NHS FORTH VALLEY
Major Emergency Response Plan

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NHS Forth Valley

CONSULTATION AND CHANGE RECORD

Contributing Authors:		Civil Contingency Tactical Group Major Emergency Planning Acute Group	
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Nov 2006 Dec 2006		Approved by NHS Forth Valley Re-issue of MEP – Version 2	2
Nov 2008 Dec 2008	EPO/Risk Management	Approved by NHS Forth Valley Re-issue of MEP – Version 3 (Section 4 – SRI Acute Operational Section has been completely rewritten, which now includes a paediatric & burns section)	3
Jan 2010	EPO	Approved by NHS Forth Valley Annual review and update – Re-issue of MEP – Version 4	4
Jan 2011 1 April 2011	EPO	Version 4 will be valid until the move to FVRH in July 2011. This is the first Working Interim version which has been revised to reflect the anticipated move of A&E to FVRH; the plan includes a section on CHP working and a better integration of business continuity dovetailing with emergency planning. DRAFT 2 – Various updated after consultation up to 7/3/11	5 (Working Interim for July 2011)

Date	Author	Change	Version
Jul 2011	EPO/Civil Contingencies Unit	For approval by NHS Forth Valley on 31/5/2011	5
	Civil Contingencies Unit	Updates to Operational Action Cards & maps	5.01
	Civil Contingencies Unit	Updates to Areas being used during incident Updated contacted numbers	5.02
Sept 2011	Civil Contingencies Unit	Update to Radiology declared action cards. Inclusion of outstanding contact numbers.	5.03
Dec 2011	Civil Contingencies Unit	Update to action cards due to Emergency Department procedure updates Updates received from Communications Department Update to information regarding Chaplains & Spiritual Care Team	5.04

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INTRODUCTION

NHS Forth Valley recognises that planning for emergencies is an integral part of good business practice for any organisation. It is particularly important that public service organisations can continue to deliver their essential functions and that they are able to respond to the needs of the community, businesses and the environment in emergency situations.

The Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 is part of new government legislation that came into force in November 2005 and focuses on local arrangements for civil protection, establishing a statutory framework of roles and responsibilities for local responders such as NHS Forth Valley. This plan reflects those changes.

NHS Forth Valley has the responsibility to meet the health care needs of the people of Forth Valley. This includes meeting needs that cannot be fully predicted or which increase or change unexpectedly. There is always a very small but finite risk of major incidents on motorways, railways, at large public events, and major industrial complexes in Forth Valley. The increased threat in terrorism from the Glasgow Airport incident in June 2007, the emergence of communicable diseases such as the Pandemic Influenza in Spring 2009, and more recently late November 2010 saw the effects of severe weather which has increased the need for preparedness and robust business continuity planning for the challenges of such events.

It is not possible to predict the exact form and nature of a future emergency, nor the amount of time available to respond to it. Any part of NHS Forth Valley may need to respond at short notice and must prepare accordingly. Major incidents may happen at any time of the week or day and those who are available at that time must be prepared to take on the urgent task of responding to the incident. Planning and managing the NHS Forth Valley emergency response must be regarded as integral to the planning and management of every service NHS Forth Valley provides. We must be fully aware of the role of other key agencies such as police, fire, ambulance and other services in the multi-agency response to major incidents.

The successful implementation of this response plan requires commitment from staff at all levels, especially to take into account the move of the Emergency Department to the new Forth Valley Royal Hospital in July 2011. The response to the first call of staff in the Emergency Department or telephonists can be as important as that of the Chief Executive. Each individual who may be involved has an obligation to ensure they are aware of and understand their role in the NHS Forth Valley response. This response plan sets standards for induction, and regular training that must be met by staff at all levels, this is detailed further in the NHS Forth Valley Civil Contingency Policy. These standards will be audited.

This response plan will be regularly monitored to ensure that its objectives are achieved and will be reviewed/revised in the light of any legislative or organisational changes through NHS Forth Valley's Acute Major Emergency Group and the Civil Contingencies Tactical Group, both of which meets regularly.

This plan is not the important aim. The primary aim is NHS Forth Valley preparedness and effective response based on this response plan.

Dr Anne Maree Wallace
Director of Public Health

TRAINING & EXERCISE RECORD

All Training & Exercises must be logged and inserted on this form relating to the Major Emergency Plan

Dates From Jan 07	Session	Description	Elements which tested the MEP
Dates throughout 2007/2008	Awareness Sessions of Major Incidents	General awareness session and impact of a Major Incident for A&E	Awareness for staff of their specific roles during a major incident
March, June & Sept 2007	Decontamination Refresher	Refresher awareness session of setting up decontamination facilities	Training and awareness refresher on how to set up and run an in-house decontamination facility
29 & 30 May 2007	Decontamination Hospital Provider Course	Session to train staff with no experience on chemical decontamination by exercising in suits and awareness session.	An in-house training session on how to set up and run a decontamination facility in suits.
4 – 6 May 2007	HMIMMS	Approx 26 staff members from across NHS FORTH VALLEY took part in the Hospital Medical Incident Management System	This led to the MEP Part 4 being re-written to coincide with this course.
May 2007 & April 2008	BASICs	BASICs Course	Provided NHS FORTH VALLEY with an enhanced team of trained BASICs in the event of a major incident.
¼ ly throughout 2007/08	MICC Awareness/ Technical Advisor Session & Exercise	Provides training and awareness to staff involved in MICC emergencies	Procedure to notify the A&E Dept, callout and activation of the CPHM to MICC
February 2007	Exercise “Winter Willow	National Exercise testing Pandemic Influenza	Activation of the SCG and testing links to the Scottish Government Emergency Room
December 2007	Decontamination “Train the Trainer	Train the Trainer on new decontamination suits by Scottish Ambulance Service	To be used to pass on a train the trainer basis

Dates From Mar 08	Session	Description	Elements which tested the MEP
March 2008	SSTP Activation and Callout	Testing the call out and set up of the NHS Board	Exercised the callout and activation of the Strategic Support Team
4th December 2008	Acute Based Tabletop Exercise "Hot Alert"	Chemical Incident to test the response of all depts. within SRI following a declared major incident	Setting up the Hospital Control Team and other depts within SRI to ensure the MEP was fit for purpose
2 & 3rd March 2009	Exercise "Ancient Mariner"	SCG & Scottish Water Tabletop exercise leading to a major water disruption in Central Scotland (NHS FORTH VALLEY was a major player)	The Hospital Control Team, Strategic Support Team & Central Scotland SCG Scientific & Technical Advice Cell was activated over a protracted period.
1/4ly throughout 2009 March & Oct 09	MICC Awareness/ Technical Advisor Sessions and MICC DISCO exercises (2/12)	Routine and on going general awareness & technical advisor training for staff that may be involved at a major incident in the Grangemouth petrochemical complex	Call out, STAC activation & support and structured A&E alerts to a major emergency
7 November 2008	1 day MIMMS	A day course for clinical staff managing a major incident	To familiarize staff to respond to a major emergency
Nov & Dec 09	Drop in sessions for the Strategic Support Team	Awareness session for staff as the Boardroom is transformed into the Control Room in the event of a strategic response	Testing the callout and activation of the Strategic Support Team
22 Sept 2009	SCORDS Tactical Managers Course	Tactical training for managers	Awareness training that looks at specific elements and multi agency working within the MEP
August 2009 – October 2010	Exercise ARGUS	Training aimed at NHS staff including estates and security staff within a hospital setting	Potential Counter Terrorism/ Firearms incident and how to be better prepared.

Dates From 2010	Session	Description	Elements which tested the MEP
June 2010	CBRN Exercise	CBRN/Hazmat Exercise to test procedures and frameworks	Tabletop & liveplay Exercise to test CBRN Frameworks
6 Monthly April – Nov	SSTP	Setting up Strategic Support Room	Tested SST room and equipment for staff – drop in sessions
Various	Recovery Training	Recovering from Emergencies and the Aftermath	External training provided recovery aspects of an emergency
Jan 10, Feb 10, Aug & Sept 10	SCORDS	Training for Strategic & Tactical Managers	CPD Sessions
Feb/ June 10	STAC Training	Scientific, Technical Advice Cell training for CPHMs	STAC Awareness - HPS
1/4ly 2010	MICC Awareness Sessions	Awareness Sessions – staff with an emergency role	Awareness Sessions
15/11/10	Port Health Exercise	Grangemouth Docks	Exercise with CPHM, Falkirk Council & Forth Ports
November 2010	MICC Tech Advisors Trg & DISCO Ex	MICC –Updated facility and test room and equipment for CPHM	Awareness Session

Dates From	Session	Description	Elements which tested the MEP

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INVENTORY OF CONTINGENCY PLANS AS AT DECEMBER 2010
EMERGENCY PLANNING (NHS FORTH VALLEY PLANS)

This form will be used as an exercise and training audit tool to record which plans and elements of the plans have been tested from 25th November 2008 onwards.

NHS Forth Valley Plans	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review date
	Strategic	**Operational**	**Acute**	**Primary Care**	
NHS FORTH VALLEY - Major Emergency Plan (Version 5)	Exercise Hot Alert 4/12/08 to validate & test ME Plan, Communications & Hospital Control Team.	Exercise Hot Alert 4/12/08 Tested the A&E staff, clinical, support & Management staff. MEP tested 31.3.11 and deployment of MMT to scene and receiving multiple casualties – considering FVRH	Awareness Sessions throughout 2008 MIMMS Refresher in Nov 2008 June 2010 – CBRN Exercise at SRI	Events from the Pandemic led to more robust planning infrastructure	April 2011 **The MEP V4 will run until July 11. V5 updated to reflect move to FVRH for Jul 11.**
Operational Section	Alva Fire – 10/11/09 Public Health Advice & response required - This incident highlighted the importance of Multi-agency working.	Alva Fire – 10/11/09 Hospital Control Room was put on standby.			

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NHS Forth Valley Plans	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review date
	Strategic	**Operational**	**Acute**	**Primary Care**	
Level 4	3/6/10 – HAZMAT/CBRN Exercise involving injured cleaned casualties and 2 self presenters arriving at A&E	3/6/10 – HAZMAT/CBRN Exercise involving injured cleaned casualties and 2 self presenters arriving at A&E	3/6/10 – HAZMAT/CBRN Exercise involving injured cleaned casualties and 2 self presenters arriving at A&E – HCT and BCP were all considerations		
NHS FORTH VALLEY – Strategic Support Team Procedures Level 4	April 2009 – The Strategic Support Team Procedure was activated and became the Control Room for several weeks during the initial phase of the H1N1 outbreak The callout procedures were tested as well as the actual procedure for setting up the strategic control room.	April 2009 - This was the hub for communication and information and acted as the command and control centre. The procedures were tested from an operational perspective and additional roles and action cards will be included in the updated version of the procedure.	Both Acute & primary Care were part of seeing how this procedure integrated from a communications perspective with the generic email & phone system. This was the hub for all communication, control and control. Ongoing SST awareness drop in sessions to see how the control room is set up.		April 11 Due Dec 12

NHS Forth Valley Plans	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review date
	Strategic	**Operational**	**Acute**	**Primary Care**	
	NHS Forth Valley Communications Team undertook a SSTP training session in April 2010.				
	Severe Weather Nov-Dec 2010 tested this plan and the Strategic Support Team was established	This had an adverse affect on operational issues – this was coordinated through the Strategic Support Team	Severe Weather impacted on Acute Services and Primary Care which was coordinated through the Strategic Support team		
NHS FORTH VALLEY – Pandemic Influenza Operational Plan Level 4	April 2009 – The Pandemic Flu Plan was invoked after moving to WHO Phase 6, but closely followed during the earlier phases to establish groups, command and control structures. As the situation developed the Pandemic Flu Plan required to be reviewed and updated to reflect the changing situation. The NHSFV Strategic Pandemic Flu Group was established followed by the Shortlife Planning Group to include partner agencies	April 2009 – All operational plans were reviewed to ensure that they were fit for purpose with the evolving challenges brought by the initial cases of H1N1 to NHS Forth Valley. The NHS Forth Valley Pandemic Operational Plan was followed from an operational perspective and revised and updated as the situation evolved.	Both Acute and Primary Care were part of the Operational Group. This group formed the basis for the ongoing revision and best practice for updating and revising the Operational Section of the Pandemic Plan, again as the situation evolved.		October 2009 WIP & Ongoing Framework approved at PMG Sept 2009

NHS Forth Valley Plans	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review date
	Strategic	**Operational**	**Acute**	**Primary Care**	
NHS FORTH VALLEY – CBRN (including decontamination Level 2) Level 4 Framework	A CBRN tabletop & live exercise took place 3/6/10. The CBRN & Decontamination Procedures were approved at the CCTG November 2010				December 2010 To be reviewed following Move to FVRH July 2011
NHS FORTH VALLEY – Bomb Threat and Evacuation Procedures (FVRH) DRAFT Level 1	This was drafted following on from Glasgow Airport bombings of July 2007. – CCTG FOR ATTENTION FOLLOWING EXERCISE ARGUS AND MOVE TO PHASE 3 AT LARBERT THIS HAS BEEN TASKED BY THE EMERGENCY PLANNING WORKSTREAM FOR FURTHER DEVELOPMENT				July 2010 Draft Agreed for FVRH 2010
NHSFV – Evacuation Procedures Framework Level 1	Drafted for FVRH up to phase 2 - MOVE TO PHASE 3 AT LARBERT THIS HAS BEEN TASKED BY THE EMERGENCY PLANNING WORKSTREAM FOR FURTHER DEVELOPMENT –				September 2010
NHS FORTH VALLEY – Deployment of Authorised Firearms with Central Scotland Police (RESTRICTED) Level 3	This is currently WIP to ensure the plan is still fit for purpose and move to FVRH				October 2008 Mar 09 with PLO for comments
NHS FORTH VALLEY – Fuel Emergency Plan Level 3	Tested and amended during potential Industrial Action in Summer 2008 and since been amended from National Guidance. This plan was approved in Nov 2010 at CCTG				December 2010 December 2012

NHS Forth Valley Plans	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review date
	Strategic	Operational	Acute	Primary Care	
NHS FORTH VALLEY – Infrastructure Failures (Estates) Level 4	DOWNLOADED INTRANET JULY 2010 (13 Plans)				
HTM2070 Contingency Planning Manual for Guidance & Advice	Many of these plans have been tested during infrastructure failures. The NHSFV Emergency Planning Workstream is revising/updating all plans relevant to FVRH				Guidance 1997
NHS Emergency Management Data for estates staff					April 2006
Major Infrastructure Failure Response Plan Major Infrastructure Failure plan - Aide Memoir					July 2010 (Draft)
Management Responsibilities during a Major Infrastructure Incident					Jan 2005
Asbestos Discovery on site emergency procedures - Sept 2006					Jan 2006
Precautions for Extreme Weather					Sept 2006
Legionella Outbreak action plan for both sites May 2006					May 2006

NHS Forth Valley Plans	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review date
	Strategic	Operational	Acute	Primary Care	
Falkirk Royal Infirmary - Water Failure Response Plan- Sept 2006					Sept 2006
Failure of Power - Use of standby Generators Response Plan - June 2005					June 2005
Flooding; Burst Pipes; Excessive Rain water response plan Sep 2004					Sept 2004
Stirling Royal Infirmary - Water Failure Response Plan - Sept 2006					Sept 2006
Pandemic flu staff shortage - response plan					2006
NHSFV – Major Infrastructure Plan for FVRH Level 1	Draft – Out for Consultation reviewed at NHSFV Emergency planning Workstream – for approval at April 2011 CCTG				November 2010 DRAFT
NHSFV – Switchboard Guidance (Infrastructure Failure & Major Incident)					May 2010
ICT – Infrastructure Disaster Recovery Plan Level 4					Version 1 March 2009
ICT DR Document Register Level 4					August 2010

There are other NHS FORTH VALLEY Public Health Plans which are routinely tested on a day to day basis i.e. Outbreak in care settings etc.

KEY
NOTE: Listed below are the 4 levels set by QIS and a brief explanation of the Continuous Quality Improvement Scales (CQI).

Level 1	Development	The NHS Board is developing its emergency and continuity planning arrangements
Level 2	Implementation	The NHS Board is implementing its emergency and continuity planning arrangements across the organisation
Level 3	Monitoring	The NHS Board is monitoring the effectiveness its emergency and continuity planning arrangements across the organisation
Level 4	Reviewing	The NHS Board is reviewing and continuously improving its emergency and continuity planning arrangements across the organisation

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INVENTORY OF CONTINGENCY PLANS AS AT DECEMBER 2010
EMERGENCY PLANNING (OTHER PLANS)

This form will be used as an exercise and training audit tool to record which plans and elements of the plans have been tested from 25th November 2008 onwards.

Multi-agency plans which NHS FORTH VALLEY has a part	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review dates discretion of SCG
	Strategic	**Operational**	**Acute**	**Primary Care**	
Central Scotland SCG Plans					
Central Scotland SCG Pandemic Influenza Plans Part 1 – Strategic Part 2 – Tactical Part 3 – Operational (TEMPLATE) LED BY EP – NHS FORTH VALLEY	All 3 Plans were invoked during the H1N1 Pandemic. The plans were fully tested from all sections, including inter-agency working, communications, STAC, command and control. Part 3 (Operational) sections from all agencies were revised and updated. The SCG Pandemic Influenza working developed an Action Plan (2010).				March 2008 Awaiting new Guidance being published – Currently out for consultation June 2011
Central Scotland SCG Community Risk Register	Planning is based on the Community Risk Register NHSFV are responsible for 5 Risk Assessments below(updated April 2010) H14 – Major Contamination Incident H22 – Epidemic H23 – Pandemic H24 – Emerging Infectious Diseases HL24 – Legionella/Meningitis				May 2010 May 2012
Central Scotland SCG Exotic Notifiable Animal Diseases Plan DRAFT 2	Spring 2009 – Central Scotland Police hosted a Foot & Mouth Exercise to test Animal Diseases Plan. EPO was involved in this exercise as there was minimal impact to the NHS				June 2008 Summer 2011

Central Scotland SCG Scientific & Technical Advice Cell Guidance (STAC) LED MY EP – NHS FORTH VALLEY	During the Swine Flu Outbreak the STAC was established.			Approved by SCG June 2010
	Exercise Ancient Mariner 2&3 March 2009 initiated a STAC, which ran for the duration of the 2 day exercise covering the incident and into recovery – The plan has been revised to reflect lessons learned and now includes multiple SCG/National STAC		Exercise Ancient Mariner 2&3 March 2009 – initiated a STAC putting pressure on Acute and Primary Care and vulnerable clients in the community. This involved close working with the local authorities providing a care and support function.	

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Multi-agency plans which NHS FORTH VALLEY has a part	What parts of the plan have been tested? (record exercise/incident date & element of plan)		What training has been undertaken?		When was plan reviewed? Review dates discretion of SCG
	Strategic	**Operational**	**Acute**	**Primary Care**	
Other Inter-agency Plans					
MICC Procedures	MICC Technical Awareness Training takes place 1.4ly and DISCO Exercises twice per year which requires Health Specialist advice from Public Health.	Ongoing MICC Awareness sessions run 1/4ly. This is open to all NHSFV staff that may have a role to play in a major incident at the Grangemouth Petro-chemcial complex. This gives an insight into the plant and the importance on multi-agency working.			April 2007 Currently WIP – being rewritten
Scottish Water – Waterborne Hazard Plan	Exercise Ancient Mariner 2-3 March 2009– SSTP interface with HCT, SCG, STAC and Communications Group		Exercise Ancient Mariner – the Hospital Control Team, Estates Water Failure Plan and A&E continuity along with BCM	Exercise Ancient Mariner – Tested the vulnerability in the Community and those patients at risk	July 2010 July 2011

SECTION 1 – INTRODUCTION

1.1 FOREWORD

NHS Forth Valley has the responsibility to meet the health care needs of the people of Forth Valley and includes those needs which are not possible to predict in detail or which rise or change unexpectedly. An emergency does not remove this statutory duty but its fulfilment may require sudden alterations as to how, where and when the diagnoses, treatment, comfort and care of patients is carried out.

It is not possible to predict the exact form and nature of a future emergency, nor the amount of time available to prepare for it, any part of NHS Forth Valley might need to contribute to the response to it and must prepare accordingly. Planning and managing the NHS Forth Valley emergency response must be regarded as integral to the planning and management of every service NHS Forth Valley provides.

This Major Emergency Plan describes NHS Forth Valley responsibilities for ensuring high levels of preparedness for a major incident in accordance with the Scottish Government Preparing Scotland Guidance and the principles of the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005.

- emergency planning
- risk assessment
- communicating with the public
- information sharing
- co-operation
- business continuity management

1.2 EMERGENCY PLANNING RESPONSIBILITIES

Forth Valley NHS Board is required to provide strategic leadership to secure the health of the population in Forth Valley for which it is accountable to the Scottish Government Health Department and the relevant Scottish Ministers.

In addition Forth Valley NHS Board is responsible for the NHS Forth Valley response to major emergency incidents, which may occur in its area.

Similarly, NHS Hospitals within Forth Valley are responsible for the management and operation of individual health care services. They have a duty to plan to overcome the effects of any emergency, which might threaten the continuance or alteration of these services.

Therefore, whilst detailed operational emergency planning is delegated to individual services, Forth Valley NHS Board will maintain an overall strategic plan in respect of the NHS Forth Valley response to a major emergency. Outlined within these procedures will be:

- the roles, responsibilities and tasks to be undertaken by the Board and Forth Valley Royal Hospital (from July 2011 as the designated control hospital), both generally and under specific circumstances.

- the arrangements for the control and co-ordination of the NHS Forth Valley response and the procedures to be used.
- the requirements of the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 and duties placed upon NHS Forth Valley.

1.3 THE AIM OF EMERGENCY PLANNING

The aim of emergency planning within Forth Valley NHS Board is in accordance with Scottish Government and National Government guidelines, as outlined in "Manual of NHS Guidance: Responding to Emergencies (revised 2009)" and "Preparing Scotland" in context with Civil Contingency Act 2004 (Contingency Planning) (Scotland) Regulations 2005, and ensures that essential health care needs are met effectively when normal services become overloaded, restricted or non-operational for whatever reason.

The process of emergency planning should be to assist the response of NHS Forth Valley to be positive, relevant, organised and well managed from the outset of the emergency and co-ordinated with the response of others to form a single integrated response to an emergency.

The principles of Emergency Planning and the management of an incident must focus on the effective response to the emergency and not on the cause.

Regardless of the nature or circumstances of the emergency, NHS Forth Valley must be prepared to:

- deal with the influx of new patients whose number, condition and location precludes treatment under normal routine arrangements
- take steps to safeguard the health of the population from the adverse effects of the emergency
- continue to provide treatment and care for existing patients

Studies from previous emergencies suggest there are five distinct and overlapping phases to the successful management of an integrated emergency response and NHS Forth Valley's emergency plans will be based on these principles where relevant:

1. **Assessment** – Risk assessment is both an integral component of risk management and the first step in the emergency planning process. It is therefore important that a realistic approach and understanding of potential hazards and threats are prepared for

2. **Prevention** – this phase encompasses measures adopted in advance of an emergency which seek either to prevent it occurring or reduce the severity of its effects

3. **Preparedness** – this involves the identification and preparation of resources, the maintenance of skills and alerting. Regular training and exercising must underpin mobilisation and operating procedures. The need to guarantee service continuity requires emergency planning to consider any potential incident or interruption to essential services and utilities

4. **Response** – this is the urgent action phase. The priorities are to save lives, prevent escalation, relieve suffering and facilitate the subsequent return to normality

5. **Recovery** – this will encompass all activities necessary to provide a return to normality, both for those affected by the emergency and for those responding to it. It should include identification and assessment of the long term, consequential or delayed effects of the emergency and planning for those to be effectively handled as routine activity. Analysis of the response and identification of lessons learned, which complete the management of the emergency, should contribute to the prevention and preparedness phases of the next incident.

Therefore Emergency Planning and Business Continuity Management within NHS Forth Valley should not be regarded as activities exclusively relevant to an emergency response, but should be an extension of, and integrated into every day procedures and management.

1.4 DEFINITIONS OF AN EMERGENCY

Emergency – An emergency is something which arises unexpectedly, and which requires urgent action to resolve. The NHS faces many emergencies in the course of its routine activities. Whilst each separate instance requiring urgent NHS action might in itself be unexpected, being faced with emergencies is a natural characteristic of meeting health care needs. To provide a basis for emergency planning, there is a requirement to form an understanding between what is considered “routine” emergencies and those, which require special action.

The Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 defines an emergency as *“an event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.”* The definition is concerned with the consequences rather than the cause or source.

Routine Emergency – a routine emergency can be defined as one that can be met within the normal capacity and procedures of those dealing with it. It is one that places no abnormal requirement upon health care services.

Major Emergency – a major emergency can be defined as a situation, either arising or threatened, which requires special mobilisation and/or redeployment of staff or other resources with consequent interruption to routine activities.

Major Incident – a major incident is the widely accepted term used by the Emergency Services to describe any emergency that requires the implementation of special arrangements by one or more of the Emergency Services, the NHS or Local Authorities. A major incident for one organisation may not be the same for the others.

NHS Forth Valley staff that are engaged in their normal routine duties are likely to be amongst the first people to become aware that an emergency has arisen or is imminent.

The process of emergency planning will:

- assist NHS Forth Valley staff to react efficiently and positively by providing them with specific instructions and guidance in dealing with the incident, which will be coupled with an overview as to how the NHS and partner organisation will respond as a whole.
- provide advice and assistance to enable the NHS Forth Valley response to be appropriate, structured, co-ordinated and managed effectively from the outset of the emergency.
- enable the NHS Forth Valley response to be co-ordinated with the responses of the Emergency Services, Local Authorities and other partner agencies, thus forming a single integrated response to the emergency.

1.5 SCOPE OF EMERGENCY PLANS

To plan separately and in detail for every possible foreseen emergency is less effective than to develop a generic plan with a generic framework to respond to any emergency and emergency plans in NHS Forth Valley will be based on this method.

It should be understood that when compiling NHS Forth Valley plans, that no emergency plan could cover every eventuality. Over prescriptive arrangements can constrain flexible thinking, which staff will be required to show so as to provide a resolution to any emergency.

1.6 POTENTIAL MAJOR EMERGENCY RISKS WITHIN FORTH VALLEY

Most major incidents occur with little or no warning and their nature and type are wide and varied. Forth Valley NHS Board will have regard to all potential emergency situations, which may occur in its area and will therefore plan accordingly. In this respect the following list must not be considered definitive, but identifies the special risks, which may be associated with the Forth Valley area.

- major hazardous industrial accident
- pipeline incident
- major outbreak of a communicable disease
- chemical pollution to air or water supplies
- major motorway or road incident
- major rail incident
- an air crash
- major prison incident
- maritime incident
- major fires or explosions
- incidents arising at mass gathering events
- severe weather incidents; including flooding
- acts of terrorism

Assessments of risk which may directly affect the Board's ability to maintain an effective healthcare service are recorded in The Central Scotland SCG Community Risk Register (See Paragraph 1.7.2)

1.7 THE CIVIL CONTINGENCIES ACT 2004 (CONTINGENCY PLANNING) (SCOTLAND) REGULATIONS 2005

This Plan sets out the framework for our response under the recently published Preparing Scotland Guidance as well as the requirements of the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005. The Act requires that local responders are divided into two categories depending on the extent of their involvement in civil protection work, and places a proportionate set of duties on each.

Category 1 responders are those organisations at the core of emergency response (e.g. Emergency Services, NHS and Local Authorities). Category 1 responders are subject to the full set of civil protection duties and statutory duties. They are required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency;
- Provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only).

These duties are expanded on below:-

Risk Assessment - NHS Forth Valley along with other partner agencies in Central Scotland has co-operated to produce the Community Risk Register. A copy of the Community Risk Register along with detailed information on the risks that Central Scotland will lead on is available on the Central Scotland Fire & Rescue website.

The Central Scotland Community Risk Register has been created for two primary reasons. Firstly, to reassure the people and communities of Central Scotland that an assessment of potential hazards and threats has been made or considered. Secondly, to satisfy the requirements outlined in the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 and its statutory Guidance (Preparing Scotland).

Cooperation - NHS Forth Valley has representation on National, Regional and Strategic Co-ordinating (SCG) Forums and relevant subgroups. This is to ensure the consistency of NHS plans with other Category 1 & 2 Responders, in fulfilling the statutory requirement of cooperation between local responder bodies as advocated by the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005.

If there is a major incident within Central Scotland then the Strategic Co-ordinating Group would be set up. This Group works well in Central Scotland demonstrating good practice of Integrated Emergency Management as no single organisation could cope with a major emergency alone. The Group consists of the Police, Fire & Rescue, Local Authorities, Scottish Ambulance Service, Military, Procurator Fiscal, Maritime Coastguard Agency & SEPA. A group at tactical level supports the Strategic Co-ordinating Group.

Communicating with the Public - NHS Forth Valley recognises it has a responsibility to provide accurate, timely and frequent information to the media and the public, and to have appropriate mechanisms in place to provide this service. *(Sections 1.8 Communications and 1.9 Media Management provide a detailed response)*

Emergency Planning and Business Continuity - The emergency planning process is a key element of emergency preparedness. NHS Forth Valley will comply with relevant Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 requirements, including:

- maintaining plans for reducing, controlling or mitigating its effects
- maintaining plans for taking other action in connection with the major incident.
- ongoing Training and Exercise programme.

Business Continuity Management (BCM) is the management process that helps manage the risks to the smooth running of an organisation or delivery of a service, ensuring that the business can continue in the event of a disruption. These risks can be from the external environment (for example, power failures, severe weather) or from within an organisation (for example, systems failures, loss of key staff). This is currently being addressed to ensure that there is a corporate complement of Business Continuity Plans in place for NHS Forth Valley; current plans are being updated to reflect operational changes to Forth Valley Royal Hospital.

Information Sharing - Information should be shared freely between responders unless it is sensitive, in which case it should be stored securely. There are many pieces of legislation which affect the use of information within individual sectors, three of these with a much wider ranging impact are the Freedom of Information Act (Scotland) 2002, Environmental Impact (Scotland) Regulations 2004 and the Data Protection Act 1998.

1.8 COMMUNICATIONS

Effective Communications will be key to the successful management of a Major Emergency.

NHS Forth Valley Emergency Plans will require to include effective communication systems to enable the mobilisation of the response to a major emergency and to support its effective management and control.

It is vital that communication systems detailed within emergency plans are regularly assessed and tested to ensure that they continue to be effective, robust, flexible and have the capacity to support flow of information required to respond to a major incident.

Corporate Communications - It is essential that the public and our staff have access to accurate, timely information during a Major Emergency. Local Authorities have their own mechanisms for communicating with their communities and we would work closely with them. The media have a very important role to play in public and staff information during a Major Emergency and this is outlined in the Media Management Section (Section 1.9). In addition to the media there are a range of other methods at our disposal which can be drawn on if appropriate.

There is also the Central Scotland SCG Communications sub-group which brings together communication representatives from our local authority partners, police, fire and ambulance. The Group have developed a communications strategy and a Major Incident Communications Template which set out the key communications actions, roles and responsibilities in the event of a major incident within Central Scotland.

Staff Communication - Managers involved in the management of the major emergency will be responsible for ensuring that staff directly involved in the treatment of casualties and any other aspect of the major emergency have an accurate flow of information to ensure that they are fully supported. In addition, if appropriate, the Head of Communications will ensure that the wider staff are kept informed.

Communication with the General Public - The Head of Communications will also ensure that, if required, the public have access to appropriate information and advice. The format, content and range of communication tools used will be tailored to suit the specific circumstances of the incident.

The requirements of ethnic minority groups and those who may be deaf/blind or suffer from other disabling illnesses need to be considered by the Communications Team when providing information to patients/public and this is especially important in emergency situations when risk to health may occur.

NHS Forth Valley staff who experience language difficulties with the public should contact the Equality and Diversity service for translation advice and assistance as they would also play a key role in providing advice and support to patients with a disability or sensory impairment and arrange access to interpreters if required.

NHS Forth Valley Hospitals should also maintain lists/have access to appropriate interpreters to assist with any language difficulties which, may occur with casualties/patients during a major emergency or on a day to day basis.

There are a number of tools available to communicate information internally and externally – these are outlined in the NHS Forth Valley Communications Strategy (2009 – 2014 – updated November 2010).

- Local and national media have a key role to play in communicating information and advice to the general public during and after a major incident – local radio, in particular, can help relay regular updates and direct people to further sources of information and support
- The NHS Forth Valley Website and Intranet – the website can be updated by the Communications Team on a 24/7 basis and is an excellent way of disseminating information immediately. The intranet is also available to keep staff updated.

- In some major emergencies it may be appropriate to set up a Helpline, this would be co-ordinated via the SCG's virtual contact centre. NHS 24 can also provide helpline services to respond to enquiries from patients and the general public.

The Forth Valley Local Authorities have methods to communicate directly with communities if required.

The Communications Team operate on a 24-hour basis during a major incident to provide professional communications support and advice to staff, manage the media response and liaise with communication leads in partner agencies, as required.

1.9 MEDIA MANAGEMENT

As with any other NHS Board areas a major incident in Forth Valley will attract significant media attention. The media attention could be local, national or international depending on the incident and the number of people involved. The modern media provides news to the public on a 24 hour basis and can provide a fast, effective method for communicating with the public in a crisis. It is also therefore critical that the media response is coordinated, accurate and timely. Effective media management during an emergency can also enhance the reputation of the organisation and reassure the public.

General Principals

- Central Scotland Police lead the media response in case of a Major Emergency involving more than one agency.
- All media enquiries and requests relating to the work of NHS Forth Valley should be forwarded to the NHS Forth Valley Communications Team. Staff should never speak to the media or give out information without the prior approval of the Communications lead.

Lead Agency - **Media** In the event of a major emergency, where more than one of the category one responder agencies is involved, the police will lead any response to the media. The NHS Forth Valley's Head of Communications, or Communications Manager, will work closely with the Communications & Marketing Manager at Central Scotland Police or a nominated deputy, to ensure a joined up and consistent approach to communications.

NHS Forth Valley Communications Team - communication with the media will be coordinated by the NHS Forth Valley Communications Team in close liaison with Incident Control Team and the NHS Strategic Support Team (SST), Major Incident Control Committee (MICC) and Strategic Coordinating Group (SCG) if they are activated.

As soon as an emergency or incident is known, the Communications Team should be contacted immediately so that they can liaise with Police and partner colleagues at an early stage.

All media enquiries relating to the NHS Forth Valley response should be directed to the Communications Team. This will ensure that all information released to the media is collated and co-ordinated.

UNCONTROLLED WHEN PRINTED

NHS Forth Valley's Head of Communications has delegated responsibility to lead and co-ordinate the NHS Forth Valley media response to a major emergency and provide overall direction and leadership in relation to external and internal communications.

The scale of the incident will determine the deployment of Communications staff. For example, in the case of an incident where the SST and SCG are not standing then the Head of Communications will be a member of the Incident Control Team.

In an incident where the SST and SCG are standing then the Head of Communications, or deputy, will be in the SST, but will receive regular updates from the Incident Control Team.

The NHS Forth Valley Communications Team operates an on-call system for out of hours (the communications on-call rota is held by helpdesk staff at Forth Valley Royal Hospital).

The Communications Team will ensure that all calls received from the media are logged and that a record of all information released to the media is kept.

Managing the Media - In the event of a major incident, it is likely that members of the media will try to get as close to the scene as possible. It is also likely that they will arrive at NHS premises as casualties are brought in. Co-ordination of the media at the scene will be the role of the police. The Communications Team will ensure that an appropriate area is provided for the media to assemble (see Media Centre section overleaf).

Information Flow - Throughout a major emergency the media need to receive regular, accurate, timely information.

Managers involved in the management of the incident will be responsible for ensuring that regular information updates are given to the Communications Team.

This will enable briefings to be given to the media at regular intervals to reflect any changes or developments.

Media Briefing - If deemed appropriate by the Police Communications Team, an initial briefing to the media should be arranged as soon as is practical. In preparation for this briefing the Hospital Control Team, will need to supply the following information to the Communications Team:

- The time the hospital was informed to expect casualties
- The time the first casualties arrived
- The number of casualties received
- General information regarding the casualties, such as gender, age, nature of injuries and treatment, the number of admissions and discharges
- Information regarding patient transfers
- A brief outline of the hospitals emergency plans, when it was activated and what effect it had on routine hospital work
- Details of numbers of staff on duty, specific specialist teams, cancelled routine work and any other appropriate background information

The Communications Team will prepare a media statement based on the information from the Hospital Medical Controller or Chair of SCG or most senior committee. The statement will then be agreed by the following prior to release:

- Central Scotland Police Designated Lead
- Hospital Medical Controller, Hospital Control Team

Where a major incident has been declared, the statement would also be cleared with Central Scotland Police Communications Lead (normally their Communications & Marketing Manager or nominated Deputy)

A number of key individuals, both clinical and non-clinical, who are able to speak to the media may be identified to deliver the media briefings. If the incident is prolonged a rota may need to be drawn up to avoid any one individual being overburdened.

The Communications Team will announce arrangements for further briefings which will be required on a regular basis and provide appropriate contact details.

Media Statements will also be posted on the NHS Forth Valley website.

Media Access - In appropriate circumstances, the Head of Communications will make suitable arrangements in consultation with medical staff, if necessary for reporters, photographers, film crews etc to have access to patients and NHS Forth Valley staff involved in the response to the emergency.

Staff Communications – Prior to the release of information to the media, the Head of Communications will ensure that appropriate consideration is given to informing staff, patients, casualties and their relatives of this information in advance. This is particularly important where fatal injuries have been sustained. It is likely that any advance briefing will be carried out by appropriate clinical and managerial staff.

Media Centres - In some instances, particularly where a major emergency is prolonged, or there is a need to provide media with dedicated space away from areas being used to treat patients, it will be necessary to provide media centres. The Media Centre would include communications equipment. In addition to such accommodation, consideration should be given to suitable parking for outside broadcast vehicles. The Media Centre/s will be used to gather media and deliver appropriate briefings and interviews with nominated NHS Forth Valley representatives.

In some circumstances it would be appropriate for a Media Centre to be established within the receiving hospital and NHS Forth Valley Hospital Emergency Plans will therefore require identifying suitable accommodation. In other circumstances it might be more appropriate to have the media gathered away from receiving hospitals, and in this case the NHS Board headquarters would be used.

It is the responsibility of the Communications Team to ensure that the Media Centre is up and running, as required. They will also ensure that a member of staff is nominated to direct the media to the Media Centre on arrival.

Hospital staff need to be alert to the possibility of unwarranted media intrusion.

Major Emergencies involving Criminal Acts - Should an act of terrorism or crime be the cause or suspected to be the cause of a major emergency, Central Scotland Police may impose a degree of security around casualties and the hospitals where they have been admitted.

Police may prevent anyone other than essential medical personnel from approaching the casualties or entering the hospital grounds and this may include the media. In such a situation the Police would respond to all media enquiries and the NHS Forth Valley Head of Communications would liaise closely with Police Communications colleagues on planned arrangements and media management.

Sustainability - Where a major emergency is prolonged, there may be an issue of sustainability for a small communications team required to provide 24/7 cover. Rota systems will be in place to ensure that adequate rest periods are possible. In addition, it may be necessary to call on assistance from neighbouring NHS Board Communications Teams as well as enlisting the assistance of administration staff to provide support.

Scottish Government Health Department Press Office - The NHS Forth Valley Communications Team will ensure that the Scottish Government Press Office is informed of the Major Incident and is updated on a regular basis.

1.10 COMMUNITY HEALTH PARTNERSHIPS

Following the declaration of a major emergency or emergency the notification to Community Health Partnerships will be cascaded through the Board Public Health Office to General Managers. The type and location of the incident will be advised although the scale and diversity of healthcare demands may not be available. Due to expediency, notification may come from other sources such as the Chief Operating Officer or Hospital Control Team.

Note: In circumstances where there is a local threat to human welfare the CHP can without reference to NHS Board or Acute Services declare a ‘major emergency’. Examples include incidents that might seriously affect the provision of care in the community such as:-

(i) The closure of a hospital that would prevent new admissions or
(ii) The evacuation of a hospital due to fire, explosion, severe weather or any other serious incident or
(iii) an extreme epidemic which threatens the continued provision of care. If that is necessary it is important the Board Chief Executive is advised to allow action to be taken to provide support to the CHP.

Immediate actions
Following a notification of a major emergency General Managers should assess the capability of the CHP to provide support. As a priority a review should be undertaken of beds for patients decanted from the acute hospitals. Consideration should be given to what additional staff will be required to sustain those beds. Other resources requirements such as nurses, doctors and administration staff should be assessed. The resultant information should be passed back to the Hospital Control Team or to the department requesting it.

CHP Locality Teams
The formation of the Locality Team may be helpful at this stage but will be dependant on the scale of the incident and the demands made on the CHP for support. Where there are requests for beds, staff and other resources it will be necessary to maintain a log of events and in those circumstances a locality team may be best prepared to provide that capability. In long term incidents such as the aftermath of severe weather where excessive demands are made on primary rather than secondary care the formation of a locality team would be encouraged. Generic local arrangements for the formation of the team and the maintenance of an accurate log of decisions made should be employed. General Managers should engage with other CHPs and share resources to meet the demands made.

Pandemic Influenza
The role of CHPs in an influenza pandemic is described in the NHS Forth Valley 'Pandemic Influenza' Framework. In essence the point of greatest demand will be at primary care level where it will be necessary for CHPs to work closely with General Practitioners and Community Pharmacists in the maintenance of healthcare.

Community Hospital Evacuation
(a) The decision to evacuate or partially evacuate a hospital will be made in circumstances where there is a threat to the life of patients from a fire, flood, structural damage or other circumstances such as air pollution or contamination. In those circumstances the decision to evacuate will have to be made quickly. There may be no time for full consultation across the CHP. A template plan has been developed for population by CHPs to meet the particular needs of each Community Hospital.

(b) Major emergency - Where the decision to evacuate has been made consideration should be given to declaring it a major emergency. That should be communicated to the Board Chief Executive to ensure that sufficient support is available to provide alternative short and long term care for decanted patients.

(c) Business continuity - The CHP Locality Team will coordinate the ongoing incident response. It will consider alternative provision of functions provided by the hospital such as minor injuries, x-ray and mental health clinics by implementing its business continuity arrangements.

NHS role in Rest Centres
The arrangements below apply equally to Survivor Reception Centre:-
A Rest Centre is a displaced community decanted to another location. Responsibility for finding appropriate premises and equipping it with staff lies with the Local Authority which has well developed plans. The arrangement would normally be initiated following an extreme weather incident, a major fire or air pollution. Every attempt will be made by the Local Authority to place the reception centre close to the affected community to minimise the disruption to local facilities including GP surgeries and healthcare provision. Individuals who are moved to a reception centre are registered on admission.

Reception centres will be administered by the Local Authority i.e. - Falkirk, Clackmannanshire or Stirling Council as part of its emergency response. When the CHP is notified it will identify staff, most likely a District Charge Nurse and Health Visitor, to work with the relevant local authority to identify immediate and longer term healthcare needs. The focus of this approach will be to work jointly with the appropriate local authority and other agencies to ensure the provision of essential Primary Health Care Services to those affected. This may involve setting up a temporary GP Surgery within the area. This complies with Scottish Government Preparing Scotland Guidance – Care for People affected by Emergencies (April 2009)

Anticipated Health Needs in a Reception Centre

- Long term illness – diabetes, coronary heart disease, bronchial conditions, long term mental health problems, asthma and pre-natal care
- Illness due to incident – stress, anxiety, hypothermia
- Incident injury – undetected but presenting at a later date
- Medication needs including lost or misplaced prescribed drugs
- Ongoing health needs

All of these issues will need to be addressed in the same way as if the casualty was in their own home through the usual range of primary and secondary care teams.

1.11 HEALTHCARE (BUSINESS) CONTINUITY

The Civil Contingencies Policy describes the strategic framework for co-ordinating the overall recovery effort with a number of other specific plans such as this Major Emergency Plan and Major Infrastructure Failure Plan for support services and critical healthcare services.

Planning for continuity will enable the continued delivery and recovery of critical services in the event of a minor/major disruption. Each Directorate is expected to have service specific 'Healthcare Continuity Plans' (HCPs) in place based on the generic template. The service specific HCPs are expected to contain information on how staff can access appropriate help and support during disruptive incidents and should cover the following information:

- The actions to be taken by the first individual to detect a possible disruptive incident or an incident that has already occurred, that is likely to disrupt the Directorates time critical services;
- The roles and responsibilities of the Management Team
- The list of tasks to be carried out
- The necessary reference information to support the actions detailed in the task lists.

Three levels of incident will provide the benchmark on which to judge the level of response/invocation required to manage an incident. Dependant on the level of the incident, NHS Forth Valley is expected to return critical services back to a pre-determined level of normality. The levels of disruption that invoke a Healthcare Continuity response are summarised below:

- **Level 1 – Local Disruption -** Defined as a local incident, which is not an emergency, and does not cause serious physical threat to people or property. Results are likely to be limited disruption to services and would pose no threat to the reputation of NHS Forth Valley.
- **Level 2 – Minor Disruption -** Defined as an incident that could pose an actual threat to people and property. However, is not expected to seriously affect the overall functioning of NHS Forth Valley critical services. They may have legal ramifications or threaten the reputation of NHS Forth Valley, and might include the isolation or evacuation of part of a building or buildings, with the assistance of the Emergency Services.
- **Level 3 – Major Disruption -** Defined as an incident causing significant disruption to NHS Forth Valley operations. It may affect an entire building or a number of buildings, staff, patients or visitors, with the escalation potential to require the intervention of the Emergency Services, who are likely to take operational control of the incident. This is likely to invoke the procedures described in the MEP.

Healthcare Continuity is seen as being an essential part of the MEP procedures and key element of making sure individual services are ready to participate in any response and recovery involving a major incident.

SECTION 2 - NOTIFICATION AND STAND DOWN

2.1 INTRODUCTION

Initial information about the occurrence that may constitute a major emergency can originate from many sources i.e. Emergency Services - Scottish Ambulance Service, Central Scotland Police. However, it is most likely that such information will be received from the Scottish Ambulance Service usually detailing their level of alert.

It is important therefore that all staff should know that if they become aware of such a situation, they must report it at once as documented in the relevant operational section of the Major Emergency Plan.

2.2 IMPLEMENTATION

A telephone message form will be completed which the operator will pass to the person identified in the Major Emergency Plan. That person will then, as detailed in the plan, authenticate the call and establish as much information as possible in order that a decision can be made on whether to implement stand-by procedures.

Information must immediately be passed to the Emergency Department Consultant/Nurse in Charge of Emergency Department (ED) who will then decide whether a Declared **Red Alert** or Standby **Yellow Alert** is to be implemented. **Only** the Hospital Medical Co-ordinator can Stand-down the NHS response to an incident once the cascade system has been implemented.

2.3 DESIGNATED CONTROL HOSPITAL

When standby or declared alert is implemented, the major emergency plan will be activated and Forth Valley Royal Hospital (FVRH) will be the designated control hospital.

The On-Call CPHM will inform the On-Call Executive Director that the Major Emergency Plan has been activated. (Refer to the Role of the CPHM Section 3 Paragraph 3.6.)

The nature and severity of the incident will dictate whether a Medical Incident Officer (MIO) and Mobile Medical Team (MMT) should attend at the scene of the incident. This will be done at the request of the Ambulance Incident Officer at the scene.

Support will be provided under mutual aid arrangements from neighbouring Boards and will be arranged through the Strategic Support Team.

2.4 MEDICAL INCIDENT OFFICER/MOBILE MEDICAL TEAM

NHS Forth Valley Designated Receiving Hospital, FVRH, must ensure that standing arrangements are in hand for the provision of a Medical Incident Officer (MIO) and Mobile Medical Team (MMT) at the scene of a major incident. Such arrangements will form part of the relevant Hospital Plan sections.

The Emergency Department Consultant / Hospital Medical Co-ordinator will decide from the staff available, including BASICs volunteers, the membership of the Mobile Medical Team.

The Scottish Ambulance Service will arrange the transportation of appropriate medical staff and their equipment to the scene of a Major Incident.

2.5 ASSISTANCE FROM ANOTHER NHS BOARD

Where an incident may subsequently prove to be beyond the resources of NHS Forth Valley due to its scale and complexity, or because of particular types of injuries sustained, for example, serious burns, assistance can be requested from other NHS Boards. Lines of communication have been pre-arranged to ensure there are no delays.

2.6 REPORTS TO SCOTTISH GOVERNMENT HEALTH DEPARTMENT (SGHD)

In a Major Emergency the Scottish Government Resilience Room (SGoRR) may be activated to provide a focal point for the co-ordination and control of Central Government support to the response to a civil emergency in Scotland. The Chief Executive/On-Call Executive Director should make contact as soon as possible with Scottish Government - NHS Management Executive - 0131 556 8400 (24hrs). The Strategic Support Team will provide the liaison with Scottish Government Health Department (SGHD) during an incident and the Strategic Support Team Controller will allocate this task to an appropriate member of the team.

Subsequent to any major emergency there should be a full debriefing of all staff involved coupled with a review of the health service response. The Chief Executive will ensure that a comprehensive report covering these aspects with details of particular successes or difficulties experienced to the Management Executive of the Health Service in Scotland. Any amendments to the Major Emergency Plan consequential to the incident must also be notified.

2.7 EXERCISING

It is essential that existing plans should be tested by regular exercises. As in the case of a real incident a subsequent report should be submitted to the Scottish Government Health Department

2.8 STAND DOWN PROCEDURES

Stand down at the **incident site** may be declared by:

- Central Scotland Police
- Scottish Ambulance Service
- Central Scotland Fire & Rescue Service
- Medical Incident Officer
- Ambulance Incident Officer
- Stand down at the incident site for **MEDICAL** can only come from a medical source i.e. Ambulance Incident Officer or Medical Incident Officer. They will inform the hospital control team of this.

The Control Hospital Medical Co-ordinator, in liaison with the Hospital Control Team, will take the decision to Stand Down the Hospital. Each member of the Control Team will ensure that the services they are responsible for are notified directly.

The appropriate Unit General Managers, in liaison with the Management Team will monitor the acute stage immediately following Stand Down to ensure that adequate resources are available to meet the increase in demand on the service.

A member of the Hospital Control Team will confirm to Central Scotland Police Control Room, Scottish Ambulance Service Control Room and other agencies involved that the Infirmary has stood down for the immediate reception of casualties from the incident.

The length of this stage will depend on the number of casualties and on the extent of the treatment required. Routine surgery may have to be postponed and other departments, e.g. Physiotherapy may have routine activity disrupted. Managers will be required to ensure that adequate staffing resources are provided, including resources to cope with media enquiries, bereaved relatives, etc.

During this stage, all staff involved in the incident will be advised that Occupational Health Support is available to assist in cases of undue stress or fatigue and Managers will ensure that staff receive regular off duty periods.

Following the ending of the acute stage, NHS Forth Valley will require to assess the impact of the incident in areas such as waiting times, waiting lists and patient activity. It is important that exceptional expenditure is accurately identified, including long-term implications. As soon as possible after the incident, Directors should provide the NHS Forth Valley Director of Finance with details of additional expenditure on staffing, supplies and equipment due to the incident and the immediate aftermath (e.g.: specialist nursing of seriously ill patients.)

There is no precise time at which the Strategic Support Team should stand down and any decision will be taken by the Chief Executive in the light of prevailing circumstances. It is foreseeable that the Strategic Support Team may be required to function for some time after the critical stages of the major emergency have passed.

2.9 INCIDENT LOGS

Any major emergency, especially an incident involving numerous fatalities will most certainly result in a subsequent enquiry, most likely to be a Fatal Accident Enquiry or/and a Public Enquiry. To assist in any response required by NHS Forth Valley, a chronological log of all actions and inputs by the Strategic Support Team/Hospital Control Team will be kept.

A Major Incident Report should be produced following the final Debrief and a Report sent to the NHS Management Executive at the Scottish Government detailing particular successes or difficulties experienced and any consequential amendments to NHS Forth Valley Major Emergency Plan. This Report must be agreed by the Chief Operating Officer and the NHS Forth Valley Chief Executive before submission to the Scottish Government.

NHS Forth Valley has developed an electronic major incident "log", this is available on the laptop retained in the Boardroom at Carseview. This Access database provides a message taking capability and enables a running log to be maintained of all transactions managed by the Strategic Support Team. This log will be retained and made available to the Chief Executive at the termination of the emergency period. Should the database fail or not be available, an alternative paper-based logging system has been devised.

2.10 FORMAL INVESTIGATIONS

In the aftermath of any major emergency, especially where large-scale casualties are involved, there will be a requirement for investigations to be carried out to determine the cause and examine the circumstances. Such investigations are likely to be conducted by the Police on behalf of the Procurator Fiscal, or another statutory body may be required to examine the facts and report the outcome.

It is more than probable that any investigation will culminate in a Fatal Accident Enquiry/Public Enquiry where evidence may be required from those involved in the response, or who have responsibility for planning a response, not least those with management and executive authority.

To assist in any subsequent enquiry NHS Forth Valley must be alert to the need for NHS personnel to give evidence and must ensure that all log sheets, records of decisions/events and other relevant material are preserved.

2.11 LONG TERM ISSUES

Following the ending of the acute stage, the Access and Capacity Team will require to assess the impact of the incident in areas such as waiting times, waiting lists, patient activity and provide the NHS Board with appropriate details.

2.12 DEBRIEFING

As soon as possible after any emergency the Strategic Support Team will contact each NHS Forth Valley service that has played a part in the emergency to ensure they have procedures in place to debrief all those involved. This also ensures that any lessons learned can be incorporated as amendments into the emergency plans.

Taking these debriefings into account and after an appropriate time, the Chief Executive will require each NHS Forth Valley service involved in the incident to submit a report concerning their response to the emergency.

The Chief Executive will thereafter conduct a review to ensure the combined NHS Forth Valley response was appropriate and met the needs of the emergency. The Chief Executive will thereafter ensure that a composite report concerning the emergency is submitted to the Scottish Government Health Department (Emergency Planning Unit) for analysis.

NHS Forth Valley within 7 working days of Stand Down (or as soon as practicable) should hold an informal internal debrief which will be undertaken by the Medical Director or designate, with as many senior medical, nursing and operational staff as possible involved in coping with the major incident who should in turn, debrief their own colleagues and staff.

Within two weeks of the internal debrief a formal and more detailed internal debrief will be held which will be chaired by the Director of Public Health and may include representatives of the Police and Ambulance Service if deemed appropriate. Details of this debrief should be included within the Major Incident Report submitted to the Scottish Government. The formal debrief and action plan will be presented to the NHS Forth Valley Civil Contingencies Tactical Group which will enable a review of the NHS Forth Valley Major Emergency Plan.

Details of this debrief will be included in the Major Incident Report Form that will be completed by the Hospital Medical Co-ordinator and Chief Operating Officer for submission via the NHS Board to the Scottish Government.

Following the Hospitals debrief there will be a Health Service debrief organised by the Board to review the response of all health service agencies involved

Within a realistic timeframe there should be an external debrief, arranged by Central Scotland Strategic Coordination Group, attended by personnel from NHS Forth Valley and the other emergency and support services involved in the major incident. *(This will only be held if the Major Incident was multi-agency)*

2.13 SPECIALIST STAFF DEBRIEFING AND COUNSELLING

The Strategic Support Team should be alert to the reality that despite the intensity of the everyday NHS task, major emergencies can still be extremely stressful for all staff involved, especially those at the frontline of our response.

The Strategic Support Team will ensure that all NHS organisations involved provide support for staff through the availability of specialist debriefing and counselling both during and in the aftermath of the incident. This should extend to all levels and sections of the National Health Service response.

Staff involved at the site of a major incident may be exposed to harrowing incidents and each person should be given the opportunity to talk about their experiences with a senior line manager on return to the hospital, before they go off duty.

All staff within the NHS Forth Valley involved in dealing with the incident should also have the opportunity of talking to their line manager or Occupational Health Adviser or any other suitable person before leaving the hospital or as soon as possible thereafter.

Managers should be alert to signs of post-incident stress affecting an employee's behaviour and performance, and be ready to discuss potential problems with the employee. Any employee affected should be given support and/or offered counselling in strict confidence, and this can be arranged via the Occupational Health Service.

Critical incident debriefs to provide counselling and support should be arranged by the Department of Clinical Psychology within 24 hours and thereafter within 72 hours offered to all those who may be directly affected.

The senior staff on duty in each discipline or department will ensure that all staff involved in the incident, are relieved at regular intervals, and that they receive appropriate meals or refreshments during their period of duty.

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2.14 DEPLOYMENT OF ARMED POLICE OFFICERS WITHIN NHS PREMISES

A plan for the deployment of armed Police Officers within NHS premises has been developed by Central Scotland Police. This plan is a restricted document, which is not available to NHS staff. In the event of such a deployment, senior NHS Management will be consulted at all times with the safety and security of members of the public and NHS staff being given the highest priority.

2.15 MAJOR EMERGENCY PLAN REVIEW

This Plan shall be reviewed annually or reviewed/revised in the light of any legislative or organisational changes, through NHS Forth Valley's Emergency Planning Acute Group, & NHS Forth Valley's Civil Contingencies Tactical Group, both of which meets regularly.

2.16 MONITORING

This response plan will be regularly monitored to ensure that its objectives are achieved

2.17 AUDIT

This response plan sets standards for induction, and regular training that must be met by staff at all levels. The successful implementation of this response plan requires commitment from staff at all levels. Each individual who may be involved has an obligation to ensure they are aware of and understand their role in the NHS Forth Valley response. These standards will be audited.

SECTION 3 –NHS FORTH VALLEY STRATEGIC SUPPORT TEAM

3.1 INTRODUCTION

In the early stages of a major emergency within NHS Forth Valley, authority is delegated by the NHS Board to Forth Valley Royal Hospital as the designated Receiving/Control Hospital, to exercise overall control of the response to the emergency on behalf of NHS Forth Valley.

However, the capacity of the Hospital Control Team to exercise an overall strategic co-ordination function with that of controlling in detail the Hospital's operational response may become limited and the establishment of NHS Forth Valley Strategic Support Team will become necessary.

The activation of the Strategic Support Team will provide individual NHS services within Forth Valley with a focal point for arranging whatever additional support and external assistance they might require both immediately and in the long term. It will provide a collation point for information regarding the NHS response to the emergency which will be required by other agencies, and by the Strategic Support Team, relieving the hospital of such tasks, whereby they can concentrate on the operational management of the emergency response.

3.2 NHS FORTH VALLEY STRATEGIC SUPPORT TEAM

LOCATION

The Strategic Support Team for NHS Forth Valley will be located in the Boardroom, within NHS Forth Valley Headquarters, Carseview House, Castle Business Park, Stirling, FK9 4SW.

STRATEGIC SUPPORT TEAM

The Strategic Support Team will be staffed by the following core members, or others as determined by the Executive Director on call. (The Strategic Support Team Procedure is a RESTRICTED document and is only available to the core membership of the Group.)

MEMBERS	
Executive Director on call TEAM CONTROLLER	SEE ROTA (Held by Helpdesk in Forth Valley Royal Hospital)
*Emergency Planning Officer	
CPHM	
*Head of Communications	
Head of Performance Management (Flexible role)	
Head of Corporate Services (Flexible role)	
Office Services Manager (Log)	
All Directors (as required)	

NOTE: * Head of Communications has role in emergency call out in hospital. Emergency Planning Officer has role in emergency at Multi-Agency Centre.

The Strategic Support Team will be assisted by the appropriate levels of support staff commensurate with the scale of the emergency. In the initial stages of the incident two members of the support staff should be considered minimum staffing levels.

3.3 FUNCTION

The purpose of the Strategic Support Team is to provide a focus for strategic control and leadership of the NHS Forth Valley response to an emergency. In this respect the role of the Strategic Support Team will include the following:

- To facilitate all external offers of assistance
- To provide a focal point for procuring whatever type of support may be required
- To maintain a liaison with other NHS Boards, Emergency Services, Local Authorities and other Agencies as required
- To advise on any Public Health issues which arise from the circumstances of the emergency
- to co-ordinate VIP visits in liaison with the Scottish Government

Although the above may be considered primary functions, the Strategic Support Team must remain flexible to respond to the developing nature of the emergency.

The task of operating and maintaining the Strategic Support Team must take priority over any other routine Board work during the life saving phase of the emergency.

To maintain continuous operation efficiency and sustainability especially if indications are that the emergency is likely to be protracted, the Strategic Support Team may require relief staff. There will also be a need to ensure that regular breaks are taken and consideration given to a rota system. If necessary it may be required to request assistance from neighbouring NHS Boards.

3.4 TELECOMMUNICATIONS

In order to facilitate the operation of the Strategic Support Team telephones and fax machines are in place within the Boardroom at Carseview.

There are network points within the Boardroom to provide web and e-mail access.

3.5 EQUIPMENT

Other supplies such as maps, stationery and other appropriate equipment are also stored in the Major Incident Cabinet within the Boardroom to assist in the smooth running of the Strategic Support Team.

3.6 NOTIFICATION AND ACTIVATION

In the event of a major emergency being declared in the NHS Forth Valley area, the Emergency Department Consultant/Nurse in Charge of Emergency Department will alert helpdesk to call out all relevant staff using the cascade system. All necessary contact details are held at Forth Valley Royal Hospital Helpdesk.

A telephone line will be identified within the Boardroom as a dedicated link with the Hospital Control Team who will do likewise.

The Executive Director on call or Chief Executive will inform the Chairman of the circumstances of the emergency and all the other Executive Directors.

3.7 IMMEDIATE ACTION AND ROLE OF THE CONSULTANT IN PUBLIC HEALTH MEDICINE

Once notified of the incident the Consultant in Public Health in Medicine (CPHM) ensures that key people across the organisation are aware of the situation; how it is being handled; and any possible wider implications. The CPHM would discuss the situation with the hospital medical controller and ensure all relevant individuals were informed (i.e. On-call Executive Director, Emergency Planning Officer (EPO) and Communications representative) early on about the incident, decide with these key people the immediate response from NHS Forth Valley and the next steps.

A degree of judgement would be required about when to alert the range of individuals.

Action cards have been produced for the CPHM and on-call Executive Director; these are available in credit card format and included in the Strategic Support Team procedures.

All the emergency plans will ensure the CPHM is high up on the on call list. This process would become an integral part of all our emergency and business continuity plans in the future.

The Strategic Support Team, in consultation with the Hospital Control Team should thereafter determine the strategy and assistance required to meet the demands of the emergency taking into account their role and responsibilities as outlined in paragraph 3 of these procedures. In these terms, consideration may be required in respect of:

- Alerting Primary Care and other NHS Forth Valley resources
- Reviewing priority for NHS Forth Valley resources
- Redeployment of NHS Forth Valley resources
- Postponement of less urgent work
- Action required to meet the needs of the emergency
- Re-allocation of work between providers of services
- Consider the need for a Scientific & Advisory Cell to be initiated

3.8 SCOTTISH GOVERNMENT

In the event of a Major Emergency occurring within the NHS Forth Valley area, the Executive on call or Chief Executive will inform the Scottish Government Health Department. It is normal for the control of the response to the emergency to remain at local level.

The Scottish Government has a key role in managing the response to any emergency affecting Scotland and will provide assistance, advice and guidance to NHS Boards on health matters.

If required, the Scottish Government Resilience Room (SGoRR) will be activated and can provide a focus for the co-ordinating of the:

- Activities of Scottish Government Departments
- Communications between response agencies
- Liaison with other Government Departments
- Information to Scottish Government Ministers
- Information to the Public and Media
- VIP visits

and as necessary, provide a lead at National level for the NHS response to the emergency.

SECTION 4 – NHS FORTH VALLEY ACUTE OPERATIONAL SECTION

This section reflects the four key elements of a major incident, declaration, reception phase, definitive care phase and the recovery phase.

1) DECLARING A MAJOR INCIDENT

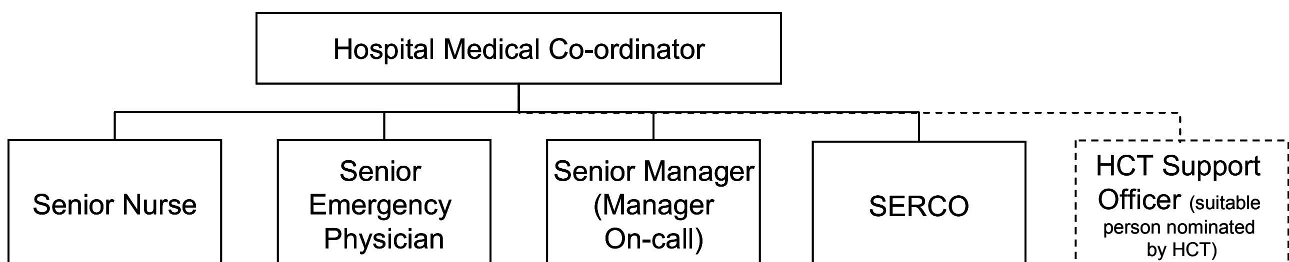
The purpose of the plan is to mobilise additional staff and resources to cope with increased workload. Initial information about an occurrence that may constitute a major emergency can originate from many sources however; it is most likely that such information will be received from either the Scottish Ambulance Service or from Central Scotland Police. This information is normally received via the Emergency Department. In addition, a Major Incident can be declared by the Emergency Department Consultant or Senior Nurse or Senior Emergency Department Nurse.

When an alert is raised, the major emergency plan will be activated and Forth Valley Royal Hospital (FVRH) will become the designated control hospital.

The key roles within the major incident are:

- Clinical roles, which include the appropriate staffing of the clinical response and the overall clinical management of the incident.
- Nursing roles, which include the management of the nursing response, including the provision of nurses as appropriate and the preparation of key areas and equipment.
- Management roles, which includes the management of support services such as Laboratories, Radiology, Pharmacy, Facilities Management, Portering, Catering, Security and traffic control.

In order to ensure a co-ordinated and appropriate response, a Hospital Control Team (HCT) will be formed, with these key roles being represented. Each role has unique responsibilities but will not act in isolation. Controlled by the Hospital Medical Co-ordinator, the role hierarchy looks like this:



Each member of the control team will report to the Control Room (Seminar room 6, adjacent to Radiology) located on ground floor off the main corridor from Staff entrance towards Radiology & Renal departments (see Appendix 7), where the first person to arrive (irrespective of role within the HCT), should ensure the room is set up.

Keys and access information for the Hospital Control Room is available from the SERCO Security desk.

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The On Call Geriatrician or the On Call Consultant Physician will fill the role of the Hospital Medical Co-ordinator, if the Associate Medical Director for Emergency Planning is not present. The criterion being that the most senior and appropriate person available at that time should fill the role.

In line with this, the most senior and suitable people available at the time should fill the supporting roles within the Hospital Control Team hierarchy. Where appropriate, as more staff arrive, these roles can be handed over, to more appropriate staff.

In addition, a HCT Support Officer will be appointed in the Control Room to provide guidance and support in all aspects of the incident. Collectively, this structure makes up the Hospital Control Team and the roles identified will oversee all groups of staff and services they are responsible for.

Similar hierarchies are in place within each of the three identified key roles (Appendix 11)

Although overall guidance is provided within this plan, individual remits are laid out within the Action Cards. The action cards are ‘role specific’ and should be used by either the designated person or the most senior person available and appropriate for that role. As has been mentioned, when a more senior person arrives, they would take over the role ‘where suitable’.

Each action card identifies whom the role is responsible to and what tasks the role is responsible for.

1A) STANDBY – (YELLOW ALERT)

At this point there are only a limited number of people contacted. These include the Senior Emergency Physician, Senior Emergency Nurse, General Manager / Service Manager Emergency Services (if available), Hospital Medical Co-ordinator, Surgical Registrar, Manager on Call, Senior Nurse, Medical Incident Officer, Hospital Control Team Support Officer and Helpdesk. The helpdesk has a formal Telephonist Log (Appendix 8) prepared for Standby (Yellow Alert) and this list of identified staff must be gone through and staff or their deputies contacted to respond. Helpdesk will brief the Hospital Medical Co-ordinator on the status of the response when requested or where there are problems with identified key personnel responding.

All staff contacted (other than the Control team) will report to the Staff Reporting Point (Staff Facilities (OJ00030), ground floor off corridor between Staff Entrance & X-Ray) for logging-in and deployment. This room will be co-ordinated by the most senior manager (not part of the HCT) available on site. Failing that, this role will fall on the Patient Flow Co-ordinators who will (at least initially) co-ordinate and set up the room. The first responders need to confirm to the HCT that the Staff Reporting Point has been set up or is in the process of being set up. Each person will access their Standby (Yellow Alert) Action Cards and follow the instructions as listed. The Hospital Medical Co-ordinator will lead the team and agree the actions required.

The most senior staff on the team will assess the state of preparedness of the hospital, particularly with regard to actions that would be necessary if the incident plan were to be fully activated and a major incident declared (Red Alert). The Senior Emergency Physician will inform all members of Emergency Department staff currently on duty and make an assessment of the current department workload and capacity.

1B) MAJOR INCIDENT CANCELLED – STAND-DOWN PROCESS

Stand down at the incident site may be declared by:

- Central Scotland Police
- Scottish Ambulance Service
- Central Scotland Fire & Rescue
- Medical Incident Officer
- Ambulance Incident Officer

On receipt of a formal message, the Hospital Medical Co-ordinator, in liaison with the Hospital Control Team, will take the decision to 'Stand Down' the Hospital. It is only the Hospital Medical Co-ordinator who has the authority to stand-down the hospital response. Once stood-down, each member of the Hospital Control Team will ensure that the services they are responsible for are notified directly.

Note: The Ambulance Service (in discussion with the MIO, where applicable) determines the medical response stand down at the site.

1C) DECLARED – (RED ALERT)

Where the information received confirms that a major incident has occurred, the full plan will be activated. This will escalate the status to Declared (Red Alert), which signifies that key personnel and departments at Forth Valley Royal Hospital (as a designated receiving hospital) will be fully mobilised in order to receive casualties from a major emergency.

All required staff will be contacted and asked to report to Staff Reporting Point for briefing. Each person will access the appropriate Declared (Red Alert) Action Cards and will follow the instructions as listed. The Hospital Medical Co-ordinator will lead the team and agree the actions required.

In the initial stages, those staff already present should help prepare the initial clinical areas to cope with the first influx of patients.

Helpdesk Call out system

The helpdesk will play a key part in the plan activation. A formal Telephonist Log has been prepared for 'Declared (Red Alert)', listing key personnel (Appendix 9), and this list must be gone through with identified staff or their deputies contacted to respond. Helpdesk will brief the Hospital Medical Co-ordinator or deputy on the status of the response when requested and/or where there are problems with identified key personnel responding.

It is expected that a pre-prepared communication system will be used by the key personnel who may need to contact other members of their 'team' as part of their response. This will be their responsibility and not the helpdesk's.

Helpdesk will hold the On-Call lists for the hospital, which will be used to ensure that the appropriate staff are called. During the callout process, the helpdesk operator will not answer incoming calls therefore the internal communication system used by management teams needs to be robust, particularly when they require to call in additional staff for their area/service.

Use of media

Under certain circumstances, it could be possible that the media (TV or Radio) would be used to alert staff or volunteers. The decision to use this media would be made by the Hospital Medical Co-ordinator and the Communication team.

Staff reporting (location)

All staff not designated as part of the Control Team, should report to Staff Reporting Point where roles will be allocated and action cards (where appropriate) distributed. A log will be kept of those who have responded and the areas they will work.

Action Cards

Action cards have been written for all key roles (Appendix 2). These will be distributed in the Staff Reporting Point and used by staff as an aide memoir or checklist of things that need to be done. The use of these cards should also help reduce the likelihood of something inadvertently being missed during the pressure of a major incident.

If the Major Incident procedure (DECLARED (Red Alert)) has been activated and staff have not read the plan, they should not read it now, but should find their action card and follow the instructions!

Staff Identification

It will be vital that key staff are easily identifiable during a major incident to ensure command, control and communication. At all times it is important that all staff involved continue to carry their normal hospital identification badges.

Security lines will be set up at key locations and only those with appropriate identification will be allowed to access unless the individual is personally recognised.

Mobile Medical Team (MMT)

The Hospital Medical Co-ordinator and the Medical Incident Officer (MIO), in consultation with the Senior Emergency Physician, will determine where the Mobile Medical Team should originate from.

If local MMT is required, it will be drawn from a pre-arranged complement of Doctors and Nurses with relevant expertise and equipment. Each Team will comprise of those nominated and will operate under the supervision of the Medical Incident Officer in their allocated roles.

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2) RECEPTION PHASE

Preparing the Hospital and setting up the Emergency Department (ED)

This is the period during which patients arrive at the hospital and receive initial triage, assessment and emergency treatment. The Emergency Department layout will be modified to ensure the best layout suitable for the different triage categories of incoming patients. Before this happens however, in order to clear space for the incoming casualties, nursing and medical staff must ensure that all 'non-incident' patients currently in the department are dealt with quickly and appropriately. Minor cases should be advised to see their GP, attend the MIU at SCH or be given a clinic appointment (Hospital Clinic or Out of Hours GP). Major cases should be admitted to a designated ward with minimal documentation.

- The preparation should be prioritised to ensure that triage and immediate life saving treatment is delivered. The department will be divided into areas for patients P1 – Resuscitation, P2 – Trolleys Area (Majors), P3 – Treatment Area (Minors). See floor plans Appendix 7.

Other key areas of the hospital such as Critical Care and Theatres should be alerted and prepared and an assessment of their current status and capacity made, as they may be required to be used early during the incident. Where required, the options of additional resources e.g. ITU beds, should be considered.

The number of available beds within the hospital should be assessed, taking into account the number of staffed beds and the number that could be opened if additional staff became available. Medical and Nursing staff should appraise the current workload and determine if there are any patients suitable for immediate discharge or transfer to less intensive clinical care areas. This information must be fed back through the hierarchy to the Hospital Control Team.

Clinical Care

The Senior Emergency Physician will co-ordinate clinical care during the incident's reception phase. Casualties will be triaged as they arrive in the Emergency Department, further assessed and provided with emergency treatment (as appropriate). Some patients will be admitted for further definitive care although many will be discharged directly from the Emergency Department (via discharge area).

Triage

A senior Doctor or senior Nurse with relevant triage experience will be designated as Triage Officer and charged with the medical supervision of casualty reception and assessment. They will retain close links with the Senior Emergency Physician and the Hospital Medical Co-ordinator.

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Reception Phase

All casualties will be met at the door of the Emergency Department. It should be noted that on occasion casualties might well have left the site of the emergency prior to the establishment of fully organised site medical facilities. It is therefore important that every casualty is assessed on arrival at the hospital and given an individual triage priority category, even if they had been previously triaged at the scene. This assessment will also effectively update any priority classification given as a result of triage at the site or while on route to the hospital.

These triage categories will reflect the urgency for intervention, be it resuscitation, surgery or transfer

Treatment

All triaged casualties will be taken to the appropriate part of the reception area where they will be reassessed and treated. Patients will be sent to the appropriate clinical area as severity and number dictate. Good communication is required between treatment teams and the Senior Physician and Senior Surgeon as problems and solutions are found. Documentation is vital therefore adequate and accurate medical notes must be made.

Discharge

There is a risk of casualties feeling isolated following an incident, which may result in psychological morbidity. This can occur particularly in cases where casualties live in a different area from where the incident takes place e.g. traffic or rail incident.

To minimise this, patients will be discharged via the Discharge Area. This will allow information to be given to patients and allow a quieter, step down area to gather their thoughts before leaving.

Each patient will be supplied with a contact card providing a contact number and advice should they have any further problems (Appendix 12).

Transfer

Casualties who are not discharged will be transferred within the hospital or to other hospitals as required.

Casualty Documentation

A senior Doctor or Senior Nurse at the triage point will assess all casualties. Each casualty will be assigned a priority group, which will be shown on a triage label. It is essential that all patients are logged, given an identifying number and issued with a set of pre-prepared notes. They must also be given a wristband with the corresponding number attached to the patient.

Triage clerks should take every opportunity to obtain and record details within the casualties' notes. These should be fed back into the main administration system as soon as time allows. It is imperative that regular checks are made by administration staff, to ensure that the numbers issued and the details provided match with any missing details or errors acted upon.

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Police Casualty Documentation

It is likely that a Police documentation team will be in the hospital at some point gathering information to assist in identification and answering of enquiries. It is important to work in close liaison with them during this time.

Casualty Property

Property bags will be supplied with each pre-prepared casualty notes. The bags need to be numbered with the corresponding patient number and all the casualties property should be placed within them. Property can be invaluable in identification of unknown casualties; therefore it is essential that nothing is lost or misplaced.

Major Incident Information Centre

The hospital will hold a central register of patient details and locations. This hospital Information Centre will be established at the Main Reception Desk in the Foyer (FVRH), which will be operated by members of the Medical Records Staff and provide an initial point of contact for members of the public, especially relatives and friends, who have arrived at the hospital seeking information on possible casualties.

Any queries from next of kin in relation to casualties should be logged and if in doubt obtain relevant details and contact back.

Information recorded on the Major Incident documentation forms for all living patients treated in the Emergency Department and for those patients who have subsequently died after initial treatment are to be passed on immediately to the Police Liaison Officer who will inform next of kin with Bereavement Team.

Direct all enquiries about casualties known to have died to the Police Liaison Officer.

Clinical Support Services

The Hospital Medical Co-ordinator will be responsible for the co-ordination of clinical support services.

Diagnostic Services

Radiology

The duty Consultant Radiologist will be responsible for the overall provision of radiological services and co-ordinating between the needs of the major incident and the ongoing in-patient needs. It will be imperative to ensure that both staffing and equipment are sufficient for the task not just for the immediate incident but also for the coming days ahead.

Laboratories

Blood
The pre-arranged plan for blood stocks will be implemented with all blood stocks (other than those listed for imminent use); being returned to stock, sampled, ABO checked and labelled appropriately. Requests for blood will be prioritised and supplied accordingly.

The National Blood Service will be contacted and informed of any blood requirements and a decision to have this delivered or to send ‘Transport’ to collect will be made at the time. Any issues with blood donations will be discussed with the National Blood Service at the time.

Other Diagnostic Services
The laboratories will be set up to deal with most requests for processing and reporting tests originating from the incident. However where a particular test is required out-with the normal range, discussions will be had with the Hospital Control Team as how this is managed.

Pathology Services
If there is a need for additional mortuary space, the Physiotherapy Gym 3 will be used and a pre-agreed action plan implemented. The consultant Pathologist will liaise closely with the Procurator Fiscal’s office and the Forensic Pathologists.

In the event of mass fatalities, it may be necessary to create a temporary mortuary and implement the pre-arranged plan via Central Scotland’s Strategic Co-ordinating Group (SCG).

Pharmacy

The Senior Pharmacist will co-ordinate the additional needs for drugs, fluids and medicines as per agreed plan. This will also take into consideration the needs for the dispensing of prescriptions for patients being discharged and the restocking of Wards, Theatres, and ITU etc.

Non-Clinical Support Services

Portering

Portering staff are key to all movements of patient’s supplies and equipment. The Portering and Logistic Manager will ensure that porters are used from the outset to set up reception areas and transport any patients needed to be relocated as a result of a major incident. They may also assist Security staff to control people and traffic around the hospital. As the incident progresses, porters will be relied upon to help transport patients and samples around the hospital and to re-supply wards and departments. In some cases other identified FV staff volunteers may be used for specific portering tasks.

Supplies (Procurement)

A senior member of staff from procurement will be tasked to oversee the re-supply of essential supplies throughout the hospital during the incident and also arrange a plan to re-stock post incident.

Sterile Supplies

When patients require operative interventions, additional sterile supplies will be required. ASDU will activate their agreed plan.

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Security

Security will be managed by the Security Team and supported by Portering as required. They will liaise closely with the local police and report directly via the Security Manager and / or the Portering and Logistic Manager. Any other appropriate staff may be used in a 'security' capacity when required.

Traffic Control

The police will manage the approach roads to the hospital however security staff will be used to direct emergency vehicles once on site. Signage will be erected identifying traffic routes and parking restrictions or locations. Visitor parking will be restricted, so far as practical, to prevent traffic congestion and ease traffic flow.

Catering

The Catering Manager shall liaise with the Soft Services Manager regarding the supply of sustenance during breaks for all staff. This will be supplied within the Main Restaurant. In addition refreshments will be allocated for the relatives and the media within their designated areas

Linen Services

Portering and Logistic Manager will liaise with the Soft Services Manager to ensure that sufficient supplies of linen are available and that soiled linen and clothing is removed.

Transport

Transport will be organised by the Senior Manager. This will include collection and delivery of supplies (including blood) and the movement of patients (if required).

Media Management

During a major incident, the media are likely to be attracted to the Emergency Department. In order to manage this, we will exclude media from Emergency Department and set up facilities for the media within Level 3 of the Learning Centre. This will become an area to hold press conferences as well as individual interviews. All media contact will be via the Head of Communications who will work with the Hospital Control Team /and or Strategic Support Team at Carseview to reduce the impact on staff.

Under no circumstances should any member of staff give direct information to the media.

Discharge Area

Casualties awaiting discharge will be accommodated within the Mental Health Waiting Area. Security (provided by security or portering staff) will be in place to ensure that any appropriate designated staff, casualties and their relatives or carers are allowed access. In order to facilitate adequate follow up of discharged patients and provision of community care, a community Liaison Nurse will also be based there.

Bereavement Area

A bereavement area will be designated within the Oncology Department. Where relatives or friends arrive enquiring after a person who has died, a member of staff who has been formally trained to deliver that information will speak them to. Bereaved relatives will be taken to a private room within this area and any delays to be kept to a minimum (where practical). They will also be offered an exit route to avoid the enquiries area. Viewing of dead relatives will be conducted within the mortuary.

Interpreters

It shall be the duty of the General Manager on site to contact interpreters via the helpdesk as required and as per standard hospital list.

Other Services

Spiritual Care Team

The Spiritual Care Team will be available to patients, relatives and staff. The team can provide appropriate emotional, psychological and spiritual support during and after an incident. Specific religious needs are will be met by either directly by a member of the team or through liaison with local faith and belief groups.

Crèche

It will not be possible to open a crèche facility in the event of a Declared (Red Alert). Any member of staff willing to respond, who needs to find facilities for childcare, should contact the hospital and identify that they will respond only when they have found an appropriate place for their children and an estimated time of arriving. These staff will predominantly be used a second wave of hospital cover.

Management of Volunteers (GP's, Other NHS staff, retired staff, WRVS)

A Volunteer Co-ordinator will be in place, within the Volunteer Office (behind main reception) to contain, categorise and utilise this resource. No volunteer will be used unless they have been vetted and deployed by the Co-ordinator. All volunteers will be provided with an official identification badge and no volunteer will be admitted into any clinical area unless they produce an official ID Badge. In general, unknown volunteers would only be used as a last resort and even then in only non-sensitive roles such as non-critical portering tasks.

3) DEFINITIVE CARE PHASE (IN PATIENT PHASE)

This phase is where the casualties with minor injuries have been seen and discharged during the reception phase and only those requiring in-patient care remain. The critically ill will require admission for life saving surgery or intensive care immediately, while those less severe injuries may need to wait and be prioritised for treatment.

The co-ordination of casualty flow is important during this phase is as important as during the reception phase.

Surgical Response

The Senior Surgeon (Consultant General Surgery on call), who not only has to supervise surgical management during the reception period but also has to oversee the surgical aspects of definitive care, will control the overall treatment of surgical casualties.

To do this they must have as full a picture as possible of the surgical requirements of the patients, the availability of staff and the state of the wards and Theatres. Proper delegation and liaison with surgeons in Pre-op and Theatres will achieve this.

Patients requiring immediate surgery will initially be concentrated in the Priority 1 and 2 areas. The number that can be moved directly from this area into a properly staffed and prepared operating suite will depend on the number of staff and theatres available.

The issue of available theatres should therefore be assessed with consideration to reviewing the priority of any current operations to decide, in exceptional cases, whether they can be abandoned. The listed cases need to be reviewed as to the possibility of cancellation. This will be less of an issue at night.

Once Theatre availability and current usage have been assessed, the Senior Surgeon (Consultant General Surgery on call) should be given an accurate picture of the likely physical facilities available for the immediate major incident surgical response.

In the early stages, Senior Staff will form operating teams. As the response develops, the senior anaesthetists and surgeons will advise of any special needs both in theatres in general and for specific needs.

The most critical time for the surgical response is early on – when the need for immediate treatment is highest and staff and theatre provision is lowest. During this time some patients may go directly to Theatre, while others are held in pre-operative ward or Emergency Department until Theatre and operating team availability improves. As well as these high priority patients, other casualties thought to be of lower priority may deteriorate. For this reason, a Senior Surgeon Pre-op will be present to both monitor resuscitation and continually assess surgical priority. This surgeon will liaise directly with the Senior Surgeon (Consultant General Surgery on call).

In the early stages, the pressure of the number of patients on limited resources may mean that surgery is not definitive. The priority is for life saving surgery; therefore in cases not requiring such critical early intervention, surgery should be limited to the minimum that is safe (i.e. damage control surgery). This will ensure that the highest numbers of patients receive a basic level of surgical care. It also ensures that when the reception phase is finished and the facts become clearer, the surgical planning for patients will be better.

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Non Surgical (Medical)

Many major incidents produce cases that do not require a surgical response and it is important to mirror the surgical arrangements with non-surgical ones. Patients not requiring surgery will range form those requiring intensive care to those who have incidental minor illnesses. The Senior Physician (Consultant Physician on call) will control the assessment and treatment of non-surgical casualties. The responsibilities will mirror those of the Senior Surgeon (Consultant General Surgery on call).

Depending on bed availability and an assessment of the overall requirement of the critical care resources, some high priority cases may be transferred to ITU. The preparation of this are is the responsibility of the Senior Nurse in ITU. The availability of beds in ITU and elsewhere must be assessed. This should include both actual and potential beds and directed through the existing ITU clearing system.

It may be impossible to accommodate all the patients requiring intensive care and the transfer of critically ill patients will be necessary. Selection of patients will depend on a number of factors and close liaison between the Senior Physician (Consultant Physician on call), Senior Surgeon (Consultant General Surgery on call), Senior Intensivist and the Charge Nurse ITU will be necessary.

Once a patient is selected for transfer and a bed identified, the Transfer Team will be allocated. This team will liaise with the treatment team and with the unit that is accepting the transfer. The principles of good transfer will be applied.

Some casualties may require admission without needing either surgery or intensive care e.g. patients with smoke inhalation that are symptom free. They will be accommodated in the admissions ward overseen by a senior physician.

A number of patients will present during a major incident response with medical conditions precipitated or exacerbated by the incident. In addition, patients not in involved in the incident may present to the Emergency Department. Once the major incident plan is activated, they must be treated as though they were part of the major incident. They should receive major incident documentation and follow the same casualty flow as if they were from the incident itself.

Clinical and Non Clinical Support

Beyond the medical and surgical services, nearly every other group/service within the hospital will be needed to support patient care. Action Cards have been created for all essential tasks.

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4) RECOVERY PHASE

Resolution

Following all but the smallest major incident, there will be a significant period of disruption to day-to-day workings within the hospital. It is very likely that the elective work of the hospital will be disrupted with admissions having to be postponed. The Business Continuity Plans should be followed to resume normal activity within an agreed timeframe.

An estimate therefore should be made of the duration of the disruption. This may then be used to formulate a timetable to restore the hospital to normal activity. Clinicians and managers will meet to decide on the priorities for cancelled patients and a list of urgent cases will be generated to the senior management team to plan for the care of the patients.

The plan will take account of:

1. Staffing levels
2. The need for further surgical procedures
3. The number of beds occupied by major incident patients
4. The number of ITU beds occupied by major incident patients
5. Equipment re-supply

Once an appraisal has been completed, solutions will be agreed and where required additional funding sought.

Good, effective communication is key to ensuring the public area aware of the situation and information about rearranging early admissions will help reduce complaints from patients.

Reflection

Following a major incident there will be a need to debrief staff and for the post-traumatic counselling of casualties and relatives. This will involve a wide range of agencies.

In addition, both the medical care provided and the operational plan itself needs to be audited.

De-brief staff

Staff debriefing is essential, with operational issues, the plan itself and the physical and emotional need of staff and patients being addressed. The NHS FORTH VALLEY de-brief process should be used and the outcomes assessed by the Acute Services MEP group prior to reporting to the Civil Contingencies Tactical Group (CCTG).

Audit

Every major incident is an opportunity to assess and improve future practice. A thorough de-brief of the events and the hospitals ability to cope will be conducted.

The audit will involve all those involved in the response, not solely on the clinical care of the patients.

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Recovery Phase

The care delivered to the casualties will be audited and the results presented to hospital staff within one month of the incident occurrence. This will serve to highlight any clinical and organisational challenges, areas for improvement and recognise areas of good practice.

Liaison's with other agencies (e.g. Scottish Ambulance Service) is important for the mutual exchange of learning points. The audit will be 'blame free' and as independent as possible. Although traditionally reluctant to do so, the identification and admission of error or failure will help improve practice and an open appraisal will be most beneficial.

The rarity of major incidents means that early dissemination of lessons learned will have great benefit.

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Appendix 1

TRIAGE

Aims

The aim is to deliver the right patient to the right place at the right time so they receive optimum treatment but it is also to 'do the most for the most'. The Triage principles will be adopted whenever the number of casualties exceeds the skilled staff available.

Timing

Triage will be a dynamic process and casualties may be triaged repeatedly at the various stages of their care e.g. incident scene, Emergency Department door or discharge. This means that the current priority of any casualty must be clearly indicated with Triage labelling.

Priorities

The end point of Triage is the allocation of a priority. The system of priorities we will use is the 'T' (treatment) system and the 'P' (priority) system. Please note that some cruciform cards have no numbers.

Category	Description	Colour	Priority System	Treatment System
Immediate	**Casualties who require immediate life saving treatment**	**Red**	**P1**	**T1**
Urgent	**Casualties who require treatment within 6 hours**	**Yellow**	**P2**	**T2**
Delayed	**Less serious cases who require treatment but not within a set time**	**Green**	**P3**	**T3**
Expectant	**Casualties:** **1. Who cannot survive treatment** **2. For whom the degree of intervention required is such that in the circumstances their treatment would serious compromise the provision of treatment for others.**	**Blue**		**T4***
Dead	**Dead**	**White** **Black**	**Dead**	**Dead**

* T4 Not automatically in use because major incident is declared. Decision to use will only be given by Hospital Medical Co-ordinator and Hospital Control Team.

Definitions

All staff involved in triage will use these criteria for categorising patients into defined priority groups. This will ensure appropriate treatment is provided at the right time.

When using the P system, where patients are identified under the 'expectant' category the mobile medical team, in conjunction with the Hospital Control team will make a decision. The 'priority' decision will take into account an overall assessment of the situation, considering the patient load and the resources available. Failure to do so will result in a higher overall morbidity and mortality therefore in some incidents; hard decisions will have to be made.

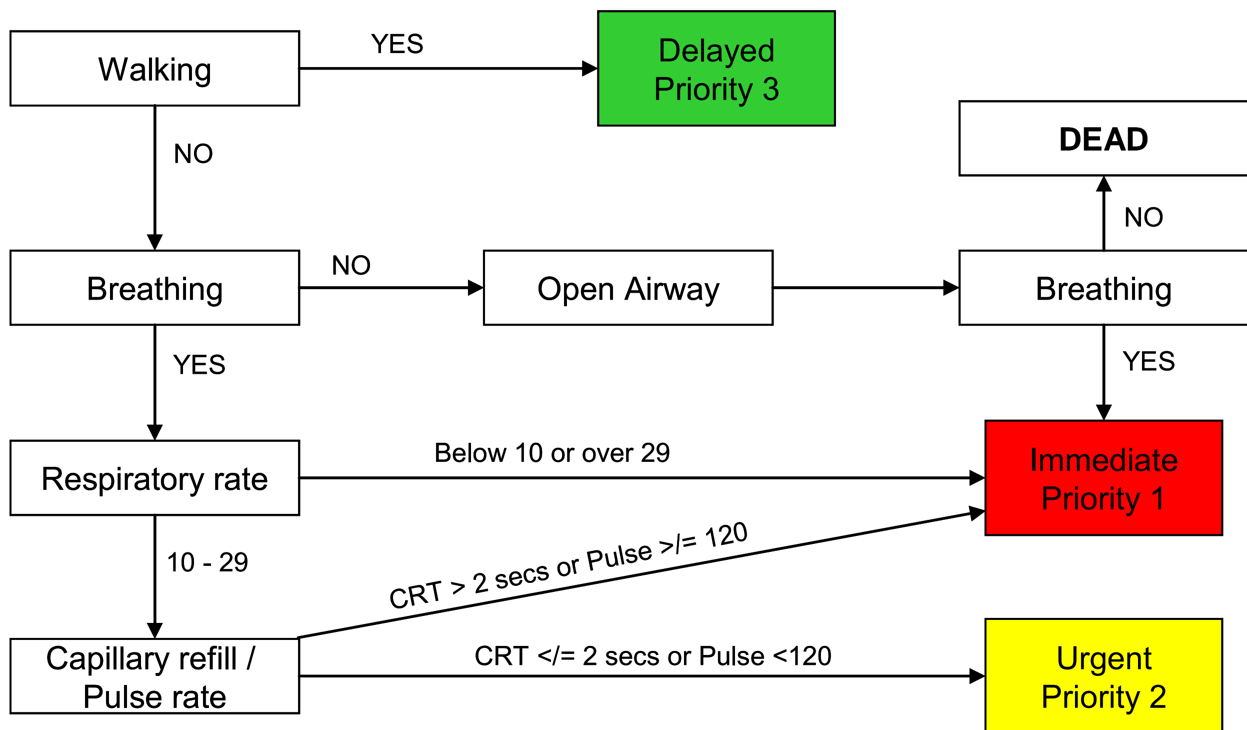
Methods

In a major incident, triage can be performed using Triage Sieve, Triage Sort, Preliminary, Primary or Secondary Survey (or even the Paediatric Triage Tape).

TRIAGE SIEVE

Rapid triage may be needed at the scene of the incident itself, the casualty clearing station or at the Emergency Department. Since the accuracy of any method depends on the amount of information used to make a decision, and gathering information takes time, there will always be a trade off between speed and accuracy.

The aim is to convert a large number of injured casualties into some sort of medical order. The most effective first step will be to separate the Priority 3 patients (delayed) from the rest. Assume that any patients that can walk do not require urgent or immediate treatment and therefore can be categorised as P3 patients. Once this has been done the state of the airway, breathing and circulation of the remainder is considered.



Any patients left after the mobility sieve has been applied must be either priority 1 (Immediate), priority 2 (urgent) or dead. They can be sorted into the appropriate category by looking at simply assessed aspects of airway, breathing and circulation.

Airway patency (not security) is assumed in conscious patients and is assessed in the unconscious by performing a simple opening manoeuvre (chin lift or jaw thrust) and seeing if breathing occurs. This will help identify those who are dead and those who can only breathe when their airway is cleared. Patients who need to have their airways cleared are Priority 1 (immediate). Some patients may need a simple airway adjunct to maintain airway patency and this can be inserted at this stage. For those who can breathe, their respiratory rate should be counted. If the rate is low (9 or less, or 30 or more) then the casualty is priority 1 (immediate). If the rate is 10 – 29 breaths per minute, then an assessment of the circulation is carried out.

This can be difficult even in a hospital, and no single measure gives a reliably accurate picture. However, the capillary refill time fulfils other criteria in that it can be measured simply and quickly in the nail bed. Pressure is applied over the quick of the nail for 5 seconds then released – the time taken for the colour to return is the refill time. If this time is over 2 seconds then the patient is assigned priority 1 (immediate), and if it is 2 seconds or less, the patient is priority 2 (urgent). If it is not possible to measure CRT then a pulse rate of greater than 120 can be used to determine priority 1 status.

The triage sieve should take no more than 20 seconds for each non-ambulant patient, and as such, first look triage can be done very rapidly. Although a broad-brush approach, this will give direction to the health service response, which can then be focussed on care of the priority 1 patients. The sieve can be repeated at any stage of the process and should always be applied when a large number of patients need to be assessed.

TRIAGE SORT (AKA Triage Revised Trauma Score)

As triage decisions become more complex, the triage methods become more refined. The next step up is the triage sort and consists of a formal physiological appraisal of the patient. No anatomical descriptors of injury are sought at this stage since the treatment being considered (i.e. the need for resuscitation) does not depend on such information.

The Triage Sort uses respiratory rate (RR), systolic blood pressure (SBP) and the Glasgow Coma Scale (GCS) to assign a score of between 0 and 12 for each patient.

The coded values are summed to give a score between 0 and 12 and the TRTS can be used to assign a triage priority.

Although the TRTS was developed using death and anatomical injury as outcome measures, it is at present the best objective physiological scoring system available.

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Appendix 1: Triage

Sort Guide

Observation	Measured Value	Score
Respiratory Rate	10-29	4
	>29	3
	6-9	2
	1-5	1
	0	0
Systolic Blood Pressure	>/= 90	4
	76-89	3
	50-75	2
	1-49	1
	0	0
Glasgow Coma Score	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0

Glasgow Coma Score table

Eye response	open spontaneously	4
	open to verbal command	3
	open to pain	2
	no response	1
Verbal Response	talking and orientated	5
	confused/disorientated	4
	inappropriate words	3
	incomprehensible words	2
	no response	1
Motor Response	obeys commands	6
	localises pain	5
	flexion-withdrawal	4
	flexion-abnormal	3
	extension	2
	no response	1

Triage Sort Score	Priority
1-10	P1
11	P2
12	P3
0	DEAD

Using the Triage Revised Trauma Score (TRTS) and Triage priority we can also show predicted outcomes:

Triage Priority	Triage Revised Trauma Score (TRTS)	Probability of Survival %
P1	1 – 10	25 – 87.9
P2	11	96.9
P3	12	99.5
Dead	0	N/A

Preliminary Survey

Sometimes the patient's priority for treatment or intervention will depend on a description of the injury or illness or on some other additional information. A full secondary survey to establish all injuries is time consuming therefore history should be limited to a preliminary survey designed to elicit the relevant information.

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The nature of the survey will vary dependant on the exact information that needs to be obtained e.g. in the case of fire there could be a risk of smoke inhalation. This could lead to casualties taking time to develop physiological signs but who would benefit from early transportation to hospital. A history of exposure together with the presence or absence of respiratory sounds could be used to categorise such patients as priority 2 (urgent). The preliminary survey would consist of a simple question and the auscultation of the chest.

The specific questions and examinations that form the preliminary survey must be used in conjunction with the physiological information obtained during triage sieve or sort to give a triage priority.

Primary and Secondary Surveys

Once the patient has reached the hospital and initial resuscitation has been carried out. A full description of the injuries must be obtained to plan the patient's treatment and priority. A standard advanced life support approach should be taken consisting of a primary survey of a full assessment of A, B, C, D and E priorities together with the appropriate resuscitative measures. Generally only casualties categorised as Priority 1 (immediate) by the triage sieve and sort methods will have any primary survey resuscitation requirements. Casualties who cannot be resuscitated through the primary survey will be categorised as Priority 1 (immediate) for further treatment (surgery or intensive care).

Those patients who require no intervention during the primary survey or who are stable after initial resuscitation should undergo a thorough secondary survey. This will be a complete head to toe, front and back all system evaluation of the patient. At the end of the survey, the treatment team will have a comprehensive list of the problems of each ill or injured patient. The overall triage category will reflect the urgency of the worst injury discovered. Each treatment team completing second surveys will report their findings to the Senior Surgeon or Physician to ensure an overall management plan can be formulated.

Summary of Triage methods

Location	Treatment Considered	Grade Performing Triage	Triage Method
Site of incident	Life Saving First Aid	Paramedic (Primary Triage Officer)	Triage Sieve
Casualty Clearing Station	Life Support	Paramedic / Doctor (Secondary Triage Officer)	Triage Sieve or Sort
Casualty Clearing Station	Advanced Life Support	Doctor (Secondary Triage Officer)	Triage Sort and preliminary survey
Hospital Reception	Advanced Life Support	Senior Emergency Physician / Triage Nurse	Triage Sieve and Sort
Hospital	Life Saving Surgery	Senior Surgeon	Primary and Secondary Surveys

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The quickest and easiest method is the triage sieve, which looks at mobility and ABC and is appropriate to any situation in which large numbers must be sorted rapidly. The triage sort using the Triage Revised Trauma Score is next; this again looks at physiological derangement and is relatively rapid. It is typically used in less frenetic environments and is an ideal monitoring tool for patients held at any stage of their care. The categorisation using these physiological methods can be supplemented by specific information sought during the preliminary survey. This survey is focussed on relevant history and examination and is relatively quick. Finally once more staff and time are available, standard advanced life support methods are used to obtain a full picture of the injury or illness.

This hierarchy of triage methods balances the time needed to reach a decision against the relative accuracy of that decision. Furthermore it allows the person performing triage to use the fast method at any stage, and should therefore encourage reassessment.

a) Order of Intervention

The triage priority of an individual casualty is only one of a number of factors that should be considered when the order of interventions is being decided.

Evacuation from the scene

Although extremely important, as well as the triage priority, a number of factors will determine the order in which casualties may be evacuated from the scene to hospital.

Factors which can determine the order of evacuation:

Resource Factors	Patient Factors
Availability of Ambulances	Need for sitting or stretcher
Availability of Escorting staff	Completeness of package for transport
Destination of individual ambulances	Need for transport to specialist centres

Therefore, although there may be high priority patients at the scene, it may be more appropriate to send minor casualties first, in order that the high priorities are resuscitated enough to survive transportation. Similarly, priority 3 casualties can be transported sitting with a priority 1 casualty because space is available in the vehicle. This will optimise resources.

Order of Surgical Intervention

The Senior Surgeon controls the order in which surgery is performed. They will take an overview of both the demand and the resources available, and consider many other factors:

Resource Factors	Patient Factors
Availability of Theatres	Number of Patients
Availability of skilled staff	Priority of Patients
Availability of Sterile Supplies	Operative time for each procedure
Availability of Specialist Equipment	

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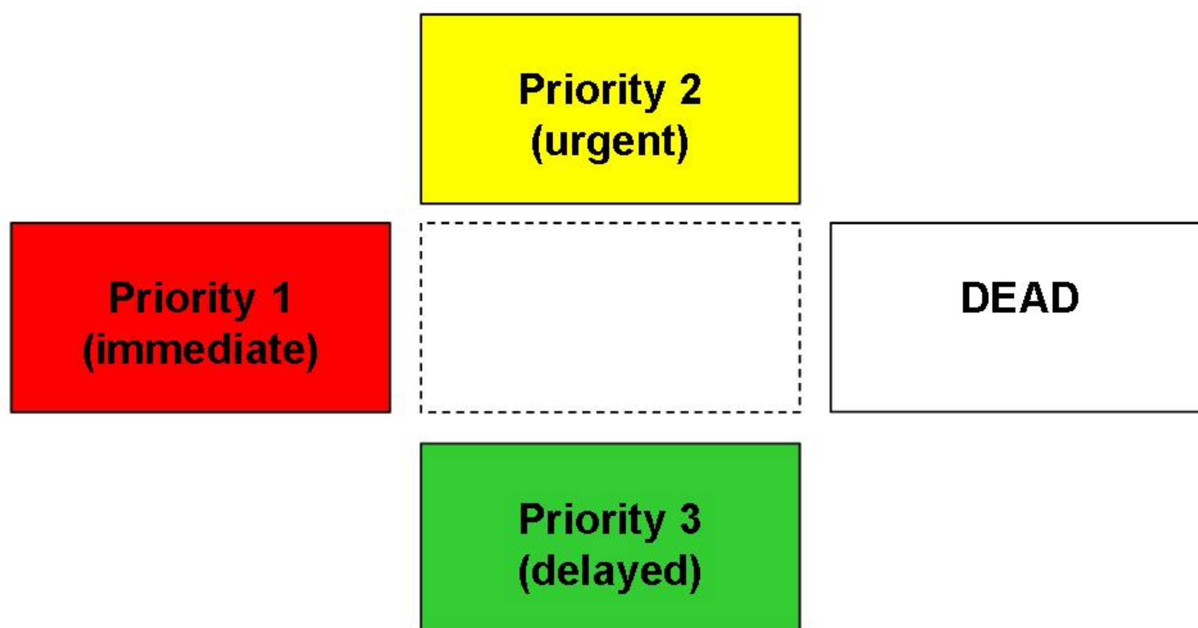
Patients for life saving surgery will always have the highest priority but only if the surgical teams have the capacity in personnel and Theatre space. It may well be that a patient with a lower priority is operated on first due to circumstances of using resources most effectively.

b) Triage Labelling

It is essential that everyone involved in the incident response is aware of the triage status of casualties. In order to achieve this, a triage label in the form of a cruciform card will be used in the pre hospital environment.



These cards are cross-shaped and concertinaed. Folding the corner of the cards into the middle causes the card to become rectangular, the colour markings that remain visible depends on the way the cross is folded, thus the card can be made to show any priority. If the priority changes, the card should simply be adjusted.

Note that some cruciform cards have no numbers and the 'Dead' label may be black with white details.

Disaster Victim Identification (DVI)

DVI (Disaster Victim Identification) teams who are deployed by the Police, to incidents involving mass fatalities or fragmented bodies carry National Body Labels.

Please note that pages 66 – 199 are restricted
and are available from the Civil Contingencies Unit.

ACRONYMS

AAU	Acute Assessment Unit
ABO	Blood Group System
AIO	Ambulance Incident Officer
AMD	Associate Medical Director
ASDU	Area Sterilisation Decontamination Unit
BASICS	British Association for Immediate Care
BMS	Biomedical Scientist
CAU	Clinical Assessment Unit
CCTG	Civil Contingencies Tactical Group
CCU	Coronary Care Unit
CPHM	Consultant Public Health Medicine
CRT	Capillary Refill Time
DDA	Dangerous Drugs Act
DVI	Disaster Victim Identification Team Police team deployed to incidents with mass fatalities or fragmented bodies
ED	Emergency Department
EDIS	Software system used for booking in patients to Emergency Dept
ENP	Emergency Nurse Practitioner
FACT	Forth Valley Acute Care Team
FCCC	Central Scotland Police Fore Communications & Control Centre
FCH	Falkirk Community Hospital (formally FDRI)
FIO	Fire Incident Officer
FV	Forth Valley
GP	General Practitioner
HCT	Hospital Control Team
HDU	High Dependency Unit
HMC	Hospital Medical Co-ordinator
ITU	Intensive Therapy Unit
MECAR	Medicine, Emergency Care and Rehabilitation
MIMMS	Major Incident Medical Management and Support
MIO	Medical Incident Officer
MIU	Minor Injuries Unit
MMT	Mobile Medical Team
MTPAS	Mobile Privileged Access Scheme (telecoms – ACCOLC replacement)
NHS	National Health Service
NHSFV	NHS Forth Valley
OPD	Out Patients Department

P1	Casualties who require immediate life saving treatment
P2	Casualties who require treatment within 6 hours
P3	Less serious casualties who require treatment but not within a set time
PF	Procurator Fiscal
PIO	Police Incident Officer
PM	Post-mortem
SAS	Scottish Ambulance Service
SCG	Strategic Co-ordinating Group
SCRO	Scottish Criminal Records Office
SCH	Stirling Community Hospital (formally Stirling Royal Infirmary)
TRTS	Triage Revised Trauma Score
WRVS	Woman's Royal Voluntary Service

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ਤੁਸੀਂ, 0845 130 1170 ਤੇ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ (interpreting services) ਨੂੰ ਸੰਪਰਕ ਕਰਕੇ ਇਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਜਾਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਆਪਣੀ ਬੋਲੀ ਵਿਚ ਅਨੁਵਾਦ ਲੈ ਸਕਦੇ ਹੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

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