Worcestershire Health and Care NHS
NHS Trust

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INCIDENT PLAN

Version	2.3
Document Effective Date	01.05.2019
Ratified By	Quality and Safety Committee September 16
Amendments issued	Will be recorded in the Amendments and Review record
Author	Emergency Planning Manager
Accountable Emergency Officer / Document Owner	Chief Operating Officer
Signature	
Date for Review	May 2020
Intended Audience	WHCT staff
Related Documents	Business Continuity Plans WHCT Internal Capacity Management Plans Control Room Handbook

DOCUMENT MANAGEMENT and VERSION CONTROL

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The Emergency Planning Manager will ensure that this plan is regularly updated, tested and disseminated.

ii. Version control

This document is the second version of the Worcestershire Health & Care NHS Trust (WHCT) Incident Plan.

iii. Ownership and authorisation

The plan is owned by the Trust's Executive Management Team and is a working document. The Emergency Planning Manager has co-ordinated the production of this plan, under the authorisation of the Director of Operations.

In developing the plan, the Trust has worked with and incorporated comments and recommendations from a wide range of partners. This includes, amongst others, staff, the Clinical Commissioning Groups, other NHS and Local Resilience Forum partners, the NHS Local Area Team (AT), and Public Health England. In preparing for emergencies the Trust works with all responding organisations as defined under the Civil Contingencies Act 2004, and a number of other local and regional partners.

iv. Publication and distribution

This plan will be kept in hard copy in the Incident Control Room at IMH, cupboard 2. It will also be available in the electronic on-call folder which can be accessed by all levels of On-Call Manager

M:\HACW\ServiceDelivery\OnCall

An abridged latest version will be published on the Trust's EPRR intranet pages and on the Trust's Website.

v. Audience

This plan is aimed at Trust staff with a role to play in an incident, and professional partners.

vi. Review

As a minimum requirement, this plan will be reviewed annually from the date of publication and following any exercises in which the plan is used, or where legislative or organisational changes occur.

Those with a role to play in the plan will be notified of amendments immediately and they will be recorded on the amendment record below. The Emergency Planning Manager will retain a record of amendments.

vii. Amendment Record

The Amendment Record can be found on page 4.

viii. Responsibilities of those with a role to play in the plan

Plan holders are required to:

- Familiarise themselves with the contents of this Plan;
- Ensure they are accessing the most up to date version of the plan when on call
- Ensure its safe custody if they chose to print a hard copy

viii. Other Plans and Guidance

This plan supersedes the Trusts Major Incident Plan. The plethora of guidance and plans available in the On Call folder should be utilised and referred to when activating this plan.

ix. Testing and exercises

Appropriate training will be carried out for those that require it to carry out their role in an Incident. Testing and exercising will be carried out in order to test and validate this plan in line with NHS England EPRR Standards and the Civil Contingencies Act 2004 requirements.

AMENDMENT RECORD

Version	Issued	Change	Date inserted	By
Draft v2.0	May 16	Issued for consultation to L3 and SDU leads. Consultation feedback with suggested amendments received and inserted throughout document	June 16	RDL
Draft 2.2	Sept 16	Various changes following training session prior to validation	Sept 16	RDL
Final 2.0	November 16	New Plan in place and replaced old plan following training and validation by exercise 05.10.2016	November 16	RDL
2.1	May 17	Light review of document following 6 months in place	May 17	RDL
2.2	May 18	Annual Review of document and inclusion of Psychosocial Support on page 19	May 18	RDL
2.3	May 2019	Removal of IMH and replace with Kings Court 2 for Control Room , light touch annual review	May 19	RDL

PART 1 – GENERAL INFORMATION

1.1 AIM

The aim of this plan is to provide those who have a role to play in any response to an incident for Worcestershire Health and Care NHS Trust (the Trust) with the necessary information they require to carry out an effective response.

1.2 OBJECTIVES

The objectives of this plan are to:

- Define the types of emergencies/incidents which the Trust will be expected to declare/ respond to;
- Detail the Trust's roles and responsibilities during an incident and establish a framework within which these can be fulfilled;
- Define the various levels of command, control and co-ordination arrangements in use both internally and in a multi-agency context;
- Identify the specific roles within the organisation which are required to take action under this plan;
- Set out clear actions for those with a role to play in the plan;
- Link to any Trust plans produced to meet specific risks e.g. Staff Mobilisation Plan, Standard Operating Procedures (SOPs)
- Identify the arrangements for communicating information to staff, patients and stakeholders both prior to, during and after an incident;
- Set out the process for recovery and debrief following an incident.

1.3 PURPOSE

This plan is produced to ensure the Trust meets it fulfils its legal and contractual responsibilities under the following:

- The Civil Contingencies Act 2004 (CCA 2004)
- The Health and Social Care Act 2012 (46 (9, 10)
- The NHS England Core Standards for EPRR
- NHS England guidance; Health Emergency Preparedness, Resilience and Response
- NHS England NHS Standard Contract, service condition 30.

1.4 SCOPE

This plan is a **Generic Incident Response Plan** and is written to allow those with a role to fulfil it no matter what the incident being faced is. It is not produced to address individual risks

Other plans have been produced for specific risks, these include:

- corporate Business Continuity Plan and associated service area recovery plans;
- LHE strategic Escalation Management Plan and WHCT internal Capacity Management Plan;

- Heatwave Plan & Cold Weather Plan
- Staff Mobilisation Plan

1.5 DECISION MAKING

Decision making during an incident, is often complex, extremely stressful and can lead to reluctance to actually make a decision. It is imperative to understand that although decisions are open to challenge, decision makers will be supported in all instances where they can demonstrate that their decisions were assessed and managed reasonably in the circumstances existing at a particular point in time. **Any decision made must be recorded in a log book.**

JOINT DECISION MODEL

The Joint Decision Model (JDM) has been developed under the Joint Emergency Services Programme. Although initially designed for use by the Emergency Services it is now seen as the ideal/best practice method to practically support decision makers working under difficult

circumstances. Decision makers will need to use their judgment and experience in deciding what additional questions to ask and considerations to take into account to reach a decision.

Gather Information & Intelligence	What is happening, What are the impacts? What are the risks? What might happen? What is being done about it?
Assess Risks and Develop a Working Strategy	Conduct dynamic and considered risk assessments, establish a risk priority, and agree risk priorities to inform working strategy.
Consider Powers, Policies and Procedures	What relevant Trust and NHS Policies & Procedures apply? How do these influence decisions?
Options and Contingencies	**Suitability** – does it fit with strategic direction? **Feasibility** – in resource terms, can it be done? **Acceptability** – is it legal, morally defensible and justifiable?
Take Action and Review	Build situation awareness, setting direction, evaluate options, feedback in to continuous loop, which in turn shapes direction and risk assessment

1.6 TYPES OF INCIDENT

The CCA 2004 defines an emergency as:

> ***An event or a situation which threatens serious damage to:***
> - ***human welfare in a place in the UK,***
> - ***the environment of a place in the UK, or***
> - ***war or terrorism which threatens serious damage to the security of the UK.***

The definition is concerned with consequences rather than the cause or source.

For the purposes of this definition, an event or situation threatens damage to human welfare only if it involves causes or may cause:

- Loss of life;
- Human illness or injury;
- Homelessness;
- Damage to property;
- Disruption of a supply of money, food, water, energy or fuel;
- Disruption of a system of communication;
- Disruption of facilities for transport; or
- Disruption of services relating to health.

NHS INCIDENTS[1]

For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

Each of these will **impact upon service delivery** within the NHS, **may undermine public confidence** and **require contingency plans to be implemented**. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

Business Continuity Incident
A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisations normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. **An example for the Trust is loss of telecoms that requires a workaround to be implemented until a permanent fix can be made.**

[1] NHS England EPRR framework 2015

Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies to restore normal operating functions. **An example for the Trust is a Severe Weather Incident that requires activation of the 4x4 protocol to allow staff to carry out their required duties in the community.**

Major Incident

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. **For the NHS/Trust this will include any event defined as an emergency e.g. a terrorist incident or large scale severe weather event such as wide scale severe flooding.**

A major incident may arise in a variety of ways and the Trust's response will be sufficiently flexible to assess and respond appropriately to any of these situations.

	Examples
Business continuity/internal incidents	Anything that affects the Trusts ability to be able to provide normal service e.g. Fire, breakdown/failure of utilities, significant equipment failure, hospital acquired infections,
Big Bang	A sudden incident, such as a major road traffic incident, explosion or series of smaller incidents
Rising Tide	A developing infectious disease epidemic, or capacity/staffing crisis or forecast of severe weather
Cloud on the Horizon	A serious threat such as a major chemical or nuclear release developing elsewhere, needing preparatory actions
Headline News	Public or media alarm about a perceived threat
Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE)	CBRNE is the actual or threatened dispersal of CBRN material (either on their own or in a combination with each other or with explosives), with deliberate criminal, malicious or murderous intent
Hazardous Materials (HAZMAT)	Accidental incident involving hazardous materials
Cyber Attacks	Attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality
Mass Casualties	Casualty numbers that are beyond the capacity created by the local implementation of major incident plans – or other major disruptive challenges to the delivery of health care, regardless of their cause

1.7 INCIDENT LEVELS

As an event evolves it may be described in terms of its level as shown. **NHS England EPRR Framework 2015 states these levels must be used by all organisations across the NHS when referring to incidents.**

Incident Level	
Level 1	**An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners (CCG's / NHS England)**
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS Coordination by the local commissioner(s) in liaison with the NHS England local office
Level 3	**An incident that requires the response of a number of health organisations across geographical areas within a NHS England region.** **NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level**
Level 4	**An incident that requires NHS England National Command and Control to support the NHS response.** **NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.**

N:B The Incident levels as defined above have no direct correlation with the hospital EMS levels however capacity is a key consideration during all Incidents.

1.8 STANDARD OPERATING PROCEDURES

This plan has been written to be a light touch plan with the essential action cards, command and control arrangements, triggers and activation algorithms. A number of essential standard operating procedures have been prepared to support this plan. These are held in the electronic on-call folder, and in the Incident Control Room, cupboard 2.

1.9 ACCOUNTABLE EMERGENCY OFFICER

As required under the NHS England contract the Trust has identified an Accountable Emergency Officer. The Director of Operations has been identified as the person to fulfil this role.

1.10 ROLES AND RESPONSIBILITIES OF THE TRUST

In addition to the statutory responsibilities contained in the CCA 2004, the *NHS England NHS Standard Contract and the NHS England EPRR Core Standards* outline the expectations placed on the Trust:

General

- Nominate an Accountable Emergency Officer;
- Contribute to area planning for EPRR through local health resilience partnerships (LHRP) and other relevant groups

EPRR

- Have suitable, up to date plans which set out how we will plan for, respond to and recover from major incidents and emergencies as identified in local and community risk registers;
- Test these plans and have suitably trained, competent staff and the right facilities available 24/7 to effectively manage a major incident or emergency;
- Share resources as required to manage a major incident or emergency;
- Have a clear route of escalation to commissioners in the event that plans are activated;
- Take into account the needs of vulnerable adults and children;
- Assist acute and ambulance trusts during and after an incident (with specific reference to supporting discharges from hospitals);
- Have plans for lockdown, evacuation and managing relatives;
- Co-ordinate and provide mental health support to staff, patients and relatives in collaboration with Social Services;
- Support local acute trusts by managing physically unwell mental health inpatients if there is an infectious disease outbreak; and
- Make sure the need of mental health service users involved in an incident are met and that they are discharged home with specific support.

Service resilience planning

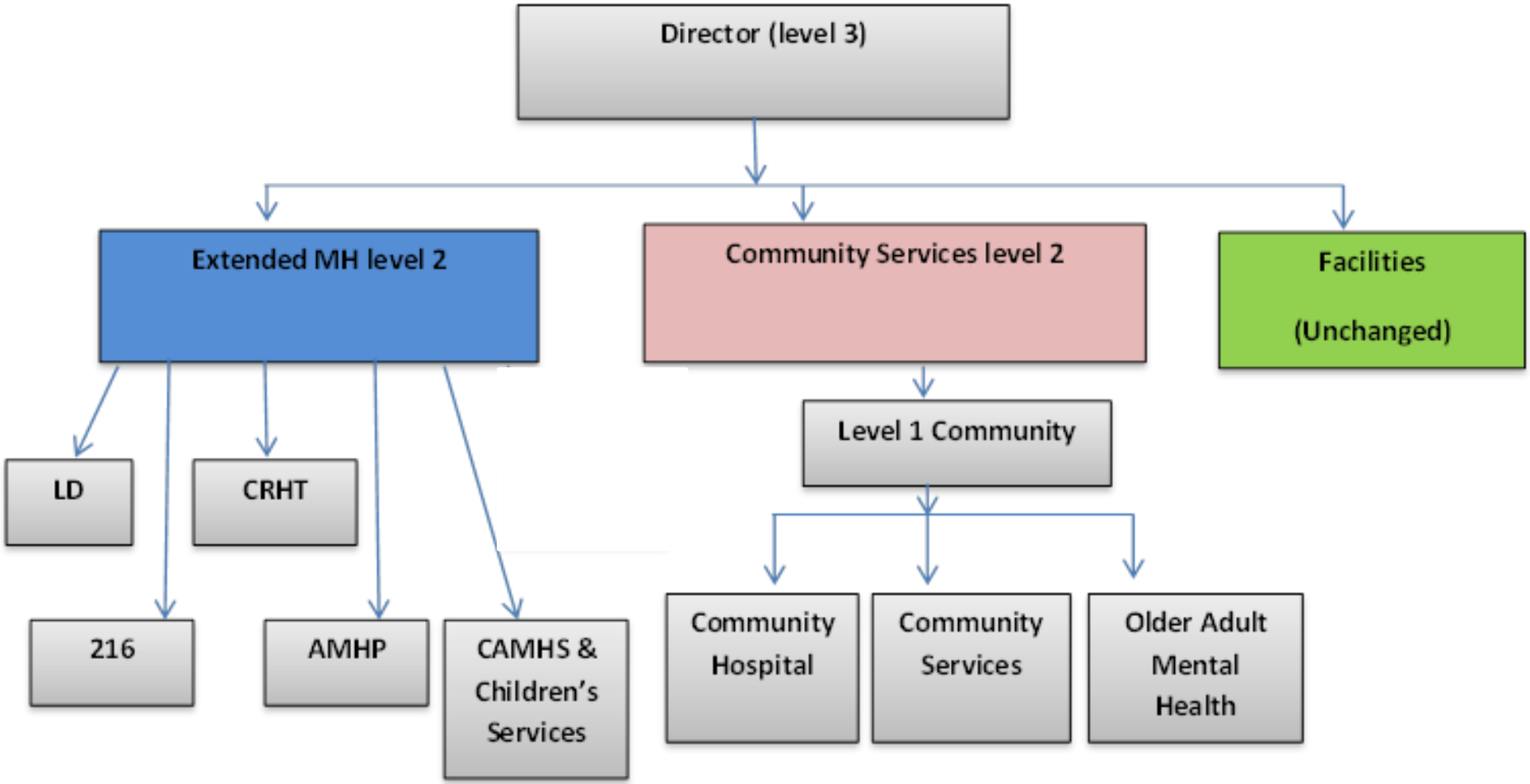
- Have suitable, up to date plans in line with international standards which set out how we will maintain continuous service when faced with a disruption from identified local risks; and
- Resume key services which have been disrupted.

In terms of a health protection incident, the Trust may be mobilised by NHS England, Public Health England or the Clinical Commissioning Groups to provide support which might include:

- Providing support with the mass distribution of counter-measures, for example, vaccinations and antibiotics, working with local authorities;
- Administration of medications, prophylactics, vaccines and counter-measures;
- Providing support and advice to the local community on health aspects of an incident;
- Screening, epidemiology and long term assessment and management of the effects of an incident;
- Assessment of the medium term impact on the community and priorities for the restoration of normality, and the need for long term monitoring;
- Providing specialist advice by Trust staff, including Estates & Facilities to other parts of the health sector.

The Trust's Staff Mobilisation plan will assist in fulfilling this requirement.

1.11 TRUST ON-CALL STRUCTURE



1.12 ON-CALL ARRANGEMENTS

The Trust ensures continuity of access to management advice and support outside of normal operating hours through its on-call system. Each of these roles has fully detailed Operational guidance for those who are participating in the on call arrangements. These can be found in M:\HACW\ServiceDelivery\OnCall.

Community Manager on-call – Level 1:
Will deal with issues in the community hospitals and community services. Where the incident cannot be dealt with, they will escalate this through the Senior Manager on-call.

Senior Manager on-call – Level 2: (Community and Mental Health)
The Senior Manager (Community and Mental Health) on-call is also the single point of contact for the local NHS for the Emergency Services during a major incident situation.

The Senior Manager on-call will also:

- Set-up the Trust's Major Incident Control Room when requested to do so by the Executive on-call.
- Support the Executive on-call when activating the communications cascade.

Executive on-call – Level 3:
Will offer advice, guidance and management support to the senior managers on the Level 2 Community rota and the Level 2 Mental Health rota. **During an incident Level 3 on–call will perform the role of Incident Director. Dependent on the type of incident they will be referred to as Business Continuity Incident Director, Critical Incident Director or Major Incident Director.**

Level 1	**Operational response**
Level 2	**Tactical Level response**
Level 3	**Strategic Level response**

PART 2 – MANAGEMENT, CONTROL & CO-ORDINATION

2.1 INCIDENT MANAGEMENT ARRANGEMENTS

The Trust's response will be managed and led by the L3 on-call; they will potentially convene a **Business Continuity, Critical or Major Incident Management Team. This team will be made up from:**

- Executive Directors,
- Service Delivery Unit Leads
- Senior Managers

The Incident Director may also co-opt 'specialists' from within the organisation, such as HR, Finance, IT, Emergency Planning and Estates and Facilities to provide advice on specific aspects.

Role of Directors and Managers

All senior managers should as far as possible seek to:

- Release staff from their normal function or call in staff to resource the response to the incident;
- Consider future input should the incident last beyond a few hours (e.g. rest periods and rotation of staff);
- Provide a triaged list of critical services dependent on the incident to the Incident management Team
- Deliver the Trust's critical services in accordance with the Trust Business Continuity Plan and service area recovery plans;
- Consider vulnerable communities and premises that are or may be directly affected by the incident.

2.2 NHS MULTI AGENCY INCIDENT MANAGEMENT

The local NHS will be represented at multi-agency command and control meetings by NHS England at an appropriate level.

Meeting	NHS representation	Suggested attendance
Strategic Co-ordinating Group SCG (multi-agency Gold)	Locality Team Director on-call	Executive on-call (with Loggist)
Tactical Coordinating Group TCG (multi-agency Silver)	CCG on-call	Senior Manager on-call (with Loggist)
Incident Control Point/Forward Control Point (Bronze)		Depending upon circumstances – Service Delivery Unit Leads/team leaders

2.3 SITUATIONAL AWARENESS & BATTLE RYTHM

For any incident there will be a requirement to ensure the incident management team has the most current situational awareness to work from. This will apply to both multi agency and single agency

incidents. The most appropriate method for teams / SDU's to record their position and what impacts they are seeing on their services is through a Situation Reports (SITREPs). For larger incidents the Trust will instigate a reporting structure for all affected parties to report at set time periods throughout the incident. There will also be a requirement of the Trust to ensure the Commissioners and NHS England are aware and have the details required. They may have a different template and reporting structure to the one the Trust sets internally in order to meet the requirements of Department of Health and Ministers. These reporting structures are called the incident 'Battle Rhythm'

METHANE

The Joint Emergency Services Interoperability Programme (JESIP) has developed an agreed format by which the three Emergency Services will share information at the scene back to control rooms during an incident. This goes by the mnemonic **METHANE:**

Major Incident Declared
Exact Location
Type of Incident
Hazards present or suspected
Access routes that are safe to use
Number type and severity of casualties
Emergency services present or required

Although this is used predominantly by the Emergency Services it is becoming the best practice example to be used by responding agencies during any multi agency incident.

Situation, Background, Assessment, Recommendation (SBAR)

NHS England suggests any organisation declaring a critical incident should adopt the following format; "Critical Incident declared by (organisation)".

	SBAR report
Situation	describe situation/incident that has occurred
Background	explain history and impact of incident on services/patient safety
Assessment	Confirm your understanding of the issues involved
Recommendation	Explain what you need, clarify expectations and what you would like to happen

SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety" (NHS Institute for Innovation and Improvement)

2.4 INCIDENT CONTROL ROOM (ICR)

The Trust has designated **conference rooms 1&2** at Trust HQ, 2 Kings Court, as its Incident Control Room. Initially the response to any incident is likely to be co-ordinated from the Emergency Planning Manager's office or any other office whilst the scale of the incident is being investigated.
24/7 access procedures, specific action cards and set up arrangements are detailed in the Incident Control Room Handbook

PURPOSE OF THE INCIDENT CONTROL ROOM

NHS England EPRR Framework 2015 states; The Incident Control Room supports the Incident Management Team to provide an enhanced level of operational support. It is widely recognised that the efficiency and effectiveness of an Incident Control Room is greatly improved through the utilisation of a formal structure. Benefits include:

- **Unity of effort –** all team members operate under a common list of objectives
- **Accountability –** each individual has a specific role for which they are responsible
- **Eliminates redundancy –** clearly established division of labour eliminates duplication of effort.

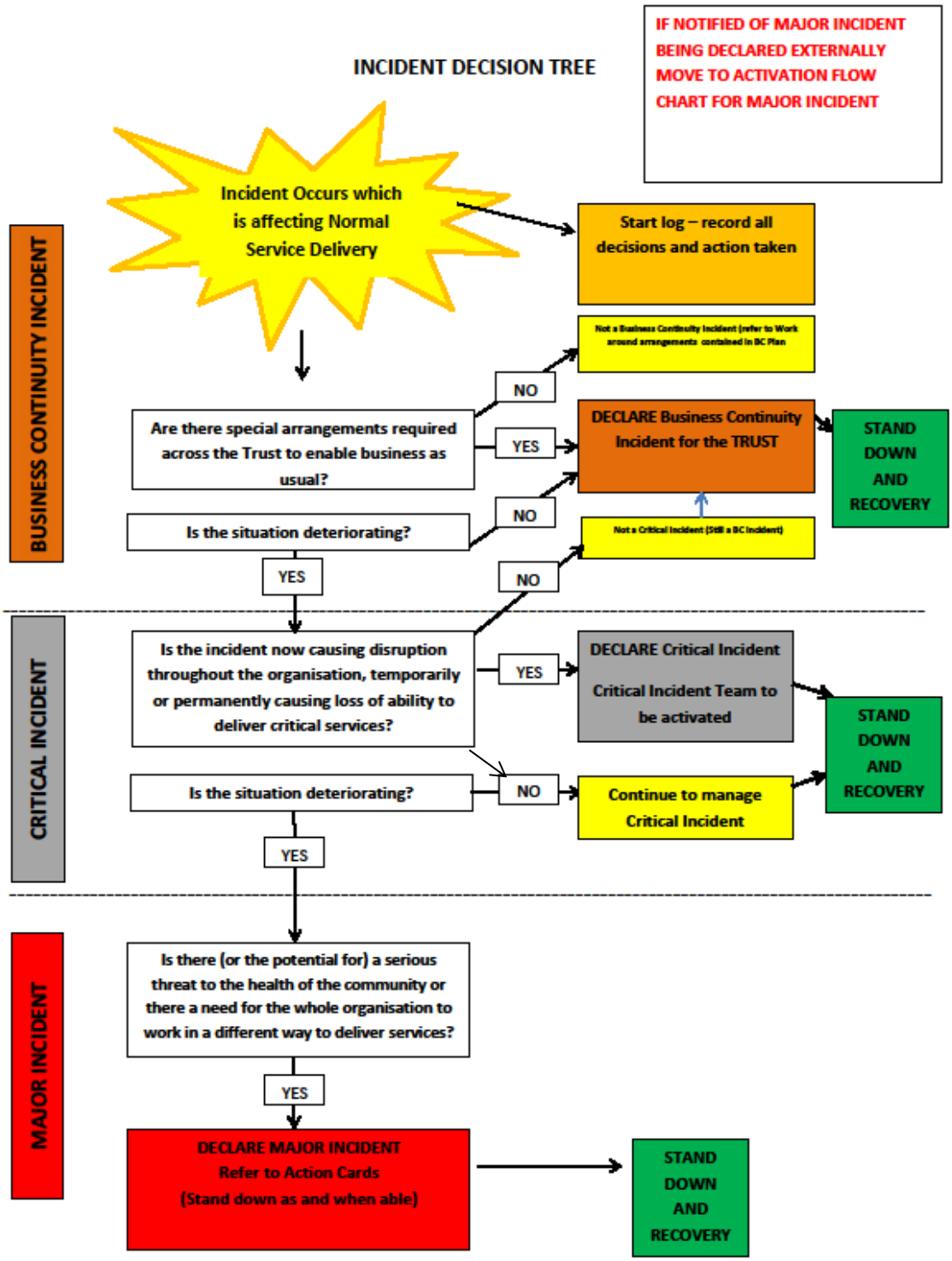
The purpose and functions of the Incident Control room and the staff working in it is also to:

- **Ensure the Incident is given the necessary 'gravitas' within the Trust**
- **Assessing the impacts on the Trust and what is required to maintain business critical services / functions**
- Provide a central focal point for the incident ensuring people are away from the 'day job'
- Helps to formalise the response by providing a Command and Control structure
- Ensures the right people are brought into the same room to manage the incident
- Is a central collection point for collating and collecting information
- Assess the likely impact to the community by working with other health and social care providers, to identify those most at risk during the emergency
- Transmits information and compiles Situational Awareness
- Implements decisions and defines and assigns specific tasks
- Records information and decisions

PART 3 – ACTIVATION & ACTION

3.1 INCIDENT DECISION TREE

This plan is a generic incident plan that can be triggered for use in any type of incident the Trust may face. The below Incident Decision Tree should be reviewed and used when deciding what type of incident is occurring and what type of response is required. A large version of this is in the control room cupboard.



3.2 TRIGGERS FOR ACTIVATION

The following may also be a cause for the Incident Plan to be activated at the appropriate level to either a potential or actual incident:

- In response to internal pressure within the NHS (an **internal** decision) in response to a local incident;
- **External** alert that a multi-agency Tactical Co-ordinating Group is being convened;
- **External** alert that a Strategic Co-ordinating Group is being convened;
- **External** alert that a major incident has been "Declared"/"Implemented"; and
- **External** In response to a national or regional NHS England direction.

3.3 ACTIVATION

Any staff member can request activation of this plan. The L2 Senior Manager on-call will be the initial contact point from external partners wishing to alert the Trust to an incident (as per normal operating procedures). They will also be the contact for any incidents requiring escalation internally from the L1 on-call officers (see Flow chart on next page).

L2 Senior Manager on-call will review the information they are being given and relate it to the Incident Decision Tree above to ensure the appropriate level response is given. Before escalation to L3 on–call they will consider and dynamically assess the following points to ensure the L3 Executive on-call has the necessary information to make the strategic decisions required:

- What category they perceive the incident to be (refer to page 6);
- the impact of the incident on the Trust;
- the Trust's ability to be able to deliver its critical services / activities in line with the arrangements set out in the Business Continuity Plan;
- any assistance being requested by NHS England and partner organisations;
- the extent to which resources will need to be deployed to deal effectively with the incident.

Executive on-call should also consider liaising with the following:

- CCG on-call
- Acute Hospitals (Director/Senior Manager on-call);
- Emergency Planning Manager;
- Public Health England if there are implications for public health/health protection;
- West Midlands Ambulance Service;
- West Mercia Police Force's Duty Inspector to convene a TCG (multi agency) meeting to ascertain nature, information & current state of preparedness.
- Internal Communications Team to ensure an appropriate holding message for the public is in place

PART 4 – STAND-DOWN & RECOVERY

4.1 DE-ESCALATION

It is vital that the Incident Management Team who is managing the incident should constantly be assessing and reviewing the situation using the Decision Making cycle (pg6) to determine when the most appropriate time to de-escalate the incident is. Once the situation is in a position to be de-escalated then messages need to be issued to all involved including commissioners and NHS England (if Major Incident) is aware the situation is descending and under control. This should be a constant review process and when the incident is over return to normality should occur.

4.2 RETURNING TO NORMALITY

Recovery must begin as the incident starts and runs alongside the response; the response should inform the recovery and form the basis for the recovery process. The transition from response to recovery will be carefully managed and may be staged depending on the size, location and type of incident.

In a multi-agency incident once the response phase has been completed, the responsibility for co-ordinating the recovery phase usually (but not always) moves from the police to the local authority. The Trust will need to liaise closely with local authorities during recovery to ensure health stakeholders are actively engaged as the focus of activity changes.

It should be recognised that recovery may last for a period of days, weeks, months, years or even longer. This circumstance may directly impact on the Trust's resources, including staff welfare, service provision and the relationship between the Trust and its community. Recovery should not be considered in isolation; it is an integral part of the response process and is also part of the business continuity planning process.

The Trust may be required to provide health related functions during recovery to support the affected community or other organisations involved in recovery activities, which may include (but may not be limited to) some or all of the following:

- mid to long-term community support and medical supplies;
- long-term case management with primary care providers;
- public health advice services for agencies dealing with the long-term effects of the incident (e.g. epidemiological follow-up);
- community mental health services and counselling services for casualties, relatives, staff and responding agencies;
- loan stores services for casualties requiring healthcare aids;
- establishing additional staff resources from within current staff resources, or externally through mutual aid to support patient care delivery and the health care of the community; and
- ensuring health service providers are able to provide services with minimum interruptions through the activation of business continuity plans.

4.3 INTERNAL RECOVERY ARRANGEMENTS

Following any incident, a number of organisational recovery activities may need to be undertaken, which might include:

- identifying appropriate support mechanisms which can be made available to staff and their families, recognising that staff may be affected directly by the incident through death, illness, disability or stress;
- staffing and resources to address the new environment;
- physical reconstruction of facilities;
- reviewing key priorities for service provision and restoration in line with the Trust's corporate Business Continuity Plan and associated service area recovery plans;
- financial implications, remunerations and commissioning agreements;
- the on-going needs for assistance from and to NHS partners and other agencies;
- equipment and restocking of supplies.

4.4 PSYCHOSOCIAL SUPPORT

As a provider of Mental Health Services the Trust is required to ensure that they are able to deliver adequate Mental Health liaison resources to responding care settings (Acute Trust) if requested. Discharge areas will need to be supported with suitable staff to give advice on where to seek treatment and support and the issuing of the Post Incident Leaflet which will help define the access routes to further post incident Mental Health Services. These services are more likely to be required following a mass casualty type incident with associated trauma such as a terrorist type attack. The Trusts Mental Health service through the SDU or Deputy SDU lead will need to be involved at any incident management team established during an incident at the earliest opportunity. Discussions with the commissioners of the services will also need to start at the earliest opportunity to ensure commissioners are involved in any strategic decisions that will be required around continuing service delivery and the scaling back of any services to meet the new requirements for the incident.

4.5 STAND-DOWN PROCEDURES

The Incident Management Team will decide on the scale down and stand down of the response phase of the Trust's response, and ensure that all staff and responding agencies are informed.

Before the Incident Management Team is stood down, the following actions will be undertaken:

- All logs are completed and passed to the Incident Director.
- A cascade of stand down messages to all staff and external organisations.
- Acknowledgement of staff roles.
- Identify the member of the team who will provide a "hot debrief" to those staff with immediate involvement in the incident

4.6 DEBRIEFING

There will be a formal staff debrief following all major incidents (SOP 4 refers). This will be co-ordinated by the Emergency Planning Manager and will include:

- Timeline of events.
- Mobilisation of procedures for personnel and equipment.
- Implementation of plans and procedures.
- Management and co-ordination of the response.
- Management and co-ordination of business continuity plans.
- Internal and external communications.
- Stakeholder perception/reaction.
- Short, medium and long term consequences of the incident.

The process will culminate in a post-incident report being prepared for consolidation in the NHS report to be forwarded to the Trust Board, Commissioners and other interested organisations.