North East and North Cumbria

Corporate	ICBP013 Incident Response Plan

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Prepared By:	Deputy Director of System Resilience Resilience Lead
Consultation Process:	ICB Board EPRR Steering Group
Formally Approved:	December 2024
Approved By:	Executive Committee

EQUALITY IMPACT ASSESSMENT

Date	Issues
June 2022	None identified

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

Version	Release Date	Author	Update comments
1	July 2022	ICS EPRR Operational Delivery Manager	Not Applicable. First Issue
2	November 2022	ICS EPRR Operational Delivery Manager/Director of System Resilience	Reviewed within first 6 months of ICB establishment
3	September 2023	ICS EPRR Operational Delivery Manager	Annual review to reflect national guidance and updates made to contact details (email, telephone)
4	October 2024	Deputy Director of System Resilience	Annual review
4	17th October 2024	Resilience Lead	Formatting and inclusion of key elements/information: mass casualty, evacuation, handover arrangements and longer duration incidents

Approval

Role	Name	Date
Approver	ICB Board	July 2022
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1. Introduction

The NHS needs to be able to plan for, respond to and recover from a wide range of incidents, emergencies or disruptive challenges that could impact on health or patient care. These could range from extreme weather conditions to an outbreak of an infectious disease, or a mass casualty incident.

Each Integrated Care Board (ICB) is a Category Responder 1 under the Civil Contingencies Act 2004 (CCA). Category 1 are organisations at the core of the response to most emergencies (the emergency services, local authorities, NHS bodies). Category 1 responders are subject to the full set of civil protection duties and 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

This plan applies to all staff within the NHS North East and North Cumbria Integrated Care Board as well as external stakeholders.

2. Aim

The aim of this plan is to ensure a timely and appropriate response to an incident. This is in order to protect the health and wellbeing of ICB staff and stakeholders and the population of the North East and North Cumbria. The Incident Response Plan also provides guidance for leading the recovery from an incident. The plan will ensure that the ICB works effectively with the emergency responders and other partner agencies. This plan falls under the scope of the ICB Emergency Preparedness, Resilience and Response (EPRR) Policy.

3. Objectives

In the event of an incident the objectives of the NENC ICB will be to:

- Ensure that the ICB complies with the statutory duties under the Civil Contingencies Act (2004) as a Category 1 responder.
- Follow the Joint Emergency Services Interoperability Principles (JESIP) of working together, saving lives & reducing harm;
- Activate relevant emergency plans and participate in response and recovery as appropriate.
- Coordinate the ICB and health economy response to an incident in the NENC area.
- Ensure appropriate communications with ICB staff and stakeholders on response and recovery from an incident.

- Reduce, control, or mitigate as far as is practicably possible the effects of the incident on the ICB and the communities of the North East & North Cumbria.
- Ensure that ICB staff and stakeholders are aware of the ICB, local and regional command and control structures to be implemented to manage incident response.
- Recover from the incident as soon as possible, identifying organisational learning from the experience and sharing it with partners.
- Put in place mechanisms to ensure additional staff welfare provision when required during response and recovery from an incident.

4. Action Cards

This plan is supported by action cards, which can be found in the appendices at the back of the document, as well as individually in the ICB On Call Folders held on the On-call SharePoint Portal or in hard copy held at ICB base locations or with individual on call staff.

The cards detail the actions to be taken by identified roles in the first few hours of an incident taking place. It is advised that staff make themselves familiar with their respective cards.

Specialist incident action cards, relating to specific incidents such as Adverse Weather can also be found in the respective emergency plan.

5. Incident Definition

The NHS England Emergency Preparedness, Resilience and Response Framework (EPRR) 2022 sets out the definitions of each type of incident. For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

Each will impact upon service delivery and may undermine public confidence and require contingency plans to be implemented.

5.1. Business Continuity Incident

an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level.

Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment or system failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

5.2. Critical Incident

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm.

It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.

A Critical Incident is principally an internal escalation response to increased system pressures or disruption to critical services.

5.3. Major Incident

The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident *as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency.*

In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS, this will include any event defined as an emergency:

Under section 1(1) of the CCA 2004 an 'emergency' is defined as:
"(a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;

(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom; or

(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".

A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multi-agency support to a lead responder e.g. the Police.

The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally.

The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

Examples of incidents which could lead to a Major Incident are, but not limited to:

Type	Key characteristics	Example
Big Bang	Happens unexpectedly.	A serious transport accident, or explosion.
Rising tide	Builds over a period of time and allows some time to prepare.	COVID-19.
Cloud on the horizon	Significant chemical or nuclear release developing elsewhere and needing preparatory action.	Volcanic Ash.
Headline news	Public or media alarm about an impending situation, which may be an overreaction.	M-pox.

Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE)	Actual or threatened dispersal of CBRNE material, with deliberate criminal, malicious or murderous intent.	Salisbury Novichok Nerve Agent Release.
Hazardous materials (HAZMAT)	Accidental incident involving hazardous materials.	Self-presenters at A&E.
Cyber attacks	Attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality.	WannaCry malware attack.
Mass Casualty	Excessive casualties where capacity is already stretched.	Manchester Arena Bombing.

5.4. In-hours Incidents (08:00-20:00)

Incidents which occur within the ICB (internal) should be categorised in line with the definitions above.

The ICB System Coordination Centre (SCC) should be contacted on **0191 217 2662** for internal incident notifications between the hours of **08:00** and **20:00**. Staff must inform the SCC when an internal incident has been declared. Upon being informed of an internal incident the SCC will escalate using the ICB Incident Escalation Process.

As a minimum, The System Resilience Team and Director of System Resilience or Chief Strategy Officer (as Accountable Emergency Officer) must be informed in-hours (Monday-Friday 0830 – 1730hrs) and between 17:30 – 20:00, the two ICB 1st (Tactical) On-Calls.

Should an internal incident require the ICB to declare a **Critica**l or **Major Incident** the NHSE NEY EPRR on-call must also be informed.

5.5. Out of Hour incidents (20:00-08:00)

For internal incidents that take place out of hours **20:00-08:00** NEAS Operational Coordination Centre (OCC) should be contacted on **0300 030 9001.** They will then inform the relevant ICB 1st (Tactical) On-calls that an incident has taken place.

5.6. NHS Incident Levels

An incident is described in terms of the level of response required. This level may change as the incident evolves.

Incident response levels describe at which level coordination takes place. For clarity, these levels must be used by all organisations across the NHS when referring to incidents.

They are specific to the NHS in England and are not interchangeable with other organisations' incident response levels. Guidance to assist with escalation and de-escalation is provided in the Appendices.

All incidents and emergencies resulting in the activation of UK Central Government

response arrangements will be managed as Level 4 incidents.

Incident Level	Description	Coordinating Organisation
1	An incident or event which impacts on a single organisation and which can be managed internally with ICB support	Led by affected organisation with support from the ICB
2	An incident or event which impacts multiple organisations within an ICB footprint or requires mutual aid between providers within a single ICB. Managed by the ICB with regional EPRR support	Led by ICB with support from the NHS NEY regional EPRR team
3	An incident or event affecting multiple organisations across ICB footprints or of such a magnitude/specialism that it requires regional coordination. May require national support	Led by NHS England North East and Yorkshire regional team
4	An incident or event affecting multiple regions or of such a magnitude that it requires national involvement in order to lead the NHS response	Lead by NHS England national team

5.7. Incident Escalation

The criteria below set out the points at which an incident could be escalated to the next level of incident response. In turn, if the measures are no longer required, the incident response level can be de-escalated.

Level 1 – Organisation level response **Coordinating organisation: NHS-funded organisation**
If the following applies the incident may need to be escalated to Level 2: • Capacity and demand reach or threaten to surpass a level that require wider resources that cannot be accessed by the provider. • A Business Continuity Incident that threatens the delivery of patient services (in line with ISO 22301). • Response to a declared Major Incident or Major Incident standby. • A media or public confidence issue that may result in local, regional or national interest. • A significant operational issue that may have implications wider than the organisation e.g. public health outbreak, suspected high consequence infectious disease (HCID), security incident, HAZMAT/CBRN incident.

Level 2 – ICB level response
Coordinating Organisation- NHS ICB

If the following applies the incident may need to be escalated to Level 3:

- Capacity and demand reach, or threaten to surpass, a level that requires wider resources that cannot be accessed by the ICB.
- A Critical Incident that threatens the delivery of critical services or presents a risk of harm to patients and/or staff.
- Response to a declared Major Incident or Major Incident standby.
- A media or public confidence issue that may result in local, regional or national interest.
- A significant operational issue that may have implications wider than the local ICS e.g. public health outbreak, suspected HCID, security incident, HAZMAT/CBRN incident.

Level 3 – Regional level response
Coordinating organisation: NHS England (Region)

If the following applies the incident may need to be escalated to Level 4:

- Capacity and demand reach, or threaten to surpass, a level that requires national coordination or NHS mutual aid e.g. need for ECMO, HCID, burns treatment or other specialist functions.
- A Business Continuity Incident that threatens the delivery of an essential NHS England function or a protracted incident effecting one or more NHS England site
- A Critical Incident with the potential to impact on more than one ICB.
- A declared Major Incident which may have a significant NHS impact and/or the establishment of an NHS England Incident Coordination Centre (ICC).
- A media or public confidence issue that may result in regional, national or international interest.
- A significant operational issue that may have implications wider than the remit of one NHS England region e.g. flooding, security incident, HAZMAT/CBRN incident, Critical National Infrastructure, collapse of a commissioned supplier that provides services to more than one region.
- An incident that may require the request and activation of Military Aid to the Civil Authorities (MACA).

Level 4 – National level response
Coordinating organisation: NHS England National Team (with DHSC where appropriate)

If any of the following apply or are required, DHSC should be informed:

- Capacity and demand reach, or threaten to surpass, a level that requires international coordination e.g. need for ECMO, HCID, burns treatment or other specialist function.
- Invocation of central government emergency response arrangements.
- Issues that may require invocation of ‘Emergency Powers’ to be invoked under the CCA 2004 or measures under sections 252A or 253 of the NHS Act 2006.
- A Business Continuity Incident with the potential to impact on significant aspects of the NHS e.g. NHS Supply Chain, NHS Blood and Transplant.
- A declared Major Incident which may have national and/or international implications e.g. CBRN, MTA.
- A media or public confidence issue that may result in national or international interest.
- A significant operational issue that may have implications wider than the remit of the NHS e.g. Critical National Infrastructure.

- An incident that may require the request and activation of Military Aid to the Civil Authorities (MACA)

6. Incident Response Plan Activation

The ICB might be alerted to an incident via a number of sources or routes including:

- Via internal NENC ICB Colleagues
- NHS Provider organisations (e.g.Trusts, Primary Care)
- North East Ambulance Service (NEAS)
- North West Ambulance Service (NWAS)
- NHS England (NHSE)
- Other Regional ICBs
- Resilience Direct
- Media
- Other Local Resilience Forum (LRF) multi-agency partners (including Local Authority, Police, UK Health Security Agency)

Although the ICB have 24/7 on-call staff, they may not be the initial route through which other agencies incident information is received. Information may be provided via the ICB System Resilience Team, via the System Coordination Centre (SCC) or a third party. Wherever the information is received it must be assessed and a decision made as to whether to activate this incident response plan.

An initial information gathering process should be taken to determine next steps using the Incident Response Aide Memoire (Appendix 1). This form comprises elements of the METHANE reporting template and the JESIP Joint Decision Model (JDM) to help staff respond to a call.

When receiving a call, it is important to distinguish between:

- Incidents that can be dealt with using normal surge or day to day business continuity arrangements.
- Incidents that can be dealt with using the resources and emergency planning arrangements of the ICB and local NHS commissioned services.
- Incidents that require a tactical level co-ordinated multi-agency response from the partner organisations forming the Northeast or Cumbria Local Resilience Forums.
- Incidents that require a strategic level co-ordinated multi-agency response across a Northeast or Cumbria Local resilience Forum area.
- Incidents that need regional co-ordination.

The decision to activate this plan must be made by the appropriate personnel within the ICB authorised to do so. It is essential that all decisions and their rationale are documented in relation to the decision whether to activate the plan and following activation of the plan.

People authorised to activate the ICB Incident Response Plan are:

- ICB Chief Strategy Officer (as EPRR Accountable Emergency Officer)
- ICB Executive Directors (2nd (Strategic) on Call)
- ICB Director On Call (1st (Tactical) on Calls)
- Director of System Resilience

6.1. ICB Incident Notification – 24/7/365

All partners call the single point of contact hosted by NEAS Operational Coordination Centre (OCC) on **0300 030 9001**

Once initial contact is made details should be emailed to:
nencicb-ng.nencicbincident@nhs.net

In-hours Monday-Sunday 7 days/week 08:00-20:00

NEAS OCC contact the ICB System Coordination Centre (SCC) via 0191 2172662
08:00-17:30 SCC will contact ICB System Resilience Team
17:30-20:00 SCC will contact both ICB 1st (Tactical) on-calls

Out of hours Monday-Sunday 7 days/week 20:00-08:00

NEAS OCC contact relevant on-call NENC ICB 1st (Tactical) on-call acting as the health strategic commander via telephone
METHANE template with key info sent to nencicb-ng.nencicbincident@nhs.net

On-call NENC ICB Tactical Commander (1st On-call) to direct any immediate remedial actions and escalate to North East & Yorkshire regional on-call if incident assessed at NHS incident levels 3 or 4

Should the LRF's request ICB representation at Local Resilience Forum (LRF) meetings (MAAT, TCG or SCG) and an ICB representative has yet to be confirmed, NEAS will contact the ICB on-call number directly.

The Regional NEY NHSE Team will assist the ICB in implementing command and control mechanisms and the deployment of appropriate NHS resources should the response extend beyond the operational area of a single ICB. They can be contacted at any time via 0113 539 7037 and emailed via england.ney-oncall@nhs.net
The Regional NEY NHSE Team will assist the ICB in implementing command and control mechanisms and the deployment of appropriate NHS resources should the response extend beyond the operational area of a single ICB. They can be contacted at any time via 0113 539 7037 and emailed via england.ney-oncall@nhs.net

6.2. Levels of ICB Response

Response to an incident should be commensurate to the impact of that incident. It should be flexible and scalable to ensure appropriate resource is made available so that the ICB can support partners and discharge its legal duties to coordinate and communicate appropriately.

The sections below describe some different types and levels of incident response as an incident develops.

When deciding on the appropriate level of response the options below and the resourcing required should be considered by the ICB 1st Tactical on-calls in consultation with the ICB 2nd (Strategic) on Call.

6.2.1. ICB Communications Team

The ICB communications team must be involved in incident response from the outset. The ICB on call communications team are available 24/7 with their contact details included in the on-call details on the surge website. They will work with the Strategic and Tactical Commanders to agree communications both internally and externally. Contact details will be disseminated to relevant personnel and stakeholders to maintain effective channels of communication.

The ICB will maintain arrangements to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident, or business continuity incident. An action card for Communications Team is included at Appendix 9

6.3. On Call Response Only

An incident that would require only on-call staff response would typically be of limited impact to providers of NHS services and may deal with BAU or surge type incidents. Since the ICB routinely has limited on-call staff this type of incident would not require attendance at simultaneous meetings, management of situation reporting or communications or ongoing support from the ICB System Resilience Team. If these requirements are needed, the ICB must scale up its response arrangements accordingly.

6.4. On Call Response with support

An incident that has limited impact to providers of NHS services but has a requirement for coordination at North East or North Cumbria local delivery level would require more than a basic on-call response.

For example, a flood affecting two or three separate locations may require attendance from an ICB representative at local LRF multi-agency Tactical Coordination Group (TCG) meetings. These meetings may take place several times a day and would coordinate tactical delivery of response objectives set out by the multi-agency LRF Strategic Coordination Group (SCG) attended by the ICB 2nd on Call. In such circumstances ICB staff from local delivery teams nominated by directors of delivery may be the most appropriate people to attend local TCGs as they have important local knowledge and experience.

6.5. Full Incident Coordination Centre (ICC) Response

An incident that has a direct impact on NHS services such as the declaration by an NHS partner of a Critical or Major Incident or a multi-agency response to a significant incident with a direct impact on NHS services would usually require the ICB to activate its Incident

Response Plan arrangements and Incident Coordination Centre (ICC). The ICB may also be required to chair a strategic or tactical coordination group meeting of health partners. Details of how that level of response is mobilised are provided in the appendices 6 – 11.

6.6. Critical or Major Incident Declaration Terminology

NENC ICB employs standard messaging, only used across NHS organisations, when communicating information regarding critical or major incidents. These are as follows;

i. Critical/Major Incident – Standby.
ii. Critical/Major Incident – Declared.
iii. Critical/Major Incident – Cancelled.
iv. Critical/Major Incident – Stand Down.

Messaging will be communicated by the ICB Communications Team or relevant LRF Communications Teams on behalf of the Chief Strategy Officer, as Accountable Emergency Officer, the Director of System Resilience or the ICB 2nd On Call.

6.6.1. Critical or Major Incident Standby

When deciding on the type of incident response it is important to use the definitions in section 5 and the terminology below. This alerts the ICB and/or partners that a Critical or Major Incident may need to be declared and will involve the ICB making preparatory arrangements appropriate to the incident. This terminology is common only to all NHS providers, not wider LRF partners.

Critical or Major Incident – Standby

This alerts the ICB that a Critical or Major Incident may need to be declared.

Critical or Major Incident – Standby will involve the ICB making preparatory arrangements appropriate to the incident, whether it be a 'big bang', a 'rising tide' or a pre-planned event.

When the ICB is alerted that a critical or major incident may have occurred, the Incident Response Plan may be initiated in-hours (Mon-Fri 08:30-17:30) by the Director of System Resilience or Chief Strategy Officer as Accountable Emergency Officer, or the 2nd On Call (operating 24/7). This message can be circulated to ICB staff and partners by the Communications Team.

6.6.2. Critical or Major Incident Declared

This confirms that a Critical or Major Incident has been declared. This alerts ICB staff and wider NHS organisations that they need to activate their emergency plans and mobilise additional resources.

Critical or Major Incident – Declared

This confirms that a Critical or Major Incident has been declared.

This alerts wider ICB staff and partner NHS organisations that they need to activate their emergency plans and mobilise additional resources.

When the ICB is alerted that a critical or major incident has been declared, the Incident Response Plan will be initiated by the Chief Strategy Officer or Director of System Resilience, in-hours (Mon-Fri 0830 – 1730hrs), or if unavailable or out of hours, the 2nd On-call (operating 24/7). This message can be circulated to ICB staff and partners by the Communications Team.

6.6.3. Critical or Major Incident Cancelled

This message cancels either of the first two messages at any time.

Critical or Major Incident – Cancelled

This message cancels either of the first two messages at any time.

'Critical or Major Incident – Cancelled' terminates either the 'Critical or Major Incident – Declared' or 'Critical or Major Incident – Standby' messages.

If a critical or major incident declaration or standby message has been cascaded, it can be cancelled on the authorisation of the Chief Strategy Officer or Director of System Resilience, in-hours (Monday-Friday 0830 – 1730hrs), or if unavailable or out of hours, the 2nd On-call (operating 24/7).

6.6.4. Critical or Major Incident Stand Down

This confirms that the Critical or Major Incident has been stood down. It should be noted that Critical or Major Incident status may be changed at differing times for other Category 1 responders. It is the responsibility of the ICB to assess when it is appropriate to declare the ICS stand down. The decision to stand down is the responsibility of the Chief Strategy Officer, the Director of System Resilience or 2nd On Call.

Critical or Major Incident – Stand Down

This confirms that the Critical or Major Incident has been stood down.

Where an incident involves Joint agencies, they will inform the receiving hospital(s) whether any further casualties are en route to a hospital.

It should be noted that Major Incident status may be changed at differing times for other Category 1 responders such as Police or Local Authorities. It is the responsibility of the ICB to assess when it is appropriate to declare ICS stand down.

6.6.5. Critical or Major Incident Declared by another agency

It should be noted that a critical or major incident for another NHS partner or another Category 1 Responder (e.g. a Local Authority) may not necessarily be a critical or major incident for NENC ICB.

It should also be noted that whilst NENC ICB will adhere to the standard incident terminology used by NHS organisations, other agencies and Local Resilience Forum (LRF) members may use different terms. However, the **Major Incident – Declared** terminology is recognised across all LRF members.

6.6.6. Mass Casualty Scenarios – The ICB Role

Any NHS response to a mass casualty incident will be managed through the principles detailed in the NHSE Concept of Operations for Managing Mass Casualties document. This document defines a mass casualty incident for the health service as an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage. This would involve an incident where the number of casualties requires a response beyond the capacity of normal Major Incident procedures to cope and therefore further measures are required to appropriately deal with the casualty numbers. A mass casualty incident is likely to involve dozens or high numbers of casualties. For the purpose of the document, the context of the response is to a mass casualty incident caused by a sudden onset of events (big bang) rather than a rising tide type of incident, such as pandemic influenza.

In terms of the Concept of Operations for Managing Mass Casualties document, the ICBs role is simply defined as "discharging their statutory duties as a Category 1 responder within the Civil Contingencies Act 2004". Specific considerations are detailed below:

Specific ICB Considerations:	
Commissioning of additional services	e.g. specialist burns services, mental health pathways
Financial support/accelerated commissioning of community services and care home placements	to support creation of bed capacity in Trusts through step-down/ discharge of patients
Co-ordination of primary care service capacity	Both in and out of hours, to feed into the regular SitRep reporting required by NHSE
Oversight of self-presentations	Associated with the incident to GP practices and other local providers not necessarily part of the initial incident category 1 responders and onward transmission of data to NHSE
Co-ordination of information	Ensure process in place for monitoring and actioning the dissemination of information and SitReps to NHSE
Provision of staff to support Acute Providers	In administration/co-ordination roles of requested (and helpful)
Participation in LRF Strategic or Tactical Co-ordination Groups	Where invited
Use of website and social media and communication methods	To reduce the impact on local receiving emergency departments and other health

	services from patients not associated with the incident who do not need priority treatment
Provision of co-ordinated media response	With NHSE, Acute Providers, LRFs and local authorities
Ensuring the welfare of staff	
Refer to action card in appendix 14	

6.6.7. Large Scale Evacuation

When a large scale evacuation of a geographical area is required, the initial response is likely to be led by the Police, but co-ordination of activities to support evacuated individuals will be undertaken by the local authority, who will have their mass evacuation plan. Where a provider is required to enact their 'mass evacuation plan', they will put in place a command structure and the ICB will support and, if required, coordinate the system response.

The ICB principal responsibilities in these circumstances will be fourfold:

1. Work in conjunction with NHS England in discharging the EPRR function and co-ordination of the overall health sector response
2. Support the local authority in the implementation of its mass evacuation and rest centre plans, ensuring the system resilience team make contact with the local LRF/Emergency planning leads
3. Mitigate the impact of any closure of healthcare premises within the exclusion zone or as a result of any other incident such as flooding renders the premises unusable
4. Warning and informing patients, the public and staff

Specific ICB Considerations

- **Support to rest centre facilities** activated by the local authorities with:
  - Provision of resourcing support from members of its workforce who are appropriately trained
- **Identification of any primary care or pharmacy support** that can be offered
- **Provision of a health link** to NHSE and other health agencies
- Co-ordination of the response from other NHS partner organisations in response to requests from local authority
- Be aware that providers may need to deploy their own 'mass evac plans' that could involve 'shelter in place', 'specific ward evacuation', 'patient priority evacuation', and 'emergency transfer or patients', a sitrep from the provider command team should detail the specifics deployed
- **Support to primary, secondary and community care providers** whose premises become unavailable through:
  - Identifying & assessing suitability of alternative temporary premises
  - Supporting the implementation of **mutual aid arrangements,** across primary care networks
  - Communicating with patients and community staff ensuring consistent messaging through use of website, social media and other communication outlets
- **Co-ordinating the health response with the local authority public health team**
- **Participating in any LRF led strategic or tactical co-ordination groups**

• **Link in with communicate leads** to warn and inform patients, the public and staff via emails, social media, news feeds and other communication networks • **Maintain arrangements for reducing inequalities** (equalities impact assessment) • **Welfare arrangements of staff**
Refer to action card in appendix 13

6.7. Mutual Aid Arrangements

In the event that mutual aid arrangements are required, it is likely that the scale of the incident will mean that the NHSE regional team will lead on discussions. The ICB may be required to assist with brokering arrangements, particularly in relation to provision of equipment or sharing of premises.

ICB Considerations in the event of mutual aid request:
• What is being requested – e.g., staffing, patient capacity, equipment
• Does the ICB have access to any commissioned services to support the mutual aid request?

6.8. Longer Duration Incidents

The Covid-19 pandemic of 2020/21 and in 2022/2023 the impact from industrial action has highlighted the need for NHS organisations to not only be able to respond to big bang, short term incidents but to be prepared to respond to an incident of an extended duration, where the system is under pressure for many weeks or months.

Although the principles of this plan will remain valid, it may be necessary, depending on the nuances of the incident, for additional planning to be put in place and recorded in a specific incident response plan. These additional documents will be written as required, in conjunction with the Incident Command Team and circulated as appropriate.

Part of the consideration for longer duration incidents is the wellbeing of those involved in the incident response. In these incidents it is vital to establish additional staff who can step in to support with the response, this includes a deputy Strategic Lead and appropriate admin support to allow for contemporaneous documentation to be stored throughout the incident without impacting on the team's resilience to respond.

As part of the team's resilience it is imperative that staff take regular breaks and do not work excessive hours as this can impact on individuals abilities to make objective and defensible decisions. The use of additional staff to respond to an incident can work towards ensure that staff's wellbeing can be maintained, and therefore have less impact on their business-as-usual role.

6.9. Command, Control, Coordination and Communication (C4)

This section gives an overview of NENC ICB Command and Control arrangements, based on best practice taken from the Joint Doctrine: The Interoperability Framework published by JESIP (Joint Emergency Services Interoperability Principles)

6.10. JESIP Principles

6.10.1. Co-location

Where commanders are co-located, they can perform the functions of command and control more effectively. Co-location for the ICB will ordinarily mean the convening of a meeting either face-to-face or via MS Teams. An initial meeting should take place as soon as practicable to establish initial objectives and a coordinated response plan.

6.10.2. Communication

Meaningful and effective communication underpins effective joint working. Sharing and understanding information aids the development of situational awareness, which underpins the best outcome for an incident.

The following considerations support successful communications:

- Exchanging reliable and accurate information, such as risks and threats.
- Ensuring the information shared is clear, minimising acronyms and other potential sources of confusion.
- Understanding the responsibilities and capabilities of each of the responder departments / support services.
- Clarifying that information shared is understood and agreed by all involved in the response.

Other LRF responders (including NHS provider organisations and local authorities) have their own robust and effective on-call capacity and capability to manage incidents which impact them directly. The ICB will work in partnership with these organisations to respond to incidents.

Where appropriate, NHS provider organisations will escalate issues to NENC ICB for support and leadership across The North East and North Cumbria region. Similarly, NENC ICB will escalate issues which require support from NHSE. In all cases Trusts must immediately escalate any declarations of Critical or Major Incidents to NENC ICB. These must then also be immediately escalated to the NHSE Region on-call.

NEAS Operational Coordination Centre (OCC) (**0300 030 9001)** host (24/7) the single ICB point of contact for local partners in the North East and North Cumbria, who may wish to contact the NHS to advise of an incident.

Effective communications are crucial. It is essential to disseminate accurate and timely information to staff, partners, stakeholders and where necessary the public during the response to an incident. The Incident Coordination Centre (ICC) Manager will liaise with the NENC ICB Communications Lead as required to ensure effective, on-going communications. Clear and consistent communication is an essential part of incident response. This involves internal ICB and health sector communication as well as with multi-agency partners to provide consistent messages and assurance to the public.

6.10.3. Co-ordination

This involves commanders discussing resources and activities, agreeing priorities and making shared decisions throughout the incident. Co-ordination underpins incident response by avoiding potential conflicts, duplication of effort and minimising risk.

6.10.4. Joint Understanding of Risk

Different teams within the ICB or different external partners may see, understand and treat risks differently. Each should carry out their own 'dynamic risk assessments' but then share the results so that they can plan control measures and contingencies collectively.

6.10.5. Shared Situational Awareness & Situation Reporting

Shared situational awareness is a common understanding of the circumstances, immediate consequences and implications of the incident, along with an appreciation of the available capabilities and the response priorities. Achieving shared situational awareness is essential for an effective response. To have shared situational awareness there must be a commonly recognised process for receiving, completing, authorising, and submitting situation reports or Sitreps. A draft situation report for the ICB to issue to Trusts is at appendix 3.

In some incidents NHSE will dictate what information Trusts will need to provide via sitrep. This occurred regularly during recent industrial action and the pandemic. In other incidents the information request may be tailored by the ICB. In all cases the ICB will ensure that Trusts have clearly identified deadlines for sitrep submission. This reporting schedule, often called a "battle rhythm" should consider previous information submissions from TCGs and SCGs and allow sufficient time for completion and quality approval by ICC staff, prior to collation and submission. Frequency of the sitrep submission will be determined by the ICB Strategic Commander and/or as the incident develops. Submission of sitreps may be by email or via online form.

Trusts will ensure that all sitrep submissions are suitably approved by an executive level member of staff before submission. ICBs will ensure the sitreps they provide to NHSE or SCG have strategic director level approval. All sitreps will be quality assured by the System Resilience Team or the Director of System Resilience before submission.

6.11. Command Roles

The management of emergency response and recovery is undertaken at one or more of three ascending levels: Strategic, Tactical or Operational with each defined below as per NHS England (2022):

6.11.1. Strategic

The purpose of the strategic level is to consider the incident in its wider context; determine the longer-term and wider impacts and risks with strategic implications; define and communicate the overarching strategy and objectives for the response; establish the framework, policy and parameters for lower-level tiers and monitor the context, risks, impacts and progress towards defined objectives.

When an event or situation has a particularly significant impact; substantial resource implications or lasts for an extended duration it may be necessary to convene a Local Resilience Forum (LRF) multi-agency coordinating group at the strategic level bringing

together the strategic commanders from relevant organisations. This group is known as the **Multi Agency Strategic Coordinating Group (SCG).**

The ICB strategic health commander will attend the SCG and will be empowered to make executive decisions on behalf of the ICB**.** The ICB strategic health commander will also consider cross border issues where an incident may span more than one LHRP or LRF area. The process for coordinating the response and ensuring clear reporting routes to incidents that sit across boundaries is included in the Action Cards.

For incidents across multiple LRF areas where a Level 3 incident is declared, then NHS England regional and national teams, as appropriate, will undertake command, control and coordination of the NHS and will be responsible for appropriate representation to regional and national coordination structures and groups. See sections 5.6 and 5.7 above for further information on NHS Incident levels.

6.11.2. Multi Agency Advisory Teams Meeting (MAAT)

Upon being notified of an incident that may require multi agency coordination Cumbria, Cleveland, County Durham & Darlington and Northumbria Local Resilience Forums (LRF's) may choose to hold a Multi-agency Advisory Teams (MAAT) The purpose of this meeting is to put North East and North Cumbria responders on the “front foot”, giving the maximum time possible to prepare when there is increased likelihood of a multiagency significant incident taking place. The MAAT is attended by tactical level staff – usually ICB System Resilience Team or Tactical /ICB Local Delivery Team or ICB Tactical (1st) on Call. As a rule, the MAAT is usually chaired by the partner organisation that contacts the LRF to request the meeting if the incident in question is a “rising tide” event. For more immediate response the MAAT will be chaired by the Police.

6.11.3. Multi Agency LRF Strategic Coordinating Group (SCG)

The purpose of the SCG is to take overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which lower tier command and coordinating groups will work. The SCG will:

- Determine and promulgate a clear strategic aim and objectives and review them regularly
- Establish a policy framework for the overall management of the event or situation
- Prioritise the requirements of the tactical tier and allocate personnel and resources accordingly
- Formulate and implement media-handling and public communication plans
- Direct planning and operations beyond the immediate response to facilitate the recovery process

SCGs are usually called by the LRF and in most cases are chaired by the Police, Local Authority or Fire and Rescue Services but in some cases may be chaired by other responders if they have a lead responsibility. The organisation that chairs the SCG provides an incident loggist that keeps a record of the decisions and actions (and rationale for these). The ICB’s strategic commander will keep their own log of their own decisions, actions, and rationale.

6.11.4. Health Partner SCG

In some circumstances it may be necessary for the ICB Strategic Health Commander to convene an SCG for Strategic Health Commanders representing Trusts and other affected health economy partners across Integrated Care Partnerships in geographical areas. Not all health partners attend LRF SCGs so this meeting would allow the ICB to provide a more focussed health related situation report but would follow the same purpose as the multi-Agency SCG as stated above. This meeting would be chaired by the ICB Strategic Health Commander and a trained loggist would keep a record of decisions and actions (and rationale for these).

6.11.5. Tactical

The purpose of the tactical level is to ensure that the actions taken by the operational level are coordinated, coherent and integrated to achieve maximum effectiveness, efficiency and desired outcomes. Where formal coordination is required at a tactical level, then a multi-agency Tactical Coordinating Group (TCG) may be convened with multi-agency partners within the area of operations. The tactical commanders at TCGs will:

- Determine priorities for allocating available resources.
- Plan and coordinate how and when tasks will be undertaken.
- Obtain additional resources, if required
- Assess significant risks and use this to inform tasking of operational commanders.
- Ensure the health and safety of the public and personnel.

The aim of an ICB Tactical Health Commander will be to ensure that all health and care providers are coordinated through tactical coordination groups and are able to effectively manage any incidents.

Not all health partners attend multi-agency TCGs since their business can be wide ranging. To ensure the local health economy is fully briefed and has a shared situational awareness the Tactical Health Commander may convene a Health Partner TCG to concentrate on those issues relevant to NHS services. This meeting would be chaired by the ICB Tactical Health Commander and a trained loggist would keep a record of decisions and actions (and rationale for these).

6.11.6. Operational

Operational is the level at which the management of immediate 'hands on' work is undertaken. Operational commanders will concentrate their effort and resources on the specific tasks within their geographical or functional area of responsibility.

Operational structures will provide information on the incident, assist providers impacted by an incident and help coordinate and liaise with partners, services and other organisations during an incident.

7. Incident Coordination Centre (ICC)

7.1. NHSE requirements for ICCs are as follows:

"Each NHS-funded organisation (including ICBs) needs to establish an ICC and maintain a state of organisational readiness. Large organisations with multiple sites may need a facility at each location where tactical and operational functions can be coordinated and supported by a separate strategic facility for overall command and control."

- *There should be sufficient resilience within the organisation to ensure an alternative ICC can be used in the event the primary ICC is unavailable.*
- *An ICC must be resilient to loss of utilities, including telecommunications, and to external hazards such as flooding.*
- *The ICC should have an activation plan with action cards for key staff working within it.*
- *Sufficient resources should be made available to coordinate an incident over an extended period.*
- *ICC equipment should be tested every three months as a minimum to ensure functionality, dates of tests must be recorded.*

NHSE EPRR Framework V3 2022.

NOTE – NENC ICB must consider these requirements when making decisions on new estate locations to maximise opportunities to ensure compliance with NHSE Core Standards for EPRR.

The Incident Coordination Centre (ICC) supports the Incident Management Team (IMT) to provide an enhanced level of operational support. It is widely recognised that the efficiency and effectiveness of an ICC is greatly improved by having a formal structure. Benefits of this include:

- unity of effort – all team members operate under a common list of objectives
- accountability – everyone has a specific role for which they are responsible
- efficiency – clearly established processes, roles and responsibilities can eliminate duplication of effort

The ICB must have an ICC in place to ensure there are suitable and sufficient arrangements to effectively manage the response to an incident. Arrangements for the ICC need to be flexible and scalable to cope with the range of incidents and hours of operation required.

7.2. ICC Functions

While the specific activities undertaken by the ICC will be dictated by the unique demands of the situation, there are five broad and typical ICC tasks:

- coordination – matching capabilities to demands
- policy-making – decisions pertaining to the response
- operations – managing as required to directly meet the demands of the
- incident
- information gathering – determining the nature and extent of the incident to ensure shared situational awareness

- dispersing public information – informing the community, news media and
- partner organisations.

The ICC will provide a focal point for coordination of the response and the information gathering, processing, archiving and dissemination of information across the NHS and externally, as required. It will coordinate ICB response across all sites and by all teams including the System Coordination Centre and local Delivery Teams. This plan also includes arrangements for the management of visitors to the ICC (see appendix 7 and 8).

7.3. Types of Incident Control Centre (ICC)

The ICC may take a variety of forms depending on the nature of the incident. If impacts are expected to be very significant then an "in person ICC" may be the best action since it allows staff to be on a single site together. If impacts are expected to be low and well managed, then a "virtual ICC" may be sufficient. Issues such as accessibility during an incident where the transport network is likely to be disrupted or there is risk of infection a "virtual ICC" may be a better option. If there is risk of power outage an "in person ICC" at a location with backup power is recommended.

In all cases arrangements should be in place to allow response arrangements to be expanded if deemed appropriate. If an ICC is established, it usually remains so for the duration of the incident and may continue into the recovery period.

7.4. "In Person ICC"

This is when the roles described above co-locate at the same office for the duration of the incident. This would occur when the incident is likely to cause a significant impact to all services with a high risk of harm to patients. Working in person facilitates better command and control arrangements and allows the ICB to react more quickly to changing events. An "in person ICC" may help to facilitate response in early the early stages of an incident when roles and responsibilities are new.

Pemberton House, Sunderland is the current primary site for an ICB "in person ICC". The office may be used 0700-1900 provided these hours have been confirmed in advance with the Security Team on 0191 516 6770. Use of the office overnight or over the weekend would need to be agreed with Property Services well in advance customer.service@property.nhs.uk.

Pemberton House is not supplied with backup power. In the event of a power outage North East Ambulance Service have agreed for the ICB to use their Silver Room at Bernicia House, Newburn Riverside, Newcastle, NE15 8NY.

7.5. "Hybrid ICC"

This would comprise of a hybrid between the "In Person ICC" and the "Virtual ICC". The In Person ICC would operate during office opening hours of 0700-1900 and then fallback to a virtual ICC outside those hours (including weekends).

7.6. "Virtual ICC"

This allows the roles described above to be performed in different offices or from home using MS Teams and mobile telephony. It allows ICC staff extra flexibility. When response to an incident is well rehearsed and risks are deemed to be low it is the most efficient method of response. This is the most common type of ICC used for BMA industrial action.

8. Incident Management Team (IMT)

The ICC will need an adequately resourced Incident Management Team (IMT) appropriate to the type of response required. The IMT will need to effectively manage an incident within the ICC and provide the appropriate support to the NHS Strategic Commander (2nd On Call).

The size and membership of the IMT will be dictated by the scale and nature of the incident and will be decided by the Director of System Resilience or NHS Strategic Commander (2nd On Call) who will nominate an ICC manager with responsibility to set up the ICC and organise the required staff.

In the event of the ICC being stood up, the following are suggested roles that may be present at the ICC when convened. However, this is dependent on the nature of the incident and decisions taken by the Director of System Resilience or Strategic Commander (2nd on Call):

8.1. Strategic Health Commander (Incident Director)

This is the most senior person on duty, who takes charge. Their primary role is to formulate the overall strategic response. This role will represent the ICB at multi-agency strategic coordinating groups (SCGs). This role would initially fall to the Director of System Resilience or to the ICB (2nd) Strategic on-call however it may be appropriate to appoint another Executive Director to be Strategic Health Commander if either of the above are needed to be kept separate from incident response. This may be done to ensure there is capacity to manage concurrent incidents. The Strategic Health Commander (Incident Director) will have been trained to the level required by the Minimum Occupational Standards for Strategic level Health Commander.

8.2. Tactical Health Commander (ICC Director)

This role will provide senior managerial support to managing the incident, implementing the agreed strategy and actions, in conjunction with members of the incident management team (IMT). This role will represent the ICB at LRF multi-agency tactical coordinating groups (TCGs). Depending on the size and/or location of the incident, there may be more than one Tactical Health Commander. Within the ICB this role will be performed by the Deputy Director of System Resilience or ICB Tactical (1st) on-call or another member of the Tactical on-call rota or a suitably senior member of staff from corporate or Local Delivery teams, provided they have been trained to the level required by the Minimum Occupational Standards for Tactical level Health Commander. The ICC Director will report to the Strategic Health Commander.

8.3. Incident Coordination Centre Manager (ICC Manager)

The primary role of the ICC Manager is to manage the ICC and provide support to the Tactical and Strategic Health Commander roles. Within the ICB this role may be performed by the ICB Resilience Lead in hours or out of hours by the ICB Tactical (1st) on-call Another member of the Tactical (1st) on-call rota or a suitably senior member of staff from corporate or LDT's may also fulfil this role provided they have been briefed beforehand. The ICC Manager will report to the Tactical Health Commander.

8.4. Incident Management Team Members

These roles will provide support to the incident senior managers and will implement actions as directed to effectively manage the incident. Depending on the size and/or location of the incident, there may be several Incident Team Members drawn from ICB staff. IMT members report to the ICC Manager.

8.5. Incident Management Support Officer

This role will provide administrative support to the incident management team. Depending on the size and/or location of the incident, there may be more than one Incident Support Officer. Incident Management Support Officers will report to the ICC Manager.

8.6. Loggist

A trained loggist will be required to maintain a contemporaneous log of decisions, rationale and actions taken at meetings chaired by the Strategic Health Commander and/or Tactical Health Commander. Strategic Health Commanders and Tactical Health Commanders will maintain their own log of decisions, actions and rationale during their periods on duty. The ICB should maintain a cadre of available trained loggists. A loggist is not a minute-taker or administrative support. The loggist should not log continuously for more than two hours at a time.

8.7. Other Roles

Any other roles as designated by the Strategic Health Commander may be established to support the management of the incident. This may include staff from clinical backgrounds such as the Chief Nurse or Medical Director or Director of Communications or appropriate deputies. They may form support cells that underpin the work of the ICC.

8.8. System Coordination Centre (SCC)

The System Coordination Centre will continue to operate during an incident but will sit below the ICC as the primary conduit for information relating to incident response and will provide information to the ICC as required. Timings of SCC meetings and deadlines for information submissions will need to fit around those dictated by the ICC who will in turn report to the multi-agency Local Resilience Forum TCGs and SCGs.

8.9. Handover Arrangements

It is possible that some incidents may become protracted, making it untenable for the same Incident Management Team to manage the incident for its whole duration. This is a

significant consideration in terms of both the welfare of the individuals concerned and the quality of the decision-making process as time progresses.

Early in the incident life span, a decision should be made concerning length of manageable "shift" times for the Incident Management Team, and a rota of appropriate staff to fulfil Incident Management Team roles should be determined.

The Strategic and Tactical lead must ensure that there is a robust process in place for ensuring continuity of incident leadership and situational awareness. Advance notice to incoming staff of their role will enable some preparation, and clear handover notes and a well-maintained log will support this arrangement. Ideally, shift changeover times should be aligned with a partnership conference call (if they are in place) to enable both the incoming and outgoing Tactical lead to attend as part of the handover process, and an overlap between the incoming team arriving and outgoing team leaving will enable an effective time period for the handover to take place.

9. Welfare of Staff

Early consideration of the welfare of staff is essential. This includes ensuring adequate staffing resource to respond to the incident and planning staffing schedules.
Staff performing the roles above should have access to regular breaks.

It will be the responsibility of the ICB to ensure that appropriate de-briefing arrangements and welfare support is in place for all persons within their employment or under their control. This also applies to the ICB and their staff or contractors. The welfare and psycho-social support will vary according to the type of incident, duration of incident and individuals involved. Strategic oversight for this welfare provision will sit with the ICB Chief Strategy Officer and the Director of System Resilience.

10. Financing of Incident Response

In the event an incident declaration or event that requires the incident response plan to be activated it is expected that financial considerations should not impact on the speed or scale of the response required to immediately manage an incident.

It is essential that financial expenditure incurred as a direct result of the incident is documented from the outset until the conclusion of the incident, including the recovery phase or until such time as the ICB Finance Director could be reasonably consulted. The ICB Finance Director will consider how specific budget codes may be employed to track expenditure on incident response and recovery.

The use of mutual aid arrangements to share or loan equipment should also be considered as this may be beneficial both financially and in terms of a shorter lead time.

Where necessary, a member of the finance team will be assigned as part of the Incident Management Team to facilitate finance support.

Insurance will play a key role in the long-term recovery from incidents. It is important that ICB insurers are informed promptly so that the claims approval can start as this may take some time to complete.

Insurance and legal advice can be obtained in the first instance from the ICB Corporate Operations team.

11. Recovery

The Tactical Health Commander or Strategic Health Commander (where strategic command has been established) will determine when the incident response will be stood down.

Criteria for de-escalation may include:

- Reduction in internal resource requirements
- A reduction in risks or severity of the incident
- Reduced demands from government departments, partners, and commissioned services
- Reduced public or media interest

12. Debrief

The Strategic Health Commander is responsible for ensuring that a debrief is held. There are different types of debrief:

- Hot debrief – immediately after the incident or period of duty
- Cold/Structured/Organisational debrief – within two weeks post-incident
- Multi-agency debrief – aiming to be within four weeks of the close of the incident - This may be conducted by an external agency.

Hot debriefs should take place as soon as possible. There may be a need to have separate debriefs depending on the nature and scope of the incident. There may be a need for separate internal debriefs looking at Strategic or Tactical Response conducted by the appropriate health commander after the incident has been stood down. The Chief Strategy Officer as ICB Accountable Emergency Officer or Director of System Resilience may request an external debrief chair.

The LRF can often facilitate de-briefs and will be keen to identify wider lessons to enable organisational learning and further resilience to be applied to the emergency plans of all organisations.

A structured debrief should be undertaken and will look at the following areas of any significant incident response and recovery to provide a framework to the process:

- Systems and procedures – such as command and control
- Equipment – communication devices, resources
- Personnel – activation and mobilisation, welfare issues and numbers

A debrief template is included in the appendices. Results of debriefs including lessons learned will be recorded and shared at both relevant LRF and LHRP and submitted to NHSE for wider learning.

13. Training & Exercising

Staff performing the role of Strategic or Tactical Commander or ICC Manager will have undergone Health Commander Training at the required level and will maintain a current training portfolio able to demonstrate their on-going competence. Health commander portfolios will be overseen by the ICB System Resilience Team.

The ICB incident response plan will facilitate ICB response to any significant incident and will be utilised for both internal and multi-agency exercises to comply with EPRR standards and may take the form of:

- Communication Exercises – every 6 months (minimum)
- Tabletop Exercises – every 12 months (minimum)
- Command Post Exercises – every 3 years (minimum)
- Live Exercises – every 3 years (minimum)

The exercising programme will:

- Identify exercises relevant to local risks (ICB, LHRP & LRF's)
- Meet the needs of the ICB and its stakeholders,
- Ensure warning and informing arrangements are effective.
- Will capture, record and act upon lessons identified as part of continuous improvement in-line with NHSE EPRR Lessons Identified Framework.

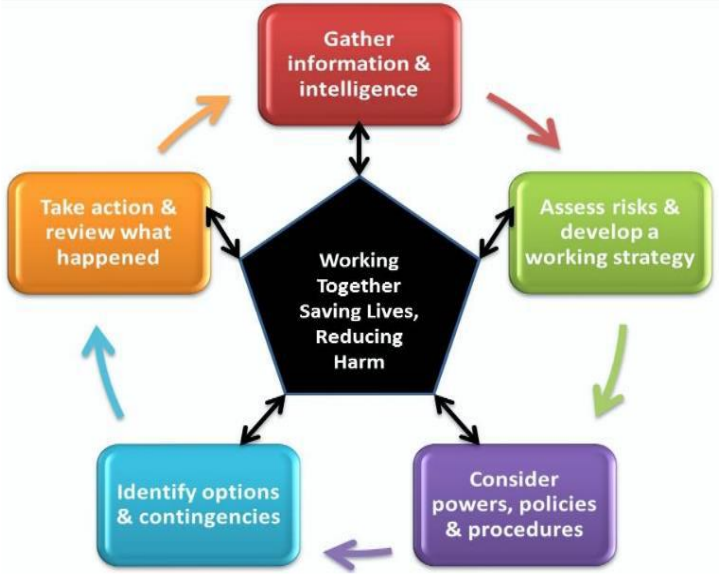
14. Governance

The incident response plan will be subject to the governance of NENC ICB and will be subject to annual review to reflect any lessons identified from any significant incidents, events or exercises as well as to comply with newly published guidance or legislation.

Appendix 1 – Incident Response Aide Memoire – Note colours mirror those of the Joint Decision Model Below:

Who is calling? Name? Agency? Position? Contact number and email? What time?	
What has happened? Location & Postcode? Building Name?	
Any Casualties? Number and type? Patient(s)? Staff? Public?	
Any hazards present? Live cables? Rising floods? Risk of infection?	
Are emergency services required? Have emergency services been called or on scene? Who is the emergency services contact? What is the impact on the ICB or NENC NHS services?	
Do I need to inform others? Inform Strategic (2nd On Call) or NHSE? Do I need to inform LRF partners?	
Check resources in on call folder. Have Business	

Continuity Plans been activated? Is this a Business Continuity, Critical or Major Incident?	
What is required? Needs? Expectations? Resources? Advice? Authority to make decisions?	
Next Steps Agree timetable for future calls Agree who will join the calls If escalating this incident fill out SBAR form.	
Start a log. Include all actions/decisions and rationale	



Appendix 2 – SBAR Form

SBAR Report – Complete When Escalating Incident to Strategic (2nd On Call) or NHSE On Call	
Situation – Describe situation that has occurred.	
Background – Explain background/history of incident and impact on services & patient safety	
Assessment – Confirm your understanding of issues/risks involved	
Recommendation – Explain needs, expectations and what you would like to happen	
Ask receiver to repeat information to ensure mutual understanding	

Appendix 3 – Situation Report Template (This template may be amended as required)

CRITICAL/MAJOR INCIDENT SITUATION REPORT – SITREP

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

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

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

Impact of business continuity arrangements	
Media interest expected/receive	
Mutual Aid Request Made (Y/N) and agreed with?	
Additional comments	
Other issues	

ICC Incident Coordination Centre contact details: **Telephone number:** **Email:**	

Appendix 4 – ICB Strategic Health Commander Action Card

Action Card – ICB Strategic Health Commander – (is ICB Strategic - 2nd On-call)

Responsibilities

- To ensure the NHS within the NENC ICB area continues to deliver its core functions during the response and recovery phases of any incident(s).
- To take overall responsibility for the command and control of the ICB response to an incident.
- To liaise with NHSE Regional Team and provide information as requested.
- To ensure strategic and tactical level responsibilities are maintained throughout the incident.

Initial Actions

1	After strategic level representation has been requested by the ICB Tactical Health Commander (Tactical – 1st On-call) start making a log of decisions, actions and your rationale.
2	Request a copy of the completed SBAR report (appendix 2) from the Tactical Health Commander (1st On-Call) Confirm if you are required to attend any LRF Strategic Coordinating Groups (SCGs) their times and if they are in person or via MS Teams.
3	Using the Joint Decision Model consult with Tactical Health Commander (ICB 1st On-call) to establish shared situational awareness and agree appropriate level of ICB response. Consider following: • Is further information required? • Nature of incident – is it a business continuity, critical or major incident? • Impact of incident on patients • Impact of incident on providers of NHS services in North East/North Cumbria • What plans need to be activated? • Do partner agencies need to be informed? Emergency Services, Trusts, Local Authorities, LRFs, NHSE, neighbouring ICBs etc. • Do you need to chair a Health Strategic Coordination Group meeting of NHS providers? When chairing a meeting you will have a trained loggist that will

	keep a record of decisions, actions and rationale. Lists of loggists can be found in the on-call folder on the Sharepoint site. • What reporting requirements have been put in place? • What are the current command and control arrangements that are in place? • Confirm that all relevant and appropriate internal personnel have been informed – Directors of System Resilience/ Communications, Medical Director, System Resilience Team. • Consider if specialist advice is needed e.g. IT, information gov, Clinical etc.
4	If a Critical or Major Incident has been declared by a partner confirm if NHSE Regional/ROCC has been informed. If not, ensure they are informed immediately. NHSE Region must be informed within 30 minutes where possible.
5	Agree with the Tactical Health Commander the ICB Strategic Aim and Objectives and if the ICB is activating its Incident Response Plan. Confirm whether a Business Continuity, Critical or Major Incident has been declared by the ICB. Agree the level of response required by the ICB. Ensure partners are aware.
6	If an Incident Coordination Centre (ICC) is required instruct the Tactical Health Commander to follow appendix 6 of this plan.
7	Confirm if a strategic or tactical coordination group meeting of NHS partners is required to provide briefing on the incident and to set situation reporting parameters. Consider what may need to be discussed including: • Mobilising resources from locally commissioned services • Providing local NHS leadership, if required liaise with relevant partner organisations • Cascading information to relevant service level providers • Informing and maintaining dialogue with neighbouring ICBs and LRF's as appropriate. • Supporting ICB commissioned organisations with any local demand, capacity and system resilience issues. A Health Strategic Coordinating Group with health partners should be chaired by the ICB Strategic (2nd On-call) A Health Tactical Coordinating Group with health partners should be chaired by the ICB Tactical (1st On-call) Draft agendas can be found in the appendix.
8	Provide an initial brief at executive level (to ensure exec level situational awareness)
9	In conjunction with the ICB Communications Team and in consultation with NHS England and/or local partners (for NHS level 3 or 4 incidents), develop and agree media strategy (which may need to be agreed by the SCG and by NHSE)
10	Plan-ahead for the coming hours not just the immediate requirements and consider staff welfare including shift length and handovers.
11	Confirm with Tactical Commander situation reporting timetable and process for collection, quality control, collation and sign off of sitreps.
12	Consider the needs for recovery arrangements for the incident as early as possible.

13	Establish liaison with the appropriate personnel from NHS England, LRF, UKHSA, NHS Trusts and partner agencies as appropriate to the incident.
14	When standing down from a shift as strategic health commander, ensure a full briefing and handover is provided to the new strategic health commander. Ensure the briefing and handover is documented, logged with a time and date.

Appendix 5 – ICB Tactical Health Commander Action Card

Action Card – ICB Tactical Health Commander – (is ICB Tactical - 1st On-Call)

Responsibilities

- To ensure that the NHS within the ICB area continues to deliver its core functions during the response and recovery phase of any incident(s).
- Deliver the ICB incident response strategy through the development of a tactical plan to coordinate the ICB and NHSE resources.
- To liaise with the LRF and NHS England Regional colleagues as required.

Initial Actions

1	Obtain as much information about the incident as possible, completing the Incident Response Aide Memoire at Appendix 1.
2	Verify the information received by other sources, the police, the local authority or other appropriate partner agencies as well as advising them of your contact details and the ICB Incident email address: **nencicb-ng.nencicbincident@nhs.net** Regularly check this inbox and the on-call inbox in case emails do not forward automatically to your account.
3	Decide if you need to escalate the call to the ICB Strategic on Call, consider If strategic level representation is needed at an LRF SCG meeting or if a health partner SCG is required. Start making a personal log of decisions, actions and your rationale.
4	Prepare a copy of the completed SBAR report (appendix 2) for the Strategic Health Commander (2nd on Call). Confirm if they are required to attend any LRF Strategic Coordination Groups (SCGs) or if you need to attend a LRF Tactical Coordination Group (TCG). Confirm the meeting times and if they are in person or via MS Teams.

	If there are multiple TCGs you may need to engage with Local Delivery Team colleagues to ensure coverage of these meetings.
5	Use the Joint Decision Model (JDM) and consult with Strategic Health Commander to establish shared situational awareness and agree appropriate level of ICB response. Consider following: • Is further information required? • Nature of incident – is it a business continuity, critical or major incident? • Impact of incident on patients • Impact of incident on providers of NHS services in North East/North Cumbria • What plans need to be activated? • Do LRF/partner agencies need to be informed? Note – all Critical and Major Incidents must be reported to NHSE EPRR on Call immediately. • Do you need to chair a Health Tactical Coordination Group meeting of NHS providers? When chairing a meeting you will have a trained loggist that will keep a record of decisions, actions and rationale. Lists of loggists can be found in the on-call folder on the On-call SharePoint Portal NENC ICB On-Call - Home. A draft agenda can be found in the appendix. • If the incident is "cross border" ensure neighbouring ICBs are informed and agree a reporting arrangement to maintain shared situational awareness. • What reporting requirements have been put in place with partners and NHSE? • What are the current command and control arrangements that are in place? • Is there a need to set up an ICB Incident Coordination Centre (ICC)? If so confirm what type is required and refer to the activation of ICC at appendix 6. • If the Incident Response Plan is activated, brief appropriate ICC personnel. • Confirm that all relevant and appropriate internal personnel have been informed: Director of System Resilience, ICB Strategic (2nd) On-call, on call ICB Communications and if in hours, Medical Director, Chief Nurse, Local Delivery Directors, System Resilience Team and Chief Strategy Officer as Accountable Emergency Officer. • Confirm situational awareness and decide which external partners need to be informed e.g. NHSE EPRR on Call, LRF, Ambulance Services, Trusts etc. • Confirm when you will provide a further update to ICB Strategic On-Call.
6	Ensure that a log of any financial expenditure relating to the incident is commenced.
7	Depending upon the scale or type of incident, anticipate requests at TCGs from Local Authorities for the following: • To support reception or rest centres if established. Clarify the location of the centres and type of assistance required (clinical, administrative or general support). • Lists of vulnerable people in specific areas. Note that this information is difficult to provide at short notice. If the information is to be used to facilitate evacuation of areas at risk, then partners should be advised to commence

	"door knocking" as soon as possible and not to wait for lists of vulnerable people from NHS partners. The "Viper" system adopted by some LRFs may be of benefit in helping identify vulnerable parties. If evacuations are to take place ascertain the streets affected and share this information with Trusts so they can cross check with their patient databases to locate patients that may need following up.
8	When the tactical health commander stands down from their shift, ensure a full briefing and handover is provided to the new tactical health commander. Ensure the briefing and handover is logged. An SBAR form may be used for this purpose (appendix 2).

Appendix 6 – ICC Activation

Action Card – Incident Coordination Centre (ICC) Activation	
This action card provides a guide to setting up the ICC – it should be followed by the Tactical Health Commander and/or the ICC Manager if appointed. If an ICC Manager is appointed, they will report to the Tactical Health Commander. The ICC Manager may be the System Resilience Lead or manager or a member of on call staff but any ICC Manager must have undergone Health Commander Training at Tactical level.	
Responsibilities • To ensure that the ICB has a functioning ICC that can be contacted via email or telephone for the duration of the incident. • To manage Incident Management Team – (the staff making up the ICC) to maintain ICB response arrangements including the management of staff rotas. • To maintain secure records of situation reports and incident logs. • Control access to any physical ICC room using the notice and forms at appendix 7 and 8. Note that you may need to restrict access to IMT members only.	
Initial Actions	
1	Respond as requested by the Tactical Health Commander – understand the type of ICC being established – see section 8.3 of this plan and confirm the Incident Management Team (IMT) staff requirements for its operation (ICC staff members, admin support, trained loggists etc). Ensure all IMT members have access to the SCC Teams discussions.
2	Start keeping a personal log of actions undertaken by the ICC using an incident log-book, this can be done using a hard copy log or electronic version. Electronic versions can be found in the on-call pack in the Teams folders. Hard copies are also stored in the EPRR cupboard in the ICC at Pemberton House, Sunderland. Ensure the log is handed onto whoever takes over as ICC Manager when your shift is complete. Ensure copies are stored securely.

3	Establish rotas and call in staff to support ICC operations as required to provide cover and continuity.
4	Ensure adequate handover arrangements are in place for ICC staff – use the SBAR form at appendix 2. Ensure copies of SBARs are stored securely.
5	Produce a "battle rhythm" document that shows the timetable for all meetings involving ICC staff and Health Commanders. Following each LRF SCG or TCG meeting the Tactical Health Commander will brief ICC staff. Facilitate the holding of any health partner SCG or TCG meetings – ensure a trained loggist is available for any meetings chaired by the Strategic or Tactical Health Commander so they can log all decisions, actions and rationale.
6	Confirm ICC telephone and email contact arrangements. This may be one or several mobile numbers of ICC staff. During an incident the ICC should ensure that contact telephone number(s) are shared as appropriate with partners such as NHSE, partner Trusts, LRFs, neighbouring ICBs and local authorities. Contact details for partners can be found in the on call pack. If they change with shift changes the new ICC contact numbers must be circulated to all partners immediately. The ICC email address to be used is nencicb-ng.eprr@nhs.net All on call staff have access to this account. Account owners can amend access rights via the ICB SRT.
7	Confirm ICC or on call contact details of other agencies in NENC that are responding to the incident. Maintain an up to date list as the incident progresses and share this with the Tactical Commander.
8	In between the hours of 08:00 and 20:00 request that an Incident Log is opened by the System Coordination Centre (SCC) to store contact details, time-lines/battle rhythm, situation report requirements etc. and to be available for access by ICC and on-call staff.
9	Should you require regular situation reports (sitreps) from partners consider what information you require and the frequency it is needed. Ensure sufficient time is allowed for partners to gather information and for you to check and collate it before submission to ICB Commanders or NHSE. The sitrep template at appendix 3 may be amended prior to circulation depending on the information sought. NHSE may provide a sitrep template or list of questions which may supersede or be used in conjunction with the form above. Agree with the Tactical Commander how information will be gathered (e.g. email, telephone or via SCC)

	It may be possible during office hours to request that an online sitrep form be developed that partners may complete via the SCC for the incident. This form may then be used 24/7.
10	Upon instruction of the Tactical Health Commander, stand down the ICC ensuring that partners are aware of how to contact the ICB. Ensure all incident related logs, documents and other materials are stored securely.

Appendix 7 – Incident Response Signage

INCIDENT RESPONSE IN PROGRESS

ENTRY RESTRICTED TO AUTHORISED PERSONNEL

ENSURE THAT YOU SIGN IN AND OUT OF THE INCIDENT ROOM

Appendix 8 – ICC Attendance List

ICC ATTENDANCE SHEET

Date: …….

NAME	JOB TITLE	SIGNATURE	IN	OUT

Appendix 9 – ICB Communications Lead

Action Card – ICB Communications Lead	
Responsible for – ICB Communications and Media **Responsible to – Tactical Health Commander**	
Initial Actions	
1	Liaise with Tactical Health Commander to gain common situational awareness.
2	Establish contact with the ICC and its Incident Management Team
3	Establish contact with any incident response communications cells or teams that have been established by the LRF, Multi Agency Strategic or Tactical Coordinating Groups or NHSE to ensure consistent and coordinated communications. Produce and maintain a list of contacts in partner organisations who are key to service delivery (e.g. local authority, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about the incident as well as sharing communications information with them to create consistent messages at a local, regional and national level.
4	Provide ICB incident messaging to staff, stakeholders and public as agreed with Strategic and Tactical Health Commanders and in line with any communications lines issued by SCG, TCG and NHSE. Maintain communications at short notice and throughout the duration of the incident including out of hours.
5	Monitor Media and Social Media channels providing updates on incident response to the IMT.
6	Develop a list of key local stakeholders (such as local elected officials, unions etc) and an established process by which you can continue to brief them during an incident
7	Consider prominent sites within the ICB's office locations for displaying of important public information (such as main points of access) if required.
8	Ensure communications lead that takes over from shift is given a full brief at handover – use SBAR form at appendix 2.

Appendix 10 – ICC – IMT Team Member

Action Card – IMT – Team Member	
Responsible for – Providing operational support to the ICC Manager and Incident Strategic or Tactical Health Commander working in the Incident Coordination Centre. **Responsible to – ICC Manager**	
Initial Actions	
1	Liaise with ICC Manager to gain common situational awareness of the incident.
2	Establish contact with the rest of the staff in the ICC and its Incident Management Team – if the ICC is established in person then familiarise yourself with layout.
3	Carry out duties as directed by members of the Incident Management Team contacting partners for situation reports, maintaining contact information, storing logs and other incident related documents in secure locations.
4	Ensure staff that take over from your shift are given a full brief at handover – use SBAR form at appendix 2.

Appendix 11 – ICC – Loggist

Action Card – IMT – Loggist	
Responsible for – Recording and documenting all actions/decisions/rationale made by the appropriate ICB Health Commander/when chairing a response meeting. Note that a loggist must have undergone the required loggist training and use the approved log book. **Responsible to – ICC Manager**	
Initial Actions	
1	Confirm which member of the IMT you are logging for and the date and time of the meeting.
2	Confirm with the ICC Manager if you are to attend in person or via Teams. Confirm the location of the meeting if it is in person. Ensure you have your staff ID badge.
3	Request an appropriate log book from the ICC Manager – Hard copy log books are kept in the EPRR cupboard – ICC, Pemberton House, Sunderland. Electronic Copies can be obtained from the On-call SharePoint Portal: NENC ICB On-Call - Home
4	Prior to the meeting meet with whoever you are logging for to discuss and confirm what will happen. The Health Commander should ask you to log decisions, actions and rationale for decisions and actions.
5	If plans, or guidance documents are used during the meeting these must be noted within the log.
6	The log must be clearly written/typed, dated and initialled by the Loggist at the start of shift and include any location
7	The log must be a complete and continuous record of all actions/decisions/rationale for actions and decisions made by the Tactical Health Commander or Strategic Health Commander.
8	Timings have to be accurate and recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented.
9	At the end of each meeting get the Health Commander to read the log and make any amendments in red and initial each amendment and date and initial the log at the end.
10	Ensure the log is stored securely by the ICC Manager. Bring to their attention any actions from the meeting that need to be discharged.

Appendix 12 – ICC – IMT Support Officer

Action Card – IMT – Support Officer	
Responsible for – Providing administrative support to the Incident Management Team working in the ICC. **Responsible to –** ICC Manager	
Initial Actions	
1	Confirm with the ICC Manager if you are to attend in person or via Teams. Confirm the location of the meeting if it is in person. Ensure you have your staff ID badge.
2	Carry out duties as directed by the members of the IMT
3	Support formulation of agendas and papers for any meetings and take minutes as required.
4	Maintain a list of key contacts and update appropriate lists
5	Act as a runner to deliver messages to other ICB offices in the event of telecoms outage

Appendix 13 - Action Card – Evacuation and Shelter

THESE ARE SPECIFIC ACTIONS IN RELATION TO EVACUATION AND SHELTER AND SHOULD BE READ IN CONJUNCTION WITH THE RELEVANT ACTION CARD FOR THE LEVEL OF COMMANDER E.G.

RESPONSIBILITIES

To work with NHS England in discharging EPRR functions. To ensure collaboration of planning arrangements across an ICS to deliver a unified response.

Establishing strategic and tactical leadership arrangements and support structures to effectively manage and co-ordinate the NHS response and recovery across the integrated care system.

Representing the NHS at LRF SCG's and TCG's when required

Providing leadership should mutual aid arrangements be activated to support an evacuation and/or shelter incident

Ensuring robust escalation procedures are in place through the EPRR command structure in line with the NHS EPRR Framework

Relevant Guidance

NHS England » Evacuation and shelter guidance for the NHS in England

Cabinet Office Evacuation and Shelter Guidance – for large scale community evacuations

IMMEDIATE ACTIONS – ICB Premises

NENC ICB staff can work from various premises, all of which will be listed in the NENC ICB Business Continuity Plan. In the main, the ICB are tenants in buildings owned by NHS Property Services. In the event an evacuation is required, all local fire procedures for that specific building should be followed.

If an ICB staff member needs to report an issue with a building or initiate an evacuation, then the responsible person for that building ought to be contacted using the contact information in the ICB Business Continuity Plan.

EVENTS THAT MAY REQUIRE EVACUATION AND SHELTER

A structural, power or other utility failure

An explosion or suspect package

Adverse weather e.g. flooding

A fire

A release of irritant fumes or hazardous materials

A terrorist event

IMMEDIATE ACTIONS – Other NHS Premises

- Ensure representation at LRF TCG's and SCG's as required.
- Complete actions associated with the action card for your level of commander (e.g. decision log)
- Make contact with NHS England Regional Team using the contact information in the On-call Pack.
- Link in with ICB Communications Team as per contact information in the On-call Pack
- Ensure discussions at SCG and TCG include consideration of patients who need additional support and any staff with a PEEP (Personal Emergency Evacuation Plan)
- Assist with arrangements for transportation where required. This may be ambulance services but could also include patient transport services, private companies, secure patient transfer or voluntary services.
- Where patents are being transferred to other facilities, check with the receiving trust that arrangements are in place to ensure access to appropriate documentation, registration on systems, prescription, and escorting.
- Support with patient dispersal team (PDT) if required by the evacuating provider to identify available capacity for moves.
- If a community evacuation/shelter situation, link in with LRF partners through LRF TCG and SCG to discuss needs for medical input to rest centres/shelters.

Evacuation and Shelter Checklist

	Points to Consider / Action	Comments
1	Ensure representation at TCG's and SCG's as required	
2	Complete actions associated with the action card for your level of commander (e.g. decision log)	
3	Make contact with NHS England Regional Team using the contact information in the On-call Pack.	
4	Link in with ICB Communications Team as per contact information in the On-call Pack	
5	Ensure discussions with evacuating provider include consideration of patients who need additional support and any staff with a PEEP (Personal Emergency Evacuation Plan)	
6	Assist with arrangements for transportation where required. This may be ambulance services but could also include patient transport services, private companies, secure patient transfer or voluntary services.	Consider discussing with LDTs in terms of PTS providers and private companies used by the ICB. Voluntary services can often be accessed through TCG and SCG meetings set up by the LRF.
7	Where patents are being transferred to other facilities, check with receiving trust that arrangements are in place to ensure access to appropriate documentation, registration on systems, prescription, and escorting.	
8	Support with patient dispersal team (PDT) if required by the evacuating provider to identify available capacity for moves.	
9	If a community evacuation/shelter situation, link in with LRF partners through TCG and SCG to discuss needs for medical input to rest centres/shelters.	

Appendix 13a – Evacuation and Shelter Action Card

1.	Collect information on the incident **M**ajor emergency declared? **E**xact location **T**ype of incident Hazards present and potential **A**ccess/ egress routes **N**umber and type of casualties (if relevant)/ number of staff involved **E**mergency services present and required
2.	Determine the scale of the response – borough, trust, ICB, escalation required
3.	Allocate key incident team roles and distribute role responsibility cards: • Strategic lead • Tactical lead • Communications adviser • Loggists
4.	Identify key communications links for the incident: • Key partners, including voluntary organisations/charities • NHS England (NHSE) • Local authority liaison/Emergency Planning lead • Provider Lead is acute/mental health trust involved
5.	Determine priority in relation to other services – do we need to redeploy resources to ensure a critical service is maintained to the detriment of service levels elsewhere?
6.	Hold initial Incident Management Team (IMT) briefing. Ensure this initial meeting covers: • Situation update for IMT members • Allocation of role responsibility cards and ensure all IMT members are clear on their role/ responsibilities/ next steps • Tactical plan for the ICBs response to the incident • Set battle rhythm for IMT meetings • Staff communications • Anticipated incident duration and initial rota period arrangements • Staff and IMT member welfare
7.	Agree public messaging content and disseminate
8.	Update staff on current situation and any actions required
9.	Maintain IMT meetings battle rhythm to secure shared situational awareness
10.	Maintain NHSE reporting as required
11.	Identify type of evacuation that is taking place i.e., Trust or Residential – Support required from ICB/ICS
12.	Identify the trigger point for incident stand down – what is considered a return to normality
13.	Maintain regular staff communications
14.	Stand down incident
15.	Conduct post- incident debrief

Appendix 14 - Mass Casualty Action Card

NHS North East and North Cumbria

THESE ARE SPECIFIC ACTIONS IN RELATION TO MASS CASUALTY INCIDENTS AND SHOULD BE READ IN CONJUNCTION WITH THE RELEVANT ACTION CARD FOR THE LEVEL OF COMMANDER E.G. TACTICAL/STRATEGIC

RESPONSIBILITIES

To work with NHS England in discharging EPRR functions as Category 1 Responders. To ensure collaboration of planning arrangements across an ICS to deliver a unified response.

Establishing strategic and tactical leadership arrangements and support structures to effectively manage and co-ordinate the NHS response and recovery across the integrated care system.

Representing the NHS at SCG's and TCG's when required and establishing shared situational awareness within the ICS in order to report to NHS England

Providing leadership should mutual aid arrangements be activated to support the response to the mass casualty incident

Ensuring robust escalation procedures are in place through the EPRR command structure in line with the NHS EPRR Framework

Relevant Guidance

- NHS England » Clinical guidelines for major incidents and mass casualty events
- concept-operations-management-mass-casualties.pdf (england.nhs.uk)
- NHS England » Concept of operations for the management of mass casualties: burns annex

Activation of plans/leadership

- Usually the ambulance service will be the first on scene and use a METHANE report as a SITREP to stakeholders including other blue light services, LRFs, ICBs and NHS England. If a receiving hospital receives notification of a mass casualty incident, they should alert their ICB as soon as possible.
- Depending on the scale of the incident (see NHS Incident Levels at 5.4 of Command and Control Framework) it is likely that the ICB will lead on the local supporting response for the NENC system and NHS England will lead with the ambulance service on casualty dispersal

Incidents that may result in activation of mass casualty arrangements

NHS England defines a Mass Casualty incident for the health services as "an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services" ability to manage. Examples include:

- Significant transport accident (such as a train crash, large road traffic collision or air crash)
- Terrorist attack or other major incident scenario

IMMEDIATE RESPONSE

- Contact NHS England to inform them of the incident. They have already been contacted, but ICBs should still alert them.
- The Ambulance Service will usually alert to the areas Major Trauma Centres (MTCs) and other receiving hospitals that are closest to the incident.
- Casualties will be transferred to receiving hospitals based on their proximity to the incident (within 1 hour) and their ability to provide the level of care required.
- Ambulance services will use the casualty dispersal grid and arrangements agreed with and held by NHS England.
- Liaise with NHS England to establish command and control and battle rhythms which may include "capacity calls" with providers and the ambulance service where trusts will identify capacity for the next two hours for P1, P2 and P3 patients (see grid below).
- Lead on discussions in NENC for trusts to create capacity by identifying all medically fit and delayed transfers of care (DTOC) patients; and work to accelerate discharges within the system. This could include the need to spot purchase beds, facilitate additional patient transport or ensure this is freed up.
- Cascade information to relevant service level providers e.g. community providers, mental health providers and GP services.
- Liaise with mental health services and acute trusts re: the provision of ED psychological liaison and support to victims and staff members affected by the incident

ICB Mass Casualty Incident Checklist

Commissioned providers have their own mass casualty plans internally which should specify things like command and control arrangements, internal surge capacity, patient tracking arrangements and so on. Below is a checklist is for use by ICB Commanders in response to mass casualty incidents.

	Points to Consider / Action	Comments
1	Contact NHS England, Acute Trusts, Community Providers, Mental Health Providers, and GP Services to make them aware of the incident. Depending on the kind of incident there is a chance of walking wounded and self-presenters so all NHS services ought to be pre-warned, and asked to collate numbers and details of casualties to be reported to the ICB.	
2	Establish an ICB IMT including as a minimum the relevant on-call commanders, EPRR SME, clinical/nursing/quality support, and communications.	
3	Liaise with NHS England on the required battle rhythm and situation reports (SITREPs) that are required, ensuring attendance at any capacity or SITREP calls. Establish mechanism for reporting into NHS England numbers of self presenters at other non-acute settings. SITREPs should reach all NHS providers at the appropriate level (e.g. for primary care, to either the ICB Primary Care Lead or named PCN leads, to be determined by the incident management team).	
4	Ensure attendance at LRF TCGs and SCGs to represent the NHS in North East and North Cumbria	
5	Commence discussions with acute trusts, community providers, adult social care providers and patient transport services to ensure discharges are accelerated and capacity created for P1, P2 and P3 patients. The aim should be to support a target of 10% bed capacity creation within 4 hours of the incident, and a total of 20% within 12 hours from the time of incident declaration.	Possible actions could include maximising spot purchase beds, arranging for additional patient transport and chairing discharge focussed system calls, cancellation of elective surgery.
6	Liaise with Community Hospitals to request urgent attendance of a consultant or GP to review amber patients to agree those suitable for accelerated discharge.	
7	Liaise with ICB Communications Team to ensure they are linking in with the NHS England Regional Communications Team on proactive communications messages to the public.	
8	Liaise with mental health services and acute trusts re: the provision of ED psychological liaison and support to victims and staff members affected by the incident	

Casualty Dispersal Crib Sheet

NHS England and the Ambulance Service will co-ordinate the dispersal of casualties in accordance with pre-determined grids and plans. This sheet has been designed to assist the ICB commander with familiarisation of the terminology that might be used to describe the casualties, the receiving trusts and speciality services. The NHS England Mass Casualty Dispersal Chart also includes information on centres that have specialist services e.g. burns, maxillofacial etc.

Type of setting	Description of setting	Locations in North East and Yorkshire NENC Specific
Major Trauma Centre (MTC)	Provides life saving treatment 24/7 for trauma patients including those with serious life threatening injuries. Supported by multi-specialist teams including ED consultants, plastic surgeons, intensivists, neurosurgeons and general surgeons.	Hull Royal Infirmary, Leeds General Infirmary (Adults & Paeds, Leeds Teaching Hospitals), Sheffield Teaching Hospitals (Northern General), Royal Victoria Infirmary (The Newcastle upon Tyne Hospitals NHS Foundation Trust), Middlesborough James Cook.
Childrens Major Trauma Centre (CMTC)	As above, for paediatric patients	Sheffield Children's Hospital, Royal Victoria Infimary (The Newcastle upon Tyne Hospitals NHS Foundation Trust)
Trauma Units (TU)	Can take patients for treatment and stablisation before transfer to the nearest and most appropriate major trauma centre for definitive treatment.	Airedale Hospital (Steeton, Airedale NHS FT), Barnsley Hospital, Bradford Royal Infirmary (Bradford Teaching Hospitals), Diana Princess of Wales Hospital Grimsby, Doncaster Royal Infirmary, Harrogate District Hospital, Huddersfield Royal Infirmary (Calderdale and Huddersfield FT), Pinderfields Hospital (Wakefield, Mid Yorkshire Hospitals NHS Trust), Rotherham Hospital, Scarborough General Hospital, Scunthorpe General Hospital, York Hospital, Castle Hill Hospital, Northumbria SECH, Gateshead QE, South Tyneside, Sunderland Royal, University Hospital of North Durham, Darlington Memorial Hospital, North Tees, West Cumberland, Cumberland Infirmary
Local Emergency Hospitals (LEH)	Walk in centres, urgent care centres, minor injury units	Friarage Hospital, Calderdale Royal Hospital A&E (Halifax, Calderdale and Huddersfield FT), Dewsbury & District Hospital A&E (Mid Yorkshire Hospitals NHS Trust), St James Hospital A&E (Leeds Teaching Hospitals) Bassetlaw Hospital, Whitby Hospital (MIU), Malton Hospital (UTC), Bridlington Hospital (UTC),Selby Hospital (MIU), Bransholme UTC, East Riding Community Hospital (Beverley UTC), Goole and District Hospital (UTC), Sheffield Teaching Royal Hallamshire (MIU), North Tees UTC
Burns centres, burns units and burn facilities	Burns centres offer the treatment for the highest level of burns injury, through to burns facilities which offer the lowest level. See NHS England » Concept of operations for the management of mass casualties: burns annex	Burns centres: Royal Victoria Infimary (The Newcastle upon Tyne Hospitals NHS Foundation Trust), Pinderfields Hospital (Adults, Wakefield, Mid Yorkshire Hospitals NHS Trust) Burns Units: Pinderfields Hospital (Paeds, Wakefield, Mid Yorkshire Hospitals NHS Trust), Sheffield Childrens Hospital (Sheffield Childrens Hospital NHS Foundation Trust), Northern General Hospital (Sheffield Teaching Hospitals NHS Foundation Trust), James Cook University Hospital (South Tees Hospital NHS Foundation Trust), Newcastle Freeman (Children's Burns Unit)

Patient Prioritisation

Responding organisations will usually triage patients in mass casualty incident into the following categories

P1 – Immediate priority – requires lifesaving treatment immediately and has time critical life-threatening injuries

P2 – Urgent priority – requires significant intervention as soon as possible. Injured or unwell and are unable to walk

P3 – Delayed priority – requires medical intervention but not with any urgency. Can walk to treatment.

Deceased – Deceased victims must be left until last and remain in situ at the scene until movement is possible.

Appendix 15 – Generic Debrief Template

GENERIC DEBRIEF TEMPLATE

INCIDENT DATE	
OUTLINE	

This debrief template provides the framework for undertaking a structured De-brief and will assist in the development of the post incident report which will cover:

•What was supposed to happen?
•What actually happened?
•Why were there differences?
•What lessons were identified?

Issue	Response
How prepared were we?	
What went well?	
What did not go well?	
What can we do better in the future?	
Is there a need to modify the plan/training?	

Other issues	
Communications	
Equipment	
Human resources	
Planning and briefing	
IT	
Other issues	

Completed by - ……

Role-……

Appendix 16 - Public Health Incidents

General - FAO ICB Tactical (1st On-Call) and Strategic (2nd On-call)

- The System Coordination Centre will be notified of any Public Health Incidents (e.g. M-Pox or Avian Influenza outbreaks). Members of the SCC Team will respond and support the initial phase of the incident. This will include mobilising any clinical intervention (e.g.chemoprophylaxis to prevent disease of infection in a care home) and attending any Outbreak Control Groups (OCGs).
- Once alerted, the SCC Team will also liaise with the appropriate 'Local Delivery Team' to ensure representation at future OCGs and where, necessary join any local Incident Management Team as well as consider any secondary impacts, both short and long term, on commissioning priorities and service delivery. If the incident takes place during the out of hours period, it will be necessary for the On Call Director to attend.
- It may be also necessary to enact business continuity arrangements as appropriate to the developing situation to ensure critical activities can be maintained, and where necessary to enable staff to work flexibly and balance the need to deliver key outputs, minimise staff illness and recognise family pressures, especially important during any long-term outbreaks or epidemics/pandemics.
- Where it is likely that the incident will be of a significant duration, also consider how ICB Tactical (1st) and Strategic (2nd) on Call rota is maintained to ensure BAU is covered.
- It is also important to ensure the early engagement of the ICB Communication Team to devise, deliver and maintain internal, external, and stakeholder/cross-partnership communications before, during and after an epidemic/pandemic or outbreak.
- For incidents which affect a large proportion of the ICS, an ICB Incident Management Team will be established to:
    - Plan for staff absence in line with likely outbreak impact and existing HR policy.
    - Consider the criteria to be met that might lead to the redeployment of staff either internally or to other parts of the system, ensuring that any redeployment of staff to a clinical role is signed off by appropriate senior management.
    - Make allowance for the likely burden of disease arising directly from the pandemic/outbreak and because of any changes to NHS priorities.
    - Consider the value of collaboration when commissioning services where there are similar health priorities.
    - Review the emerging trends referencing changes to the individual health behaviours of the population and consider the impacts on service requirements and delivery.
    - Determine at regular intervals the ability to access general health and social care services during the pandemic/outbreak.
    - Capture the learning from any changes in service access and provision to determine if they should remain in place post pandemic/outbreak.
    - Review regularly changes to service provision and delivery, determined nationally and/or locally, to understand the impact on commissioning intentions and budgets

Appendix 17 - Links to Other Plans

Please note that this plan links to the following ICB plans and policies

ICB EPRR Policy
ICB Business Continuity Policy
ICB On Call framework
ICB Business Continuity Plan

Plans owned by other organisations can be found via the On-call SharePoint Portal: NENC ICB On-Call - Home