>S-HS P4</td><td>Arun House Fire Emergency Procedures</td></tr><tr><td>S-HS P5</td><td>Elizabeth House Fire Emergency Procedures</td></tr><tr><td>S-OM 786</td><td>Business Continuity - Centre Relocation</td></tr><tr><td>S-OM 787</td><td>Wolverhampton UCC Safety Procedures</td></tr><tr><td>SO-OM 682</td><td>Wellington House Fire Evacuation</td></tr><tr><td>SU-OM 8004</td><td>Safety Procedures at Washington UCC</td></tr><tr><td>SU-OM 8006</td><td>Safety Procedures at Houghton UCC</td></tr><tr><td>T HS P2</td><td>Crutes House Fire and Emergency Procedures</td></tr><tr><td>YS-OM 1308</td><td>Maple House Fire and Evacuation Procedure</td></tr></table> <div>Include all medical staff available on triage priorities</div>	HSP 1	Fire Emergency Procedures Vocare House	S-HS P3	Staffordshire House Fire Emergency Procedures	S-HS P4	Arun House Fire Emergency Procedures	S-HS P5	Elizabeth House Fire Emergency Procedures	S-OM 786	Business Continuity - Centre Relocation	S-OM 787	Wolverhampton UCC Safety Procedures	SO-OM 682	Wellington House Fire Evacuation	SU-OM 8004	Safety Procedures at Washington UCC	SU-OM 8006	Safety Procedures at Houghton UCC	T HS P2	Crutes House Fire and Emergency Procedures	YS-OM 1308	Maple House Fire and Evacuation Procedure	<div>Fire: Evacuation using Firecode and other tactical principles including assessment of threat and local evacuation and health and safety plans</div> <div>Incident Command to determine replication of functions</div> <div>See specific advice on triage on the Professional Incident Team Action Card. Rapid assessment of which patients can be moved and by what means: triage at exit cordon if necessary</div>
HSP 1	Fire Emergency Procedures Vocare House																							
S-HS P3	Staffordshire House Fire Emergency Procedures																							
S-HS P4	Arun House Fire Emergency Procedures																							
S-HS P5	Elizabeth House Fire Emergency Procedures																							
S-OM 786	Business Continuity - Centre Relocation																							
S-OM 787	Wolverhampton UCC Safety Procedures																							
SO-OM 682	Wellington House Fire Evacuation																							
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SU-OM 8006	Safety Procedures at Houghton UCC																							
T HS P2	Crutes House Fire and Emergency Procedures																							
YS-OM 1308	Maple House Fire and Evacuation Procedure																							
Local Ambulance Service	Via local Control contacts	<div>Emergency patient transport - main source following rapid assessment of patient requirements.</div> <div>Consider other organisations transport with/without nurse escort as dictated by rapid risk evaluation.</div>																						
Security/Facilities	Implementation of local NHS Trust Lockdown Policy	Following local lead site instructions or																						

		specific Vocare plans below
Local Authority	Local Authorities are Category 1 responders under the Civil Contingencies Act 2004 and as such obliged to co-operate with other local responders such as Vocare.	<p>Access during snow maintained preferentially to main trunk roads</p> <p>Lead agency for humanitarian assistance if basic shelter is required before final transfer of patients to other sites.</p> <p>Fuel plan requirements.</p>
Estates	via switchboard to the local on call estates manager: or out of hours via bleep	<p>Local Estates Emergency On-Call Manual</p> <p>On-site gritting/snow removal/small scale water pumping</p> <p>Following local lead site instructions or specific Vocare plans below</p>
Fire wardens	Via individual sites	Lead response to evacuation including fire on NHS principles: Primary horizontal evacuation
IT Department	IT escalation	<p>IT Business Continuity Plan - fixing; evaluation and procurement of alternative supplies - consideration of short-term replacement</p> <p><i>.....overleaf</i></p>
Local Health Resilience Forum and Local Authority-led Local Resilience	<p>National Emergency Plan - Fuel</p> <p>See BCM Plan for Fuel below</p>	First stage will be the limiting of national usage to 15 litres at the pumps

Forums		Second stage will be NHS logoed vehicles. See detailed notes below
Total Evacuation	Appendix A4ii	
Flooding	Incident hotline: You should use the incident hotline to report an incident, such as pollution: 0800 807060 (Freephone, 24 hour service) Floodline: 0845 988 1188 (24 hour service) or Type talk 0845 602 6340	
Gold Commander	Via escalation	Setting up of Silver Command?

Scenario-specific - FUEL

Fuel restrictions

likely to be preceded by considerable press warning:

Communications

Communications will be realistic, constructive and creative, and have an accent on self-help including car sharing and use of public transport, but will not raise unrealistic expectations of meeting increased staff demand for fuel, and not seek to take the responsibility away from staff of attending for work: it will not be feasible for Vocare to completely replace failing public transport services for the numbers of staff involved in a period of fuel restrictions.

Specifically in relation to staff, communications will differentiate between the 2000 DoH response, in which all healthcare staff were seen as key users, and any future DoH position on interruption to supply, in which we are led to believe at the time of writing that very few staff will be given priority supply.

Communications will also need to use currently in place systems for the following stakeholders;

- The press
- Suppliers, including non-local contracts
- Commissioners, specifically in relation to the application of *force majeure* in NHS Standard Contract - note however, the reputation effects of service closure or deferral.

Fulfilment of sitrep requests from NHS England and resilience partners and issuing of necessary permits will be the responsibility of the Director of Operations.

Development of long-term response - avoiding problems

The following desirable developments will help manage the situation:

- Staff travel plans including green alternatives and current travel plans used by staff
- Use through Vocare purchasing of more fuel-economical vehicles
- Shared use of other bulk areas with the permission of those areas and within the national framework.

Technical briefing - likely stages of UK Fuel restrictions

1. *Alert via Local Health Resilience Partnerships³ etc of fuel issue: out-of-organisation sitrep schemes established*

Director of Operations uses intelligence from press to influence communications. Staff communications have 'basic facts' of NEP-F and 'don't panic' elements - DoH approach in 2000 and DoH approach now.

Logo scheme advice from LHRPs and Local Authorities - and other internal reviews External sitrep requirements.

Establish capacity for joint use of local bulk fuel supplies

Assessment of fuel criticalities: out-of-hours doctors and isolated units community midwives, dialysis units and other outreach: ophthalmic, low clearance, food and linen supplies: estates support for generators

Review applicability of Flexible Working Policy.

2. *NEP-F universal 15 litre scheme (known in NEP-F as 'Maximum Purchase Scheme - MPS') implemented*

Fuel specific Business Continuity Management Team established by Director of Operations using some elements of pandemic plan (e.g. sitreps as required, accommodation options).

Effect on services monitored via Ops Room routines

Advice to members of staff on the technical requirements of how the MPS works - reminder of obligation to attend work, no use of permit scheme for journeys to work, car sharing provisions.

Advice to members of staff re public transport: to other stakeholders via systems described.

Assess suppliers' ability to cope.

3. *National situation deteriorates - MPS limited below 15 litres - internal consideration intensifies*

Consideration by BCM team with commissioners of restriction of non-urgent activity - scope, extent - using PanFluPlan and Business Continuity Management / Business Impact Analysis priorities as guide - discuss with commissioners

Internal/external monitoring requirements extended intensively

Final preparation for issuing of Temporary Logo Scheme permits under secure and

auditable conditions - reminder to staff involved of conditions and criminal penalties for abuse.

Staff info on conditions prevailing.

Consider feasibility/extent of staff transportation.

4. *Permit scheme (known in NEP-F as Temporary Logo Scheme (TLS)) implemented*

Restriction of non-urgent activity by Business Continuity Management team - scope, extent - using current situation & PanFluPlan and Business Continuity Management / Business Impact Analysis priorities as guide

Issuing of Temporary Logo Scheme permits under secure and auditable conditions

Staff info on conditions prevailing.

Consider feasibility/extent of staff bus runs.

Assess suppliers' ability to cope - supplies will begin to fail.

Fuel Estimates for use under operation of the National Emergency Plan - Fuel (NEP-F)

One item of NHS EPRR work is the need for organisations to estimate fuel requirements in the event of fuel shortages such as those caused by the 2000 fuel strike.

There are a number of reasons for this:

- To inform national planning assumptions
- To form a negotiation starting point with local fuel sources and local authorities during conditions of shortage and
- Ultimately, to safeguard the essential services which Vocare provides.

Not all activity will be safeguarded during conditions of shortage – obviously – and the criteria for what can and what cannot be applied for by organisations as essential is set out in a government document called the National Emergency Plan – Fuel (NEP-F). This will of course also be a moving feast as conditions deteriorate or get better.

The NEP-F is not a public document due to considerations of fuel security, but has been taken into account, and was last used practically during the Hoyer Strike and closure of Grangemouth fuel terminal at the end of the last decade. Again, obviously, it is important that Vocare is seen to be on the same page as NHS organisations in this respect as an essential service provider.

The **criteria for eligibility for essential fuel support** is expected to be as follows, defined for planning purposes as:

INCLUDED:

- Continuity Plans that allow NHS organisations to scale back care in a planned way in the event of a disruption to the distribution of road fuel
- Guidance to NHS organisations for defining essential users/functions, in priority order, should be followed and is based upon:
 - ***Activities to reduce mortality, morbidity and significant progression of disease.***
 - ***Activities that will alleviate human suffering, including palliative care.***
 - ***Activities that meet any legal obligations, such as those contained in The Children Act 2004, Mental Health Act 2007 and others***

RESTRICTIONS AND CONSIDERATIONS:

- **Priority supplies are not generally for the purpose of getting staff to work when public transport should be used**
- Abuse of any privileged position in obtaining fuel under the NEP-F, is a criminal offence. This can result in offenders being prosecuted under section 18(2) of the Energy Act 1976 and be subject to any internal disciplinary procedures by their employer
- Whilst acknowledging the high number of community-based healthcare workers who use their own vehicles, organisations are to be robust in determining priorities as the inclusion of too many users will create further strain on already limited stocks to the detriment of other essential users.

Fuel use estimates in April 2018

<i>Region</i>	<i>Normal usage</i>	<i>80% of normal usage to meet priority functions</i>
North East	113/ltrs per day	91/ltrs per day
Staffs	155/ltrs per day	124/ltrs per day
South West	57/ltrs per day	46/ltrs per day
Yorkshire	35/ltrs per day	35/ltrs per day
London	65/ltrs per day	55/ltrs per day

The figure of 80% of normal consumption covers priority functions noted above during a petrol shortage. This is based on the fact that we operate an essential service as business as usual: of course, in practice, less may be available, and it is a good idea to start negotiations with a figure that isn't too low. Vocare uses no bunkered fuel, and the primary supplier is 5 Star.

Use of the information in this paper

The final results from this exercise will be put into the amended EPRR Plan for this year. The figures and above discussions on priority should be used as the basis for discussions with the relevant local authorities and Police in the event of a declaration of a fuel crisis under the National Emergency Plan-Fuel in order to safeguard Vocare's essential service provision to the public.

Russell King, Vocare EPRR, April 2018

Specific recovery issues:

- Debrief
- Establish the reason for the loss of access
- Assess cost of any loss of service or damage to plant, buildings or equipment resulting from loss of access
- Use by other agencies of Vocare facilities
- Assess service/HR effect
- Accounting - personal and corporate - of Temporary Logo Scheme permits
- Remedial action.

Section A.4

Problem: Flooding		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> the saving of life maintenance of safe clinical practice and critical service provision (see Section B) the protection of Vocare staff, assets, and finances co-operation with other responders under the Civil Contingencies Act warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing.</p> <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If evacuation is required or is under consideration, or if higher level co-ordination is required - likely to be under a situation where multiple business continuity problems such as loss of power, IT, telephones, and safe drinking water combine - it will be necessary to consider wider community aspects, including any warning and informing, humanitarian assistance, mass transport requests, and any community confidence issues with the local authority.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard</p>	<ul style="list-style-type: none"> Duty Director of Operations (in-hours) or Manager/Director on Call (out-of-hours) should be informed - see Business Continuity Plan page 4 -if necessary, a Business Continuity cascade will be made The generic response section of the Business Continuity Plan should be used to guide further action -but may require further action from other parts of the Business Continuity Plan Public Health England will advise on potability of drinking water in case of doubt. The following should take place with immediate effect: Isolate the electrics so that the ground floor of the building is without power All electrical/PC equipment and sensitive material (e.g. nuclear waste) to be raised off the floor in the affected areas. Also consider raising any items stored at ground floor level to a safe level - see attached briefing on sites. <p style="text-align: right;">....over</p>	
	Incident Commander to cascade to	

Contract requirement	<p>staff containing the following information;</p> <ul style="list-style-type: none"> ○ Background information; current situation ○ Contingencies in place ○ Directive to ensure equipment and sensitive equipment is raised to safe level if based on the ground and if flooding expected, need to remove cars from car park and to what areas it is safe to do so ○ Forecast ○ Communication details (i.e. unless you hear anything to the contrary, please turn up for work as usual) <p>If evacuation is required or is under consideration, or if higher level co-ordination is required - likely to be under a situation where multiple business continuity problems such as loss of power, IT, telephones and safe drinking water combine - it will be necessary to consider wider community aspects, including any warning and informing, humanitarian assistance, mass transport requests, and any community confidence issues with the local authority.</p>	
Key Contacts:	Contact Details:	What action will happen/what plan invoked
As App.A.4a		
Environment Agency	<p>Incident hotline: use the incident hotline to report an incident, such as pollution: 0800 807060 (Freephone, 24 hour service)</p> <p>Floodline: 0845 988 1188 (24 hour service) or Type talk 0845 602 6340</p>	High risk flood areas: will be advised by the EA.
Flood plan triggers:		

Warnings may come from: BBC and Met Office forecasting, the Environment Agency <http://www.environment-agency.gov.uk/homeandleisure/floods/125305.aspx>. These warnings are not likely to be sufficiently localised to positively indicate action so should be the subject of discussion in-hours between local duty operational staff, and out-of-hours between the on-call.

Out of Hours

If there is serious call for concern, contact Director on Call for advice on implementation of the Business Continuity Plan.

Triggers - when:

- the water level reaches the edge of the site
- or when flooding takes place which affects access
- or when Business Continuity difficulties affect the main site, the following actions should be taken.

Access routes - Ascertain which following local access routes are expected to remain open.

IT and telephony - check IT and telephony dependencies. These may be distant.

Replicate service elsewhere - Incident Control to consider solution with Business Continuity Priorities Section B

Damage assessment

Insurance

Recovery programme

Section A.4ii

Problem: Evacuation		
Operating risk and information requirements appropriate for each level of decision maker		
Gold	Silver	
<p>Patients should be evacuated only when absolutely necessary; and taking advantage of external (i.e. Ambulance) support.</p> <ul style="list-style-type: none"> • Situations worthy of evacuation include danger posed by fire, smoke, flooding or a potential exposure to hazardous materials - or more likely a combination of those issues which make immediate recovery and any critical functioning impossible. • Evacuation may also be required as a result of facility structural damage or the potential for damage imposed by severe climatic changes, where personnel and patients are in more danger within the facility than any risks posed by evacuation. • During any evacuation, unique challenges will be faced due to the physical layout of the facility and the unstable nature of the patients within the facility. All staff members perform important roles in the implementation of an evacuation. <p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> • the saving of life • maintenance of safe clinical practice and critical service provision (see Section B) • the protection of Vocare staff, assets, and finances • co-operation with other responders under the Civil 	<ul style="list-style-type: none"> • The implementation of evacuation should be determined taking into account such advice as relevant to the situation (Police, Ambulance, Fire, estates, etc) • A Bomb Threat is not an indication in itself to evacuate - there may be more risk - in this case the Incident Commander must seek Police advice • Personnel in the vicinity of an incident requiring immediate life-saving action may order the partial, (either horizontal or vertical evacuation) of a particular area when conditions are life threatening. The objective is to get patients and personnel to safe refuge areas • Choice and designation of triage/safe refuge areas: based on prevailing conditions • Possible choice of tactics: <ul style="list-style-type: none"> ○ Immediate movement due to danger ○ Discharge ○ Defend in place ○ External liaison to move patients to other facilities 	
	over

<p>Contingencies Act</p> <ul style="list-style-type: none"> • warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing.</p> <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement</p>		
<p><i>Detailed plan</i></p> <p>Not all emergencies will require an emergency evacuation response. The procedures that follow apply only to those situations when an actual evacuation is necessary. This is a sub-plan of the Vocare EPRR Plan and should be read in the context of that plan.</p> <ol style="list-style-type: none"> 1. When the decision is made to evacuate, the magnitude of the emergency response must be determined. For large scale events or total facility evacuation, the Duty Director of Operations should declare an internal major incident and immediately notify: <ul style="list-style-type: none"> • Gold Commander • All local operational managers and centre leads • Commissioners • The local Ambulance Service and Community Trust 2. Evacuation triggers: <p>The following are examples of what might lead to a decision to evacuate.</p> <p>A. INTERNAL EMERGENCIES</p> <p>Fire, smoke, hazardous materials release, or irritant fumes in the following areas:</p> <ul style="list-style-type: none"> • Laboratories • Mechanical rooms 		

- Operating rooms
 - Emergency department
 - Clinics and patient rooms
 - Facility services and maintenance areas
- Loss of environmental support services
- Heat
 - Water supply
 - Air conditioning
 - Sterilization
 - Electrical power
 - Computer network
 - Telecommunications (paging, telephones)

Loss of medical gases

- Oxygen
- Compressed air
- Vacuum suction

Other examples

- Explosion
- Police actions
- Armed or violent visitor

B. EXTERNAL EMERGENCIES

Natural Hazards

- Earthquake
- Hurricane
- Flood
- Tornado
- Blizzard

Regional power outage

Civil disturbance

Terrorism

Transportation accidents

Hazardous materials releases

Contaminated victims/toxic agents

Radiation

3. GENERAL EVACUATION GUIDELINES

During an emergency, initial evacuation of persons in immediate danger must take precedence over all other actions. Initial evacuation routes identified should be used in the context of the dangers posed.

Initiation of a vertical or complete evacuation of the hospital, with the exception of the need to move persons in immediate danger, should be coordinated under the direction of the Incident Commander, who will agree *Refuge* or *Triage Areas* away from dangerous areas dynamically risk-assessed at the time of the incident.

Evacuation and specific guidance for travel route and in-house transportation must be a systematic, coordinated effort in order to remove all patients, visitors, and staff from the facility in a safe and timely manner away from dangerous areas dynamically risk-assessed at the time of the incident.

The Executives should handle and coordinate internal communications.

A designated representative should be allocated to the affected department(s) or unit discharge/exit point. This individual should be able to help provide in-house transportation information and real time guidance required to move patients to the designated *Refuge or Triage Areas*. This individual should maintain contact with the SILVER COMMANDER and relay information regarding departmental conditions and needs throughout the incident or until evacuation of the area is complete.

5. EVACUATION RESPONSIBILITIES

The *INCIDENT COMMANDER* or representative assigned for an incident should retain the full authority and remain responsible for the decision-making process until relieved by the GOLD COMMANDER. Evacuation responsibilities for specific departments are summarized below.

A. ALL EMPLOYEES

If a disaster occurs in a patient care area, or threatens a patient care area, employees should remove patients who are in immediate danger. In this event, **DO NOT WAIT FOR INSTRUCTIONS**. Patients should be taken to the nearest safe area on the same floor if possible (horizontal evacuation). If the patients are not in immediate danger and the alarm has been activated, **WAIT** for evacuation orders.

Do not leave patients unattended. It should be ensured that hospital staff members assume responsibility for patients under someone else's care before they leave to report to plan roles. For example, appropriate hand-over must be conducted before leaving any patient.

Normal visiting rights will be suspended during the disaster situation.

Any employee, who reasonably believes that an emergency is taking place, or is about to take place, that could put patients or staff in imminent danger, should initiate the emergency evacuation of an area. When the fire alarm sounds, employees should be expected to implement fire response protocol appropriate to his or her work area. There is no code to indicate if an alarm signifies a drill or real fire. Therefore, every alarm should be treated as a potentially serious event.

Section A.5

Problem: Supply chain disruption		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> the saving of life maintenance of safe clinical practice and critical service provision (see Section B) the protection of Vocare staff, assets, and finances co-operation with other responders under the Civil Contingencies Act warning and informing the public. <p>These may be amended by the Gold Commander according to circumstances prevailing.</p> <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none"> Evaluation and procurement of alternative supplies - consideration of short-term replacement. Assessment of supplier business BCPlan (s) In-hours major incident support Out-of-hours major incident and stock provision support Assess the availability of essential stock items within local areas. Pool items of essential stock items collectively for access by the whole division. Establish an order of priority for access to pooled essential stock. Identify methods for maintenance of stock efficiency to prevent wastage, whilst maintaining safe delivery of patient care. 	
Key Contacts:	Contact Details:	What action will happen/what plan invoked
Site team	Via switchboard	Assessment of alternative internal supplies cross-organisation
Supplies	In hours ext 35900	Evaluation and procurement of alternative supplies - consideration of short-term replacement.
	Major incident support	Assessment of business BCPlan(s) In-hours major incident support

	available in-hours	Out-of-hours major incident and stock provision support
Fuel Plan	See "Denial of site"	
Silver Commander	Via cascade	Setting up of Incident Command?
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Debrief • Identify the cause of the shortage and take steps to eliminate any further repeat within Vocare • Assess cost of any loss of service resulting from shortage • Consider diverting essential services to alternative healthcare settings as appropriate. • Remedial action. 		

Section A.6

Problem: Extreme weather	
Operating risk and information requirements appropriate for each level of decision maker	
Executive	Incident Commander
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> • the saving of life • maintenance of safe clinical practice and critical service provision (see Section B) • the protection of Vocare staff, assets, and finances • co-operation with other responders under the Civil Contingencies Act • warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing.</p> <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement</p>	<ul style="list-style-type: none"> • Substantially business as usual, but with adjustments as indicated below • The main effect may be through service escalation and the effect on business continuity priorities • Line to hold in communications with commissioners, and with staff and the public: Vocare has to keep services going throughout difficult conditions and does expect staff to attend for work • Maintain or change pathways and direct patients appropriately as linked to above discussions, via 111.
<p>Triggers to invoke: National weather warnings levels:</p> <ul style="list-style-type: none"> • Heatwave Plan https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/801539/Heatwave_plan_for_England_2019.pdf and • Cold Weather Plan https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/748492/the_cold_weather_plan_for_england_2018.pdf <p style="text-align: right;"><i>overleaf</i></p>	

Actioned by: as below. Warnings received by operations managers and triggers for action will be communicated by calling Incident Control in response to service escalation: the below are indicative actions for implementation by local staff as indicated by the national plans and should be read in conjunction with national decisions about levels of severity.	
HEATWAVE	
Action	Response
Monitor indoor temperatures	Patients are for the vast majority of the time with Vocare for short periods and staff will ensure a comfortable environment for themselves and patients
Additional fluids	Provide regular cool drinks. Extra fluids to be taken on patient transport.
Cooling environments	Maximise external shading and night time ventilation, ensure blinds and curtains are kept closed- especially those south-facing.
Keeping environments cool	Turn off unnecessary equipment, especially at night.
Cool room	Identify naturally cooler rooms that vulnerable patients can be moved to if necessary.
Clinical briefings	Raise awareness of risk to patients from excess heat including risk on discharge.
Staff & patient messages	Via Vocare email and nurse communication to patients. This will include advice to patients on discharge.

COLD WEATHER PLAN

Overall, the additional demand on the service (such as from respiratory difficulties and hazards such as falls) will be managed under the Vocare Escalation Plan in conjunction with other sector partners.

As a general policy statement, Vocare has to keep services going throughout difficult conditions and does expect staff to attend for work - warnings of expected poor weather are expected to be available via national and local media. During snow and other adverse conditions staff are advised to carry a mobile phone, leave extra time for journeys and to check out their journey before leaving, for instance with colleagues, via local radio, and ensure that if using their car that it is well maintained. The Highways Agency and Local Authority will generally prioritise the gritting of trunk routes during snow or cold weather conditions. Service heads will advise business continuity processes on logistics issues arising from extreme weather conditions, including any additional stockpiling needed as a result of conditions.

The following specific plans apply:

P30	Severe Weather Contingency Plan
S-P30	SDUC Severe Weather Contingency Plan
V-HR P250	Inclement Weather Policy and Procedures
YS-OM 1305	Severe Weather Contingency Plan
YS-OM 1306	YDUC Severe Weather Action Checklist

The following table shows how Vocare meets the requirements of the National Cold Weather Plan.

Description	How discharged at Vocare and the national emergency planning arrangements
<p>Level 0</p> <p>Year-round planning</p> <p>All Year</p> <ol style="list-style-type: none"> 1) Ensure organisation can identify and support most vulnerable. 2) Plan for joined up support with partner organisations. 3) Work with partners and staff on risk reduction awareness (eg flu vaccinations, signposting for winter warmth initiatives). <hr/> <ol style="list-style-type: none"> 1) Use patient contact to identify vulnerable people and advise of cold weather actions; be aware of referral mechanisms for winter warmth and data sharing procedures. 2) Ensure awareness of health effects of cold and how to spot symptoms. 3) Encourage colleagues/clients to have flu vaccinations. 	<ul style="list-style-type: none"> • Vocare conform to NHS EPRR Core Standards • Data sharing on patients and referral is part of normal part of business. • Via National Risk Register • Via multi-agency emergency planning arrangements, NHS EP fora and integrated care. • On-site Flu vaccination available to all staff. • Attendance at LHRP • EPRR/BC Plan App A.6 is on extreme weather.
<p>Level 1</p> <p>Winter preparedness and action</p> <p>1 November to 31 March</p> <ol style="list-style-type: none"> 1) Ensure cold weather alerts are going to right staff and actions agreed and implemented. 2) Ensure staff in all settings are considering room temperature. 3) Ensure data sharing and referral arrangements in place. <hr/> <ol style="list-style-type: none"> 1) Identify vulnerable clients on caseload; ensure care plans incorporate cold risk reduction. 2) Check room temperatures and ensure referral as appropriate. 3) Signpost clients to other services using 'Keep Warm Keep Well' booklet. 	<ul style="list-style-type: none"> • Weather alerts via Ops Room meetings when required as per Central Alerts Policy • Function of records transfer, integrated care, discharge planning via multi-agency emergency planning arrangements, LHRP. • HR lead on staff flu vaccination with comms input as necessary - also part of emergency planning mandatory training. • Gritting and route maintenance policies and practice • EPRR/BC Plan App A.6 is on extreme weather. • Awareness of staff conducting patient assessments to consider environmental factors • Winter & self-care publications

	available in all patient centres.
<p>Level 2</p> <p>Severe winter weather forecast – Alert and readiness</p> <p>Mean temperatures of 2°C and/or widespread ice and heavy snow predicted with 60% confidence</p> <p>1) Continue level 1 actions.</p> <p>2) Ensure carers receiving support and advice.</p> <p>3) Activate business continuity arrangements as required; plan for surge in demand.</p> <hr/> <p>1) Continue level 1 actions.</p> <p>2) Consider prioritising those most vulnerable and provide advice as appropriate.</p> <p>3) Check room temperatures and ensure urgent referral as appropriate.</p>	<ul style="list-style-type: none"> • As level 1 plus: • Vehicles equipped with winter equipment such as shovels • Many core fleet vehicles are 4x4 plus links to external providers of 4x4 vehicles. • Function of integrated care, discharge planning. • Ability to provide 111 and other OOH telephone assessments from multiple locations. • EPRR BC Plan App A.6 is on extreme weather • Winter/surge arrangements in place
<p>Level 3</p> <p>Severe weather action</p> <p>Mean temperatures of 2°C and/or widespread ice and heavy snow</p> <p>1) Continue level 2.</p> <p>2) Implement emergency and business continuity plans; expect surge in demand in near future.</p> <p>3) Implement local plans to ensure vulnerable people contacted.</p> <hr/> <p>1) Continue level 2 actions.</p> <p>2) Implement emergency and business continuity plans; expect surge in demand in near future.</p> <p>3) Prioritise those most vulnerable.</p>	<ul style="list-style-type: none"> • As per level 1&2 plus; • Via operational routines • Function of integrated care, discharge planning • Winter/surge arrangements in place and shared with commissioners. • BAU Escalation Frameworks in place • Link with National & LHRP Communications Strategy • Provide transport for staff wherever possible using core 4x4 fleet and other suppliers. • Maximise use of remote working, including clinicians. • Support other providers where possible via LHRP coordination control. • EPRR BC Plan App A.6

<p>Level 4</p> <p>Major incident – Emergency response</p> <p>Level 4 alert issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office.</p> <p>All level 3 responsibilities to be maintained unless advised to the contrary.</p>	<ul style="list-style-type: none">• As per level 3 or go to Page 11 of this EPRR Policy if Major Incident declared.• Via multi-agency emergency planning arrangements• EPRR BC Plan App A.6 is on extreme weather
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Section A7

Problem: Service escalation

Operating risk and information requirements appropriate for each level of decision maker

Executive

The strategic objectives behind all incident response will be:

- the saving of life
- maintenance of safe clinical practice and critical service provision (see Section B)
- the protection of Vocare staff, assets and finances
- co-operation with other responders under the Civil Contingencies Act
- warning and informing the public: with the Communications team as a key arm.

These may be amended by the Gold Commander according to circumstances prevailing.

Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 36.

If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement

Incident Commander

- Implementation of detailed operational guidelines - see below
- Key Policy is V51, Vocare Escalation Policy
- EPRR Plan activated at VEP 4 (Red)

This section of the EPRR plan is the key to the transition between business as usual and states key approach to EPRR at Vocare: of working in which Incident Control is implemented at Vocare. In policy terms, it enables the treatment of *the emergency* as an extrapolation of *the routine*, to minimise untried and obscure systems: minimising a bulk of costly, hard-to-find and ineffective large paper plans: a high level of senior staff familiarity: greater facility to deal with

combinations of problems, which is a characteristic of incident management: a high level of integration of emergency preparedness with other functions: and a direct link between 'just in time' philosophy of NHS target achievement and business continuity.

Specific policies in place to support service escalation:

P51	Vocare Escalation Framework <i>EPRR Plan activated at VEP 4 (Red)</i>
NDUC P52	Winter Plan
NE-OM 688	Clinical Service Escalation Sunderland UCC
YS-OM 1307	YDUC Service Escalation
V OM 530	NHS111 - service escalation
S-C 9009	UHNS Service Escalation

Section A8

Problem: Major Incident (including external Mass Casualty and Mass Fatality declarations, and the administration of Mass Countermeasures)

Operating risk and information requirements appropriate for each level of decision maker

Executive

The strategic objectives behind all incident response will be:

- the saving of life
- maintenance of safe clinical practice and critical service provision (see Section B)
- the protection of Vocare staff, assets and finances
- co-operation with other responders under the Civil Contingencies Act
- warning and informing the public.

These may be amended by the Gold Commander according to circumstances prevailing.

Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 36.

If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.

Incident Commander

- **NB - the declaration of a major incident by other organisations does not in itself trigger a Vocare Major Incident, but should be considered for Vocare action**
- The Vocare approach to Major Incidents declared by NHS organisations is to have detailed agreements with sites on joint operations affecting Vocare's services:
 - NHS 111
 - GP triage
 - Out-of-hours arrangements
- Implementation of detailed operational guidelines for local Urgent Care Centres - see below
- Site focus - which sites are affected?
 - Are multiple sites affected?
- Is a different type of service to the normal required and can Vocare's service adapt to that required configuration?
 - For how long will this be required?
 - How sustainable is this different model for Vocare?
- HAZMAT/CBRN protocols will be in use - see "Chemical contamination" below.

Specific agreements/procedures in place:

BA 7003	BDUC and RUH Joint Business Continuity SOP
S-C 9006	UHNS CBRN Procedure
S-HS 765	EPRR Chemical Contamination

The **UCC action card overleaf** was discussed in conjunction with the Imperial College Hospitals NHSFT EPRR lead in July 2017. It contains generic advice which can be added to or varied from as long as they are complied with in full to suit local conditions.

The administration of Mass Countermeasures in the NHS

Under UK doctrine, Vocare may be called upon in the aftermath of a large-scale terrorist attack to contribute towards the administration of Mass Countermeasures in the NHS from their centres.

The likely intention behind this will be to assist national distribution of countermeasures which will primarily be focused on acute Trusts, which are focused on prevention, and therefore on people currently asymptomatic. Currently the following shows the likely portfolio of responses and will be accompanied by advice available from the Public Health England website. There may also be staging of release advised by PHE and the NHS (for example, “people with surnames beginning with ‘A’ to ‘D’ may should present at their local centre on the morning of 1st July”.

A. NHS Acute Trusts and CCGs should access the following items by contacting their local NHS Ambulance Service Trust Emergency Control Room (0844 822 2888):

1. Nerve agent antidote pod to treat 90 people.
2. Obidoxime further treatment for nerve agent poisoning.
3. Dicobalt edetate pod for treatment of cyanide poisoning in 90 people.
4. Botulinum antitoxin.

B. NHS Acute Trusts and CCGs should access the following 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 tularaemia.
2. Further stocks of ciprofloxacin to complete a treatment course, and stocks of doxycycline to change treatment if required.
3. Ciprofloxacin intravenous injection for post-exposure treatment.
4. Gentamicin intravenous/intramuscular injection for post-exposure treatment.
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.
7. Naloxone for the treatment of opioid poisoning.

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

At the end of the alert, conduct debrief of response across Vocare.

Data protection and data sharing in emergencies

In response to lessons identified from the 7 July London bombings, the Cabinet Office has published guidance on data protection and sharing in emergencies. Problems with data sharing between Category 1 and 2 responders after the attacks hampered the connection of survivors to some support services. Category 1 and 2 responders include local authorities, health bodies, private sector utility companies and transport operators amongst others. This guidance can help you to understand and promote your information sharing roles and responsibilities in planning for, responding to and recovering from emergencies.

The guidance provides clear and understandable explanations on the law surrounding personal data so that you know what can and cannot be done when handling personal data. The key points are summarised here: visit https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60970/dataprotection.pdf to download the guidance. Here you will also find further advice on information sharing and data protection, and the relevant responsibilities placed on authorities in emergency and non-emergency situations. This advice which is required in plans under the NHS EPRR Core Standards builds on practice in the NHS on sharing information for preventative purposes eg knife crime and gun crime.

Data Protection and Sharing - some Key Principles

- Data protection legislation does not prohibit the collection and sharing of personal data - it provides a framework where personal data can be used with confidence that individuals' privacy rights are respected.
- Emergency responders' starting point should be to consider the risks and the potential harm that may arise if they do not share information.
- Emergency responders should balance the potential damage to the individual (and where appropriate the public interest of keeping the information confidential) against the public interest in sharing the information.
- In emergencies, the public interest test will generally be easier to meet than during day-to-day business.
- Always check whether the objective can still be achieved by passing less personal data.
- Category 1 and 2 responders (Vocare is outside this Civil Contingencies Act framework) should be confident in asserting their power to share personal data when lawful in emergency planning, response and recovery situations.

- The consent of the data subject is not always a necessary pre-condition to lawful data sharing.
- You should seek advice where you are in doubt - though prepare on the basis that you will need to make a decision without formal advice during an emergency. As well as the UK Resilience website, the Ministry of Justice offers guidance and a helpline (Tel:020 7210 8034).

https://assets.publishing.service.gov.uk/government/data_protection_handout.pdf,

- The Cabinet Office publication “Data Protection and Sharing - Guidance for Emergency Planners and Responders” has been endorsed by the Ministry of Justice, the Information Commissioners Office, the Department of Health, the Local Government Association and the Association of Chief Police Officers amongst many others.

Further details on information sharing and data protection in emergency and non-emergency scenarios can be found at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60970/dataprotection.pdf

UCC Major Incident Action Card

Preparation; the lead Unit manager should:

1. Ensure the host NHS organisation has a contact number which will always be answered during UCC opening hours: a 'major incident only' number is needed so that communication from A&E to the UCC is not delayed by normal telephone traffic
2. Respond positively to offers of major incident training and exercising from the host NHS organisation and keep records of staff and events attended
3. Ensure medical and surgical supplies are always kept within safe limits
4. Know the content of this plan, ensure it is available, and inform all staff of it.

If there is a "Major Incident Stand-By" or "Major Incident Declared"; The person in charge should:

1. Receive a briefing from the host NHS organisation on the nature of the Incident (this will normally be from the A&E lead consultant): keep Unit open
2. Advise the host NHS organisation on any upcoming closing hours or any current limitation of UCC service
3. Follow any NHS organisation advice about security and safety issues including any advice on site lockdown or other movement restrictions during the incident
4. Advise your Vocare manager on the action being sought from the UCC
5. Respond as far as possible within normal clinical guidelines
6. Avoid redstreaming as far as possible to the host NHS organisation
7. Respond to any HAZMAT/CBRN incident as below: get help quickly
8. At the end of the incident, advise your Vocare manager on any action needed to deescalate the incident: eg staffing, record systems catch-up
9. Hold a simple "what went well/what went less well" debrief after the incident is over and share it with your Vocare manager.

In the event of a person attending the Unit with a suspected chemical, powder or HAZMAT/CBRN issue⁴:

1. The UCC will declare itself to the host NHS organisation A&E if any such patient attends for advice, in-situ decontamination, and other assessment. Also, if further specialist help is needed, contact the local Ambulance Service via 999 or Public Health England local office

Continues overleaf

⁴ Based on http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf

2. Access to the UCC should be stopped and all other patients held in place until the incident is risk-assessed in conjunction with the host NHS site and specialist advice as outlined above
3. Isolate and reassure the patient: occupy the nearest free clinical room immediately with as little contact as possibly, and if possible, none
4. Attending staff should use gowns, goggles, gloves, and masks - if available, FFP3 or N95 masks or similar
5. While assessment by the host organisation is awaited, the patient and any member of staff affected should be given dry towels to remove the contaminant. If blistering occurs, the patient should be encouraged to wash themselves with warm water: take off clothes; wash top to toe: take care with armpits and groin; wash for 2-3 minutes; blow nose and cough
6. Waste and used towels should be double bagged for investigation
7. Alert your Vocare manager and go through steps 8 and 9 above.

NB: This advice can be used by telephone to guide practitioners and patients, where appropriate, remotely by telephone and other remote advice.

NHS 111 Major Incident Action Card

Note: this plan is aimed at the calling by the emergency services of a major incident. If this is an internal problem, look instead at the section of how to fix problems given on page 47 of this plan.

Preparation; the lead Unit manager should:

1. Ensure the host NHS organisation has a contact number which will always be answered
2. Respond positively to offers of major incident training and exercising from the host NHS organisation and keep records of staff and events attended
3. Ensure medical and surgical supplies are always kept within safe limits and that any staff gaps are dealt with promptly
4. Know the content of this plan, ensure it is available, and inform all staff of it.

If there is a “Major Incident Stand-By” or “Major Incident Declared”; The person in charge should:

1. Receive a **briefing** from the local (or national in the case of 111 service transference due to national major incident NHS; either
 - a. On service reconfiguration or
 - b. Actual major incident situation briefing
2. Check, in conjunction with local clinician,
<https://www.gov.uk/government/organisations/public-health-england>
for relevant advice
3. Advise the host NHS CCG on any current limitation of 111 service
4. Follow any NHS organisation advice about security and safety issues including any advice on site lockdown or other movement restrictions during the incident
5. Advise your Vocare manager/on call manager on the action being sought from commissioners/CCG
6. Respond as far as possible within normal clinical guidelines
7. Avoid red streaming as far as possible to the host NHS organisation
8. Respond to any HAZMAT/CBRN incident as below: seek advice either from Public Health England or the local ambulance service
9. Lead on staff welfare and rotas including a succession plan for your own function in 4 hours
10. Record key events and decisions made locally and with on-call Manager, local director, and clinical leads
11. At the end of the incident, advise your Vocare manager on any action needed to deescalate the incident: eg staffing, record systems catch-up. Secure all incident information and data

Continues overleaf

12. Hold a simple "what went well/what went less well" debrief after the incident is over and share it with your Vocare manager.

Reporting

Commence hourly reporting of:

1. Number and % of calls abandoned
2. % of calls answered in 60s
3. Number of priority 1 calls exceeding 30-minute call back
4. Mitigation activities

In the event of a person requiring attention for a suspected chemical, powder or HAZMAT/CBRN issue⁵:

1. The 111 service will declare to NHS local organisations if any patient requires advice on CBRN/HAZMAT. Also, if further specialist help is needed, contact the local Ambulance Service via 999 or Public Health England local office. The following advice may be helpful to the caller before additional help arrives
2. Isolate and reassure the patient: occupy the nearest empty room immediately and do not touch the patient if all possible
3. Use gloves and masks if available
4. While assessment by the host Ambulance Service or Public Health England is awaited, the patient affected should be given dry towels to remove the contaminant. If blistering occurs, the patient should be encouraged to wash themselves with warm water: take off clothes; wash top to toe: take care with armpits and groin; wash for 2-3 minutes; blow nose and cough
5. Waste and used towels should be double bagged for investigation
6. Alert your Vocare manager and go through the debrief above.

NB: This advice can be used by telephone to guide practitioners and patients, where appropriate, remotely by telephone and other remote advice.

⁵ Based on http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf

Section A.9

Problem: Pandemic Flu (and principles to be followed in other large scale disease outbreaks)

Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Commander	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> the saving of life maintenance of safe clinical practice and critical service provision (see Appendix B) the protection of Vocare staff, assets and finances co-operation with other responders under the Civil Contingencies Act warning and informing the public. <p>These may be amended by the Gold Commander according to circumstances prevailing:</p> <ul style="list-style-type: none"> the ability to adapt and maintain services under the difficult societal conditions dictated by this scenario. <p>Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>Communication with commissioners is expected to be intensive during this period.</p>	<ul style="list-style-type: none"> Implementation of detailed operational guidelines - see below Maintenance of service away from critical areas <p>Long-scale incidents, including pandemic and other large-scale infectious disease activity, will demand the answer to large-scale management questions:</p> <ul style="list-style-type: none"> “can we keep all activities going?”, “have we got the resources?”, “are we in charge or is another agency?”, “how soon can we get back to normal?” <p>The distinguishing characteristics of short and longer-term problems are illustrated in the table on page 9⁶. Any given situation may require both types of responses - less flexible and more rehearsed mode for those elements which are more fixed and predictable, more flexible approach for less predictable / novel elements. Put more simply, longer term incidents require a less certain response. This plan is flexible enough to allow for this and has operated in acute settings in this way.over</p>	
Key Contacts:	Contact Details:	What action will happen/what plan

⁶ from Crisis Response Vol 4 issue 3

		<i>invoked</i>
Surge management plans	Via escalation routines	Incident control
Staff vaccination	Via Vocare Infection Control policies	Compliance % of staff - not a core standards issue up to 2018 but via A&E delivery board and contractual requirements classed as salaried frontline staff only
Outbreak controllers	Via Vocare Infection Control policies	Professional leadership of outbreak control - surveillance, detection, management, and review of outbreak Operationalisation of Public Health England (PHE) advice
Ethical decision making under extreme demand including of ITU resources	ITU Clinical Directors of NHS organisations	CRITCON and commissioner management. Implementation of London SHA wide arrangements at CRITCON 3/4 for triage and implementation of ethical arrangements Likely 111 scripts will change - check Public Health England website daily for up-to-date
Public Health England and other external bodies	Lead scientific advice Treatment signs, symptoms, and algorithms Staged response leadership	Chiefly available on a web basis. See intranet EPRR PHE link to ensure advice is up-to-date

		Likely 111 scripts will change
Communications	Guided by https://www.wp.dh.gov.uk/publications/files/2012/12/UK-infectious-Influenza-Communications-Strategy-2012.pdf and internal outbreak routines	Director of infection Control
<p>Commentary</p> <p>This plan brings together elements of existing plans to form a flexible and graded response to a pandemic declaration as advocated by 2014 Public Health England advice. The risk to the Vocare is outlined in this key document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/344695/PI_Response_Plan_13_Aug.pdf</p> <p>How a pandemic might unfold</p> <ul style="list-style-type: none"> • A pandemic is most likely to be caused by a new subtype of the Influenza A virus but plans could be appropriately adapted and deployed for any epidemic infectious disease. • An influenza pandemic could emerge at any time of the year anywhere in the world, including in the UK. Regardless of where or when it emerges, it is likely to reach the UK very rapidly and, from arrival, it will probably be a further one to two weeks until sporadic cases and small clusters of cases are occurring across the country. • The potential scale of impact, risk and severity from related secondary bacterial infection and clinical risk groups affected by the pandemic virus will not be known in advance. • It will not be possible to completely stop the spread of the pandemic influenza virus in the country of origin or in the UK, as it will spread too rapidly and too widely. • Initially, pandemic influenza activity in the UK may last for up to three to five months, depending on the season. There may be subsequent waves of activity of the pandemic virus weeks or months apart, even after the WHO has declared the pandemic to be over. • Following an influenza pandemic, the new virus is likely to persist as one of a number of seasonal influenza viruses. Based on observations of previous pandemics, subsequent winters are likely to see increased seasonal flu activity compared to pre-pandemic winters. 		

The health response required for a pandemic predominantly reflects established issues in managing other adverse incidents or events, such as winter pressures or severe weather, such as:

- *uncertainty* - there may be little or no information available initially so rapid gathering and sharing of reliable data will be important to inform the response;
- *speed* - in local areas the increase in demand on services can develop very rapidly, requiring an agile and coordinated response;
- *profile* - media pressure and public demand for information will be intense, requiring frequent, consistent and coherent communications;
- *cross-sector* - the response will span different sectors and organisations, requiring close working and mutual support, and
- *local hotspots* - the demand in each area may not be uniform with different geographic areas being under pressure at different times, requiring good information exchange and flexibility of local plans.

However, the *duration* of the pandemic may be much longer than for other emergencies (up to several months) requiring resilience and a sustained response.

UK strategic aims are:

- maintaining *surveillance* to detect the emergence of a novel virus strain or any illness attributable to it, monitoring its spread, assessing the impact of the virus and identifying the groups most at risk of severe illness and death and monitoring the uptake, effectiveness and safety of the various clinical counter-measures including vaccination;
- *reducing risk of transmission and infection* by applying individual and community infection control measures and assisting self support by providing public advice and information and promoting messages of good respiratory and hand hygiene;
- *reducing illness and complications* and minimising deaths of symptomatic individuals by rapid access to health assessment, providing antiviral medicines promptly where they are needed and providing other effective treatment including antibiotics for those suffering from secondary bacterial infections;
- *protecting the public through preventing* the disease when possible and appropriate, through pandemic specific vaccination, and
- *promoting work during the inter-pandemic period* to increase capacity and resilience in the UK.

Stages of pandemic management under the 2011 guidance

These are defined as:

- planning
- detection and assessment

- treatment and escalation
- recovery, including second wave preparation.

Actions suggested as necessary under the 2014 guidance and relevant to Vocare are:

Planning	<p>Ensure business continuity, surge, winter and pandemic flu plans are up to date and reflect latest guidance/science</p> <p>Undertake regular training and exercising</p> <p>Participate in relevant multi-agency fora</p> <p>Independent sector engaged re mutual aid</p> <p>Maintain lists of staff contact details</p> <p>Maintain lists of vulnerable patients</p> <p>Maintain robust seasonal flu vaccination programmes for staff and patients</p> <p>Multi-agency engagement</p> <p>Participation in relevant assurance processes</p>
Detect/ Assess	<p>Communication with staff and public</p> <p>Local telephone helpline, if required</p> <p>Communications to local NHS and public</p> <p>Review pandemic plans and related plans</p> <p>Isolate patients to slow spread</p> <p>Set up Flu ED if required</p> <p>Set up ACPs in hotspots if required</p> <p>Prepare to commence storage and distribution of antivirals and personal protective equipment</p>
Treat/ Escalate	<p>EPRR Plan activated at VEP 4 (Red)</p> <p>Communication with staff and public</p> <p>PPE storage, stock management and distribution to users</p> <p>Maintain support to community patients</p> <p>Vaccination of staff</p> <p>Manufacture of oral oseltamivir solution (designated licensed Hospital Pharmacy Manufacturing Units)</p> <p>Cohort patients as necessary</p> <p>Reduce minor impact services that will not put lives at risk if necessary</p> <p>Maintain core services</p> <p>Set up Flu ED if required</p> <p>Discharge patients into the community if safe to do so</p>
Recover	<p>Continue wider vaccination campaign</p> <p>Identify lessons</p> <p>Prepare for second wave</p>

	Maintain seasonal flu vaccination campaign	
<p>ACTIONS LIKELY TO FORM RESPONSE</p> <p>Ongoing actions</p> <ol style="list-style-type: none"> 1. Fit testing - infection control will need a regime of mechanical/physical briefing and testing in place for FFP3 wear 2. Pharmacy - pharmacy remain ready to respond to any requirement caused by the new strain including meeting vaccination requirements <p>Actions under the Business Continuity Plan (this document)</p> <ol style="list-style-type: none"> 3. Command structure and leadership - EPRR plan 4. Sitrep reporting in association with the information department 5. Retrenchment of services towards emergency care 6. Staffing and materials management including stockpiling requirements 7. Link from internal to multi-agency management - the amount of central advice is expected to be voluminous 8. Interpretation of tactical DoH guidance re stages of response 9. Debrief 10. Recovery including programme management <p>Actions</p> <ol style="list-style-type: none"> 11. Scenario-based information issued by Public Health England <p>Actions under local business continuity plans</p> <ol style="list-style-type: none"> 12. Local business continuity plans for escalation - See A9 and Business Continuity Prioritisation at Section C <p>Actions under outbreak management</p> <ol style="list-style-type: none"> 13. Professional leadership of outbreak control - Vocare Infection Control arrangement and SOPs - accessing national stocks of PPE 14. Operationalisation of Public Health England scientific advice at the time of the outbreak dependent upon strain - the intent will be to give clinicians direct line access to updating advice on the PHE website via 		

the Vocare website rather than re write plans internally unless this is indicated. Advice is expected to be voluminous.

15. Vaccination and other pharmaceutical measures for staff will be-co-ordinated by the occupational health and HR with other professional support as necessary

Other actions which may be called for

16. **Ethical body provisions** including corporate legal and indemnification support to staff can be sourced at , [NHSE Policies/Ethical Guidelines](#) or [General Medical Council/ethical-guidance](#) or [Nursing & Midwifery Council. Professional-and-ethical-practice](#) as established ethical practice advisory groups

17. **The setting up of anti-viral centres**

18. **Assistance to PHE in operation of a national pandemic flu service:** but note that PHE and other public health bodies, including community health services, should have a full range of business continuity plans in place before Vocare activates its own staff for this

19. **Communications:** we would follow national guidance and trigger the appropriate amended pathways and advise including the inclusion of the specific pathways question set. Our IT department are available 24/7 to support this process.

Section A 10

Problem: Managing VIPs		
Operating risk and information requirements appropriate for each level of decision maker		
Executive	Incident Controller	
<p>The strategic objectives behind all incident response will be:</p> <ul style="list-style-type: none"> • the saving of life • maintenance of safe clinical practice and critical service provision (see Section B) • the protection of Vocare staff, assets, and finances • co-operation with other responders under the Civil Contingencies Act • warning and informing the public: with the Communications team as a key arm. <p>These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.</p> <p>If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.</p>	<ul style="list-style-type: none"> • Implementation of detailed operational guidelines via local staff - see below • Patients who fall into this category may include: <ul style="list-style-type: none"> • Patients who are not necessarily famous but are in the news, or who are likely to attract media attention, for instance, the driver of a train which has been involved in a crash, or a victim or perpetrator of a local crime; • Category A prisoners who pose a risk to themselves or others, this includes patients treated and held on Vocare premises who have been arrested or due to their immigration status. • If in doubt, staff should assume the individual is a VIP, or a patient with enhanced privacy requirements and act according to this guidance. 	
Key Contacts:	Contact Details:	What action will happen/what plan invoked
Clinician-in-charge of functional area housing VIP	At time of admission	<p>Keep the following appraised of agreed code names, visiting lists and discharge plans</p> <ul style="list-style-type: none"> • Incident Commander • Lead on record keeping on the guidance notes below.

Comms Team	In hours via comms department extensions Out-of-hours via switchboard	Specific communications plans for VIPs
Gold Commander	Via escalation	Action co-ordination Setting up of Silver Command?

Specific VIP considerations

- The purpose of this plan is to deal with VIP specific requirements whilst not affecting clinical priority.
- All patients treated by Vocare are entitled to privacy. This poses particular challenges if VIPs are patients. In these cases, it is important that only employees who are directly treating the patient, and senior managers who have a corporate responsibility, know of the presence of such patients. Senior managers should only be given the level of clinical detail about the patient that they require to manage the VIP's treatment. All information should be on a strictly 'need to know' basis.
- In placing patients, clinical priority must always take precedence when making the decision.
- If there is advanced warning of attendance, then the VIP should be directed to and be met at the admission service the senior person available, and be receive treatment as discreetly as possible according to clinical criteria
- Special care should be taken with children or pregnancies
- The Chief Executive will agree media handling, and any press statements
- Under no circumstances may other staff give out any information about the patient over the phone. A senior member of staff will handle any media enquiries.
- As far as possible discharge arrangements should be discussed well in advance, and if relevant with the security staff and communications team, allowing plenty of notice for an exit route to be arranged, for example, using the rear stairs or a lift which allows discrete exit. Discharge letters should be handed to patients directly with an instruction for them to pass to their GP
- VIP patients will not be expected to walk out of the front door of a facility if there is a choice of exits
- If follow up is required post discharge at a clinic or in outpatients, staff with responsibility for these areas should be notified at the earliest opportunity and arrangements put in place to protect the privacy of the patient.
- Emails should not be used to share information. Direct reference to the patient's name should be avoided after the initial notification. The initials of the patient should be used as the identifier. The use of mobile phones to discuss the situation should also be limited.
- The clinical records should be available and kept in a locked cupboard.

- VIPs who wish for their identity to be protected should be electronically registered as an unknown male/female. A identifier number should be generated and they should remain on the IT system under the pseudo name 'unknown name' during the course of their in or outpatient treatment.
- The patients address but not telephone number should be recorded - personal telephone contact details should be documented in the patient's health care record, only.
- On the inside of the health care records the patient's actual name should be used i.e, on the documentation used locally.
- In exceptional/special circumstances where a VIP expresses that they do not wish for their named records to be held electronically post discharge, or where the patient is regarded by Police or Security services to be a potential target or high risk, if their location or treatment details are disclosed, it may be possible for the patient to remain as an 'unknown /..... male/female' post discharge. In the latter circumstances, it may be prudent to seek and act on advice from the Police and/or CID. In these circumstances, the procedures outlined above should be followed
- When a patient is conscious, they should be given a copy of their treatment details.
- The decision to withhold the patient's full details post treatment is reserved to the patient alone and should be taken in consultation with the clinical team. When a patient does not have the capacity to make the decision, the advice of the patient's significant others should be sought. And, the decision must be taken by the most senior clinician with responsibility for the patient's treatment, acting on advice from security services as appropriate. The Director of Nursing must be notified of the reasons for the decision: also, the reasons for the decision should be fully documented in the patient's health care record. The Caldicott Guardian should be informed of such practice.
- Complaints or enquiries should be handled exclusively by the Director of Nursing.

Specific recovery issues:

- Debrief, plan review
- Cost assessment and recovery if appropriate.

Section A11

Problem: Requesting Military Aid for Civil Authorities

Operating risk and information requirements appropriate for each level of decision maker

Executive

The strategic objectives behind all incident response will be:

- the saving of life
- maintenance of safe clinical practice and critical service provision (see Section B)
- the protection of Vocare staff, assets and finances
- co-operation with other responders under the Civil Contingencies Act
- warning and informing the public: with the Communications team as a key arm.

These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.

If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.

Wherever possible the escalation to MACA will be signed off by the Managing Director.

Incident Controller

- Follow advice on <https://www.england.nhs.uk/publication/requests-for-military-aid-to-the-civil-authorities/>
- ***In summary***, this is:
- The NHS is generally expected to manage emergency response within its own capabilities. However, where a capacity has been exceeded or the NHS does not have the specific capability to deliver, the military may be required to augment responses.
- To maintain their clinical competency, many Armed Forces personnel undertake work within the NHS. Any MACA request for Armed Forces medical support may see these staff recalled from the NHS, which could significantly impact on the provision of NHS services.
- Personnel from the Defence Medical Service (DMS) have experience of blast and high velocity injuries.
- Military assistance is governed by four principles and should only be provided:
 1. When there is a definite need to act and the tasks the Armed Forces are being asked to perform are clear.
 2. Where all other options have been discounted. The use of mutual aid, other agencies, and the private sector must be otherwise considered as insufficient or be unsuitable.
 3. If the NHS lacks the required level of capability to fulfil the task and it is unreasonable or prohibitively expensive to

	<p>expect it to develop one.</p> <p>4. The NHS has a capability, but the need to act is urgent and it lacks readily available resources.</p> <ul style="list-style-type: none"> • MACA requests for the NHS are made by NHS England (National) through the Department of Health (DH) and require authorisation from a Health Minister prior to submission to Ministry of Defence (MoD). • NHS England (National) will coordinate all MACA requests on behalf of the NHS. <p>Use the following request form overleaf only after taking the above into consideration:</p>	
<p><i>Specific recovery issues:</i></p> <ul style="list-style-type: none"> • Debrief, plan review • Cost assessment - likely to be costly if not underwritten by commissioners - and recovery if appropriate. 		

Generic Military Aid to Civil Authorities Request Form

Use this only in conjunction with advice at

<https://www.england.nhs.uk/publication/requests-for-military-aid-to-the-civil-authorities/>

<i>Please complete as much of this form as possible</i> <i>Delete text in italics prior to completion</i>	
Time and date of request	
1) Summary of incident	
Brief outline of the background situation <i>A brief summary of the request including the background and nature of the incident/event, where it is taking place and timings.</i> <i>For Major Events - For large events or events where more than one military capability is likely to be required, you should seek the appointment of a military liaison officer as early as possible during the planning process. The appointment of a liaison officer does not, however, eliminate the need to submit a detailed request once an appropriate package of support has been identified.</i> <i>If appropriate, a detailed and up to date threat assessment to justify the deployment of military resources should be included. This should be event-specific, and not based on the general threat state. For annual or recurring events, the threat assessment should not merely be a re-use of previous assessments.</i> <ul style="list-style-type: none"><i>• Estimate of the severity and the number of properties/people affected</i><i>• Special considerations, i.e. vulnerable communities, future forecasts, etc.</i><i>• Implications of not achieving this request</i><i>• Outline of next actions or events</i>	
2) What effect is military support sought to achieve? <i>(text below is an example)</i>	
<i>Include a clear statement of what you are trying to achieve. You should not aim to identify a particular military unit that can achieve this outcome.</i>	

The MoD will always determine the best means of delivering the desired effect.

You should list your objectives here

e.g. In view of the identified risks of 'widespread flooding' in multiple locations throughout the county, the request for military assistance is as follows:

Preparation and Prevention

Assist multi-agency responders to maximise the safety and security of communities by taking all reasonable steps to protect vulnerable premises and locations by:

- Erecting temporary demountable flood defence barriers (where, how many, by when).*
- Constructing sandbag flood defences as required (where, how many, by when).*
- Clearing debris that may lead to blockages of waterways (where, how many, by when).*

Response

Assist multi-agency responders by:

- Warn & inform the community of the flood risk (where, how many people, by when).*
- Be prepared to provide support to evacuate the community to designated rest centres (where, how many people and are any vulnerable communities involved, by when).*
- Gain access to communities cut off by flood waters, ensuring that essential provisions are provided (where, how many people and are any vulnerable communities involved, by when).*

3) Is there a requirement for armed assistance?

No

4) When is the effect required?

Details are needed about when the assistance is required and for how long. Military assets are not always available, so more notice means greater flexibility. Conversely, there may be an opportunity to utilise an asset already in the area or on route so the more notice the better.

Routine Operations - planned operations should be submitted at least 14 days, preferably 28 days, in advance of the requirement.

Special Operations - For incidents where there is an imminent threat to life, the staffing process can be completed in a much-reduced timeframe.

This also needs to include time for any additional training prior to deployment and post deployment debrief.

5) What alternatives have been considered? Include mutual aid and commercial alternatives.

You should confirm that the ability to achieve the desired effect is not available either from within own resources, or from other sources i.e. commercial providers and/or mutual aid. This should include consideration of whether the capability can be obtained from another Government Department or Agency.

e.g. Due to the size of response measures, and potential requirement for large scale evacuation effort, the multi-agency response capabilities of responders has become stretched. Mutual aid to is already in place along with a number of volunteer organizations

Requesting NHS Organisation		Contact email	
Requesting Officer (empowered to agree spend): Email	Name	Signed:	
NHS England (Region) Email	Name	Signed:	
NHS England Incident Director	Name	Signed:	

Keep a record of what you do... If it isn't written down, it didn't happen!

(National)			
Email			

Section A12

Problem: Multi-site/country-wide major incident

Operating risk and information requirements appropriate for each level of decision maker

Executive

The strategic objectives behind all incident response will be:

- the saving of life
- maintenance of safe clinical practice and critical service provision (see Section B)
- the protection of Vocare staff, assets, and finances
- co-operation with other responders under the Civil Contingencies Act
- warning and informing the public: with the Communications team as a key arm.

These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.

If service interruption is substantial, warn service commissioners and prompt list of affected patients from Incident Command - NHS Standard Contract requirement.

Incident Controller

• Potential causes of this situation are:

- Weather
- Widespread malicious attacks and mass casualties
- Cybercrime affecting a large area
- Pandemic

This may consist of a combination of all of the above issues especially affecting:

- Levels of NHS England CONOPS response - see summary diagram at the end of this section and <https://www.england.nhs.uk/wp-content/uploads/2018/03/concept-operations-management-mass-casualties.pdf>
- Key learning from Exercise Optimus wide-area response - see below.

Key learning from July 2019 Pandemic Table Top Exercise on wide-area response (Exercise Optimus)

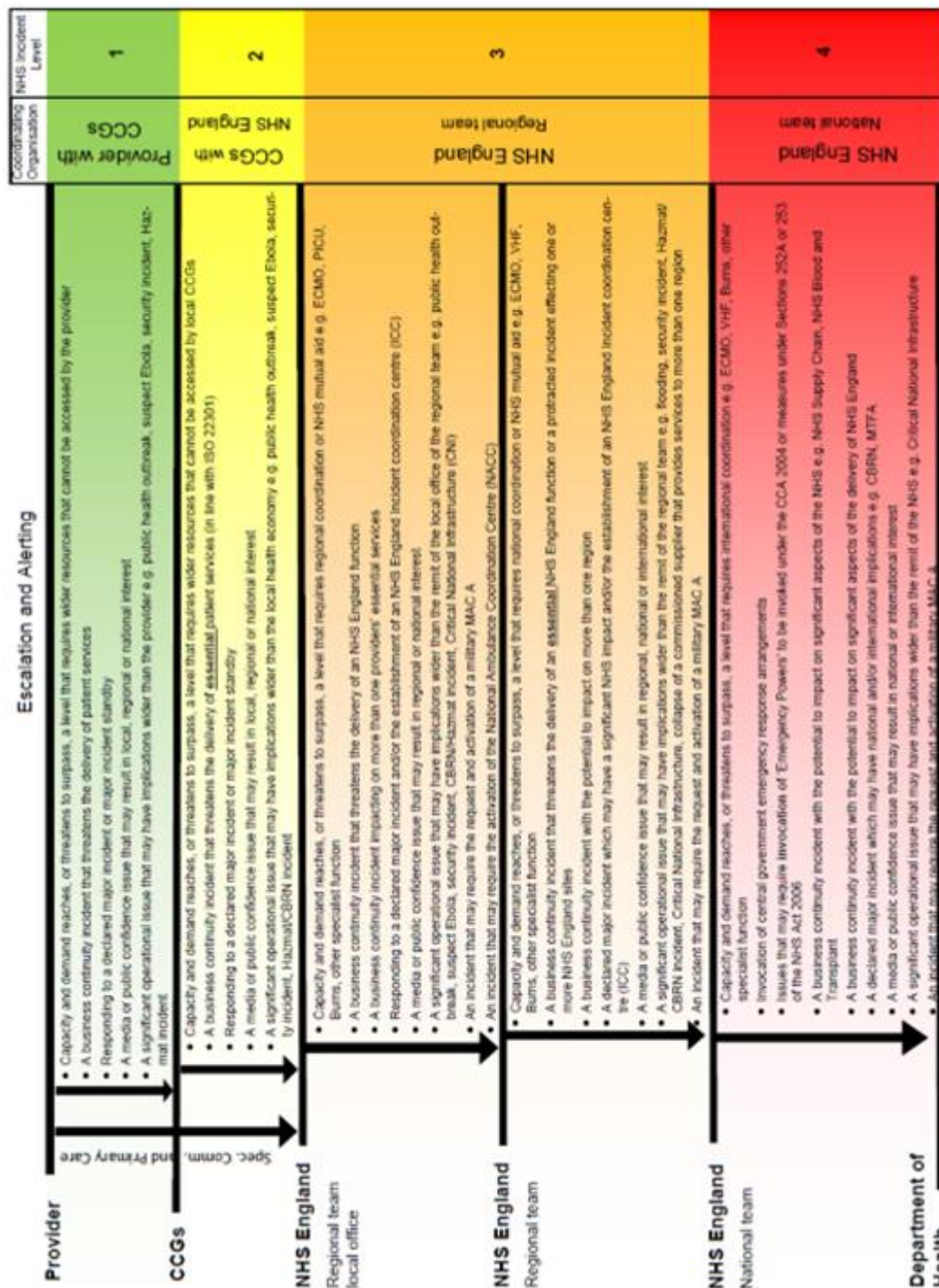
- A national Pandemic incident was the subject of the exercise. Key considerations were proper use of intelligence and the communication channels of intelligence.
- The local, regional, and national command structures and lines of communication.
- The national status - as opposed to regional status - of NHS England
- Consideration of impact to urgent/primary care providers outside of the acute sector.

- The interaction with the acute sector and other partners.
- Consideration of triage priorities involving clinical advisers was enacted via regional leads including for home visiting.
- Reconsideration of rotas of staff in view of strong likelihood that staff would be affected by the pandemic themselves, either directly or in the care of their meaningful others.
- Consideration of much higher levels of work via regional leads of call handling, patients on the line and pooling of GP out of hours calls was made - one of the Group managers was assigned the lead of temporary redesign of services with the Digital department with the aim of supporting more flexibility across the organisation the geographical areas which came under greatest pressure
- The national activation of 111 IVR
- Responsibility for recording and dissemination of situation and decisions was made.
- Additional pressures on Urgent Care Centres but remain under Vocare management
- The need to change 111 messages at short notice, possibly driven by NHS England requirements - and changes required in the direction of volumes caused by number and predominant diagnosis, and adjustment of KPIs
- Consideration of much higher levels of work via call handling, patients on the line and pooling of Vocare Resources
- The duty of co-operation was considered in the context of different commissioners wanting different courses of action
- Consideration of whether Vocare were the 111 providers for the region or not as this would ultimately impact our approach as well - in a region where Vocare operates 111, we could divert patients away from centre visits, home visits etc. at the earliest point of the patient journey. In locations where Vocare is not the 111 Provider, we will need to advise the Providers at the earliest point and work with them to try and divert patients.
- Consideration of locations; are Vocare co-located at those sites or are we standalone? If we are co-located, Vocare will likely be following another Provider's lead but in premises where Vocare are standalone, we will be the one declaring a Major Incident.
- Responsibility for recording and dissemination of situation and decisions was made

Specific recovery issues:

- Debrief, plan review
- Cost assessment - likely to be costly if not underwritten by commissioners - and recovery if appropriate.

NHS England CONOPS escalation levels



Section A13

Problem: Evacuation and shelter

Operating risk and information requirements appropriate for each level of decision maker

Executive

The strategic objectives behind all incident response will be:

- the saving of life
- maintenance of safe clinical practice and critical service provision (see Section B)
- the protection of Vocare staff, assets, and finances
- co-operation with other responders under the Civil Contingencies Act
- warning and informing the public: with the Communications team as a key arm.

These may be amended by the Gold Commander according to circumstances prevailing. Gold Command will also ensure the integrity of Silver Command and set in train any recovery activity necessary - see page 40.

Incident Controller

- Potential causes of this situation are varied - for example they may be caused by the large-scale sudden non-availability of accommodation for vulnerable and other people - but may be caused by or result in:
 - Requests from other public authorities, probably originating from fire or police multi-agency command
 - The evacuation of members of the public to designated local authority areas either on a temporary or permanent basis
 - Requirement of those members of the public to receive medical services: this may most likely, but not exclusively, include such features as:
 - GP and other advice for routine medical problems
 - Access to prescriptions and medicines
 - For one-off issues occurring during evacuation
 - For patients suffering from chronic diseases

Key elements of response

- These could take place across the urgent care spectrum but are most likely to be of the nature described above.
- If a response on wider than purely local basis is required, this is most likely to be accounted for by the NHS England
- Consideration of triage priorities involving clinical advisers enacted via regional leads including for home visiting
- Consideration of much higher levels of work via call handling, patients on

the line and pooling of GP Out of Hours calls was made

- Work under the statutory duty of co-operation under the Civil Contingencies Act and the common-law duty to co-operate with police officers in the course of their duties.
- Consideration of locations; are Vocare co-located at those sites or are we standalone?

Specific recovery issues:

- Debrief, plan review
- Cost assessment and recovery if appropriate.

Section B - Vocare Incident Impact Analysis and default Recovery Time Objectives

ESSENTIAL Activities Class 0 MPTD⁷/ RTO: Now Activities which cannot tolerate any disruption. If activities are not resumed immediately it may result in the loss of life, significantly impact patient outcomes, significant impact on other NHS services	HIGH PRIORITY Activities Class A MPTD / RTO: 24hrs Activities which can tolerate very short periods of disruption. If activities are not resumed within 24hrs patient care may be compromised, infrastructure may be lost and/or may result in significant loss of revenue.	MEDIUM PRIORITY Activities Class B MPTD / RTO: 48hrs Activities which can tolerate disruption between 24hr & 48hr. If service / functions are not resumed in this time frame it may result in deterioration in patient(s) condition, infrastructure or significant loss of revenue.	LOW PRIORITY Activities Class C MPTD / RTO: 72hrs+ Activities that could be delayed for 72 hours or more <i>but are required</i> in order to return to normal operation conditions and alleviate further disruption to normal conditions.
List activities - Complete Electrical outage including generator failure - Serious environmental incident <ul style="list-style-type: none"> • Fire • No water supply • Gas Leak • Bomb Threat • Severe Weather • Flood - Clinical and operational staffing resources 50% below minimum requirements - Major local incident requiring support to the wider health economy and CCG's that would impact on Vocare capacity to provide expected contractual service requirements - Fuel Shortage contingency. - Any condition which has reduced the capacity to provide expected service delivery levels and may have the potential deescalate to code Amber	List activities - Full Adastra outage with no access to systems - Full Telephone outage - unable to receive or make calls - Service pressures on local primary and emergency care providers – ie A&E on Level 4 escalation and are diverting patients away to alternative services - Disruption to medicine supplies – i.e. limited supplies of palliative care drugs - Clinical Resources 25% below minimum staffing. - Any condition which has reduced the capacity to provide expected service delivery levels and may have the potential to escalate to code red or deescalate to code Yellow	List activities - Partial Adastra failure – outage at specific sites but not the whole service - Partial Telephone Outage – i.e. unable to make outgoing calls but are still receiving incoming calls - Laptop Failure: faulty components, loss of signal - False Fire Evacuation - Post event messaging system failure - Public Health Outbreaks - Supportive measures for other healthcare providers in the locality ie increased referral activity from community services due to staffing issues. - Any condition which has reduced the capacity to provide expected service delivery levels and may have the potential to escalate to code Amber or deescalate to code Green	List activities - No Prescriptions - Limited Medication access - Operational Absence - Any condition which has reduced the capacity to provide expected service delivery levels and may have the potential to escalate to code Yellow

The purpose of this framework is to guide incident managers and local plans as to which areas are **critical by priority order** and what are the **key issues** within those areas. The focus should be on the **safety of patients and staff** and based upon **risk assessment**.

⁷ Time target and priority indicator: Maximum Tolerable Period of Disruption

Section C

Locality Risks

This appendix contains information on accessing local risks that have been identified by the Local Health Resilience Partnerships where Vocare delivers services.

1 London & South West Locality Risks

- 1.1 Specific Risk Registers and Action Plans are available in support of EPRR for Vocare London Services.
- 1.2 Printed Copies will be held in on-site packs.
- 1.3 Richmond Risk Register
https://www.richmond.gov.uk/media/18323/richmond_risk_register.pdf
- 1.4 Wandsworth Risk Register
https://www.wandsworth.gov.uk/media/2473/wandsworth_borough_risk_register.pdf
- 1.5 Pan-London Risk Register
https://www.london.gov.uk/sites/default/files/london_risk_register_v10_summarised_threats_public_0.pdf
- 1.6 Wiltshire Community Risk Register
https://wiltshireandswindonprepared.org.uk/media/booklets/LRF_WiltshireandSwindonCRR11.7.pdf
- 1.7 Cornwall Community Risk Register
<https://www.dcisprepared.org.uk/media/2238/public-facing-crr-print-lrf-dcios-20180713-v1.pdf>

2 Central Locality Risks

- 2.1 Specific Risk Registers and Action Plans are available in support of EPRR for Vocare Central Services.
- 2.2 Printed Copies will be held in on-site packs.
- 2.3 <https://www.staffordshireprepared.gov.uk/Preparing-yourself/Staffordshire-Community-Risk-Register-Jun-2021-Public.pdf>

3 North Locality Risks

- 3.1 Specific Risk Registers and Action Plans are available in support of EPRR for Vocare North Services.
- 3.2 Printed Copies will be held in on-site packs.
- 3.3 Northumberland Risk Register
<https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Local-Resilience-Forum/Northumbria-Community-Risk-Register-version-7.pdf>
- 3.4 North Yorkshire Risk Register
<https://www.emergencynorthyorks.gov.uk/node/10> and follow “Community Risk Register”
- 3.5 Lancashire Risk Register
<https://www.stayintheknow.co.uk/Documents/PreparingForEmergenciesBooklet.pdf>
- 3.6 Cleveland Community Risk Register
<https://www.clevelandemergencyplanning.info/information-for-residents/>

15. Debrief process

1. hot debriefs including out-of-hours within 24 hours ideally, max 30 minutes - always thank staff for their efforts - if out-of-hours, led by on-call manager
2. cold debriefs
3. report circulated for comment - if none, publish
4. report used for learning - receive at next Resilience Group
5. report to V-Central section on Emergency Planning (debriefs of incidents and exercises page), and DATIX lead
6. clear project management of learning
7. overall aim to work through the plan to identify good points and areas to improve on when another incident occurs. EP lead or other suitable senior manager to lead: recommended completion in one week.

Format of meeting is always:

- What evidence (eg logs, notes) is being used?
- What went well?
- What went less well?
- What plans, training, equipment or process must change
- Thanks to staff

For multi-agency meetings, the JESIP format overleaf must be used.

Keep a record of what you do... If it isn't written down, it didn't happen!

DEBRIEF TEAM NAMES:	LOCATION:	DATE OF EVENT:
	EVENT TYPE: (Exercise, Live Incident, Other)	

JESIP Principle - Co-location	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
Were commanders easily identifiable? (Tabards)	
What command structures were in place?	

Keep a record of what you do... If it isn't written down, it didn't happen!

JESIP Principle - Co-location	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
Did commanders meet face to face?	
Was a Forward Command Post (FCP) established?	
Did commanders have timely on-scene briefings?	

Keep a record of what you do... If it isn't written down, it didn't happen!

JESIP Principle - Communication	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
Was common terminology used?	
Was an Airwave interoperability talk group used?	
Was relevant information shared across all services and control rooms throughout the incident?	
Was METHANE used to pass information to control?	

Keep a record of what you do... If it isn't written down, it didn't happen!

JESIP Principle - Communication	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
<p>Were effective communications established between:</p> <ul style="list-style-type: none">• Operational & tactical commanders• Commanders and control rooms• Emergency service commanders and other responding organisations• Local emergency service control rooms• Emergency service control rooms and national co-ordinating centres	

Keep a record of what you do... If it isn't written down, it didn't happen!

JESIP Principle - Co-ordination	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
Did Commanders use the JDM as single decision model?	
Were Capabilities & Responsibilities identified?	
Were joint decisions on priorities made and if so, how were the priorities arrived at and agreed?	
Were actions joined up and therefore efficient and effective?	
Were ALL on scene resources used appropriately?	

Keep a record of what you do... If it isn't written down, it didn't happen!

Was there an understanding of the capability, capacity, and limitations of each other's assets?	
Did someone take the lead co-ordinators role during Multi-Agency meetings?	

Keep a record of what you do... If it isn't written down, it didn't happen!

JESIP Principle - Understanding of Risk	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
Were threats and hazards identified, understood, and treated different by each emergency service?	
Were limitations and capabilities of people and equipment identified?	
Was a joint understanding of risk achieved by sharing information about the likelihood and potential impacts of threats and hazards? e.g. sharing of risk assessments	

Keep a record of what you do... If it isn't written down, it didn't happen!

JESIP Principle - Shared Situational Awareness	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
Did Commanders have a common understanding of what has happened, what is happening now and the consequences of events?	
Did each of the emergency services understand their roles in resolving the emergency?	
Was METHANE regularly used to provide a Common Operating Picture (CoP)	

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JESIP Principle - Shared Situational Awareness	
OBJECTIVES	LEARNING/RECOMMENDATIONS - Record observations below
<p>Was the Joint Decision Model utilised identifying:</p> <p>Situation: What is happening? What are the impacts and risks? What might happen and what is being done about it?</p> <p>Direction: What end state is desired? What is the aim and objective of the emergency response? What priorities will inform and guide direction?</p> <p>Action: Were actions decided? What needed to be done to achieve a positive end state?</p>	

Keep a record of what you do... If it isn't written down, it didn't happen!

Any other information/issues:	
Other Issues	LEARNING/RECOMMENDATIONS - Record observations below
<i>[Describe the issue here]</i>	<i>[Provide details and observations about the issue, what went wrong and who it affected. New rows can be added for multiple issues]</i>

Keep a record of what you do... If it isn't written down, it didn't happen!

Any other information/issues:	
Other Issues	LEARNING/RECOMMENDATIONS - Record observations below
<i>[Describe the issue here]</i>	<i>[Provide details and observations about the issue, what went wrong and who it affected. New rows can be added for multiple issues]</i>
<i>[Describe the issue here]</i>	<i>[Provide details and observations about the issue, what went wrong and who it affected. New rows can be added for multiple issues]</i>

Keep a record of what you do... If it isn't written down, it didn't happen!

Do any of the issues raised during this de-brief meet the criteria for submitting to the national JOL App?	Yes/ No (delete as appropriate)
Who will submit onto JOL? (agree with all parties)	
Name	Organisation

Do any of the issues raised during this de-brief meet the criteria for submitting to the national JOL App?	Yes/ No (delete as appropriate)
Who will submit onto JOL? (agree with all parties)	
Name	Organisation

National submission triggers to JOL

Any issues raised as part of this de-brief which meet any or all of the following criteria should be submitted onto JOL:

- relate to emergency response interoperability, primarily the use of M/ETHANE, the five JESIP principles for joint working and use of the Joint Decision Model;
- had an impact on the effectiveness of at least two of the response organisations;
- impeded successful interoperability;
- are known recurring issues; and/or
- if resolved could benefit other organisations therefore may have national impact.

What needs to be changed in the plan, training, or risk assessment for this type of incident?

PLAN END