

## ***RESPONDING TO MAJOR INCIDENTS***

# **Operational Guide for Staff During and Immediately After an Incident**



**Version: V 1.2**  
**Date: 2<sup>nd</sup> July 2007**

This document will be publicly available, however the accompanying Appendices (including Resource Packs) will not be publicly available as they contain personal contact details.

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## **1. FOREWORD, INTRODUCTION AND CONTEXT**

We live in a world where we now have to expect the unexpected and be prepared for the unthinkable. It is our responsibility to make sure we respond to incidents, which cannot be dealt with as part of the normal, day-to-day activity, regardless of the nature or scale of the event (and including potential incidents, actual incidents or threats).

However, incidents can take a range of forms, requiring different responses depending on the nature and scale of the event. The purpose of this plan is to enable Eastern and North Birmingham PCTs to respond to, or prevent an occurrence escalating into a major incident, and to recover quickly from that incident. Its objectives are to:

- Enable the PCT to respond in a planned and co-ordinated manner, to effectively manage and support health service providers involved in a major incident of any scale in a way that:
  - delivers optimum care and assistance to the victims,
  - minimizes the consequential disruption to healthcare services and
  - brings about a speedy return to normal levels of functioning;
- Provide guidance for staff in the assessment and management of incidents, regardless of their nature.
- Integrate and operate with the emergency plans of other Trusts, emergency services, other responding agencies and provide an integrated approach that will enhance the response to an incident by working as part of a multi-agency response across organisational boundaries.

The planning principles this plan are based on are contained with a separate document – “Emergency Planning: Principles and Structures”.

As the Chief Executive, I take ultimate responsibility for emergency planning; risk assessment and business continuity for the PCT. However, it is everyone's responsibility to actively make sure that they know what to do and help improve what we do.

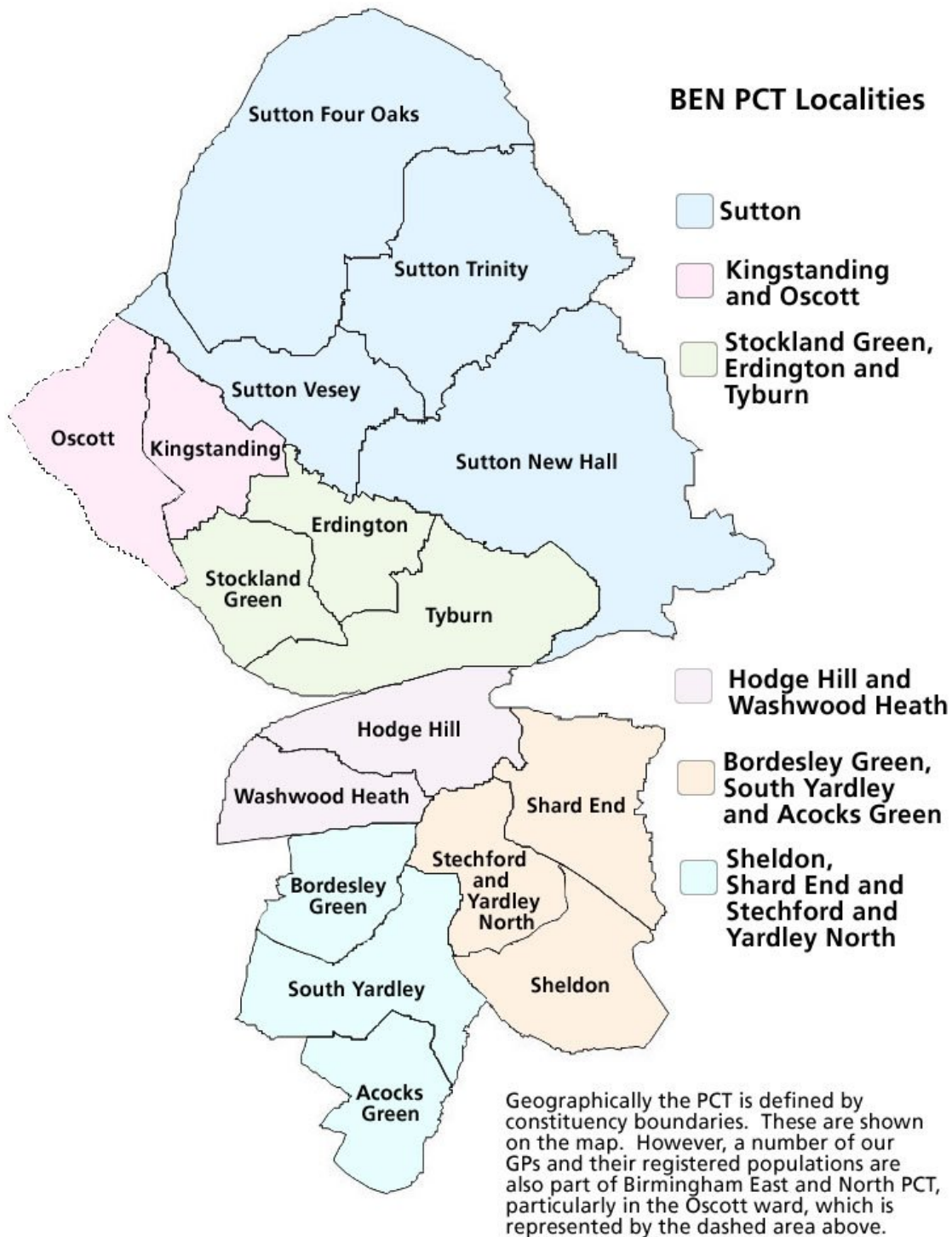
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**Sophia Christie**  
**Chief Executive**

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**Date:**

## 2. GEOGRAPHICAL AREA COVERED



A Map marking up health centres, GP surgeries, Acute Hospitals, Community Hospitals, dentists, pharmacists, and opticians is contained within each Major Incident Room.

### 3. WHAT'S A MAJOR INCIDENT

#### 3.1. HOW IS A MAJOR INCIDENT DEFINED?

The NHS will usually use the word “*major incident*”, however, the Civil Contingencies Act (and its partners such as police, fire, City Council) also use the word “*emergency*”. For both, the reference is to:

**Actual:**

**“any event whose impact cannot be handled within routine service arrangements and requires the implementation of special procedures by one or more of the emergency services, the NHS, or a Local Authority to respond to it.”**

**Possible:**

**“Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organizations.”**

Threats can include: **“An event or situation which threatens serious damage to human welfare/ environment/security (including war or terrorism)”**

**Beyond a Major Incident** is defined as:

**“Incidents that threaten severe disruption to health and social care and exceed the collective local capability available in the NHS”.**

Individual NHS organizations can self-declare a major incident when their own facilities and/or resources, or those of its neighbours are overwhelmed. What is a major incident to the NHS may not be a major incident for other local agencies.

#### 3.2. IS IT A MAJOR INCIDENT? (Examples)

It is impossible to predict every incident or possible scenario, however, they can be categorized as:

	Example	Who Will Tell PCT?
<b>ACTUAL INCIDENTS:</b>		
<b>BIG BANG:</b> A sudden major transport accident or an industrial accident such as an explosion classically triggers a health service major incident.	Train crashes Car accidents Explosions	Ambulance service
<b>INTERNAL INCIDENTS:</b> The Trust itself maybe affected by its own internal major incident or by an external incident that inhibits its ability to work	Fire, flood, breakdown of utilities (water, sewerage, gas, electrical,	Own staff

normally.	telecommunications), major equipment failure, hospital-acquired infection or violent crime	
<b>CHEMICAL, BIOLOGICAL, RADIOLOGICAL OR NUCLEAR TERRORISM:</b> This is different to a “big bang” event because it may not be clear immediately what the effects are, or what type of incident has occurred. Ongoing monitoring will be required, and preventative measures (such as vaccination) may be required.	Smallpox  Train crash (carrying radioactive material)	Health Protection Agency
<b>SYSTEMATIC ERRORS AT LOCAL PROVIDER:</b> Such incidents will require support for patients affected by the error, and increased level of services to deal with both rectification and queries, including public concern/fear.	An example may be a laboratory error over smear tests.  Missing patient attacks public  Rogue worker	
<b>POTENTIAL INCIDENTS/KNOCK-ON EFFECT:</b>		
<b>RISING TIDE:</b> This type of incident has no clear starting point as the problem creeps up gradually.	Developing infectious disease outbreak (eg D&V) Winter bed availability crisis. Flu	PCT will have to find out – messages from own staff
<b>A CLOUD ON THE HORIZON:</b> An incident in one place may affect others following the incident. Preparatory action could be taken in response to an evolving threat elsewhere.	Transport problem Fuel shortage Closure of schools	PCT will have to find out – messages from own staff
<b>COINCIDING PRESSURE:</b> Single problems can sometimes be dealt with without the need for an exceptional response, however two or more problems coinciding can cause significant problems.	An example may be fuel shortages combined with severe staff shortages due to sickness.	PCT will have to find out – messages from own staff
<b>THREAT - REAL OR PERCEIVED:</b> Increasing concern over terrorist action and actual threats can lead to problems for health services eg temporary loss of facilities due to bomb threat, increased number of “worried well” seeking health advice.		Police / Security Press Service
<b>EFFECT OF EXTERNAL INCIDENTS:</b> An incident elsewhere can lead to knock-on effects for health services	Large-scale demonstration causing traffic congestion/ diversions thus affecting ability of community staff to get to their patients; or help may be required to support health services in other parts of the city during an incident in their area). Water contamination	
<b>HEADLINE NEWS:</b> A wave of public or media alarm over a health issue as a reaction to a perceived threat may create a major incident for health services even if the fears prove unfounded. It is the urgent need to manage information that creates the major incident.	Bird flu  Infected worker	Media contacts

### **3.3. HOW BIG IS A MAJOR INCIDENT? – LEVELS OF RESPONSE**

#### ***Normal Fluctuations:***

Trusts in the NHS are accustomed to normal fluctuations in daily demand for services (peaks and troughs). Whilst at times this may lead to facilities being fully stretched such fluctuations are managed without the activation of special measures.

#### ***Level I - Beyond Normal Fluctuations/Local Incident:***

A local incident is defined as any occurrence which:

- May seriously disrupt the services which are a direct responsibility of the PCT
- Or cause such demand on services that special arrangements must be put in place
- Or create serious public concern or alarm which needs to be managed, and is within the scope of the PCT to manage and contain.

Examples of the above include:

- The closure or evacuation of one or more health premises or major equipment failure.
- A significant increase in demand for additional nursing or beds in the community, over and above the agreed escalation levels.
- A request by Good Hope Hospital or Heart of England Foundation Trust for support during a period above and beyond seasonal fluctuations, and escalation levels.
- A request by the police to establish a local evacuation or rest centre.
- An adverse health incident or communicable/infectious disease scare.
- Breakdown of utilities such as water or electrical supply.
- Transport difficulties (eg petrol strike, blocked road network).

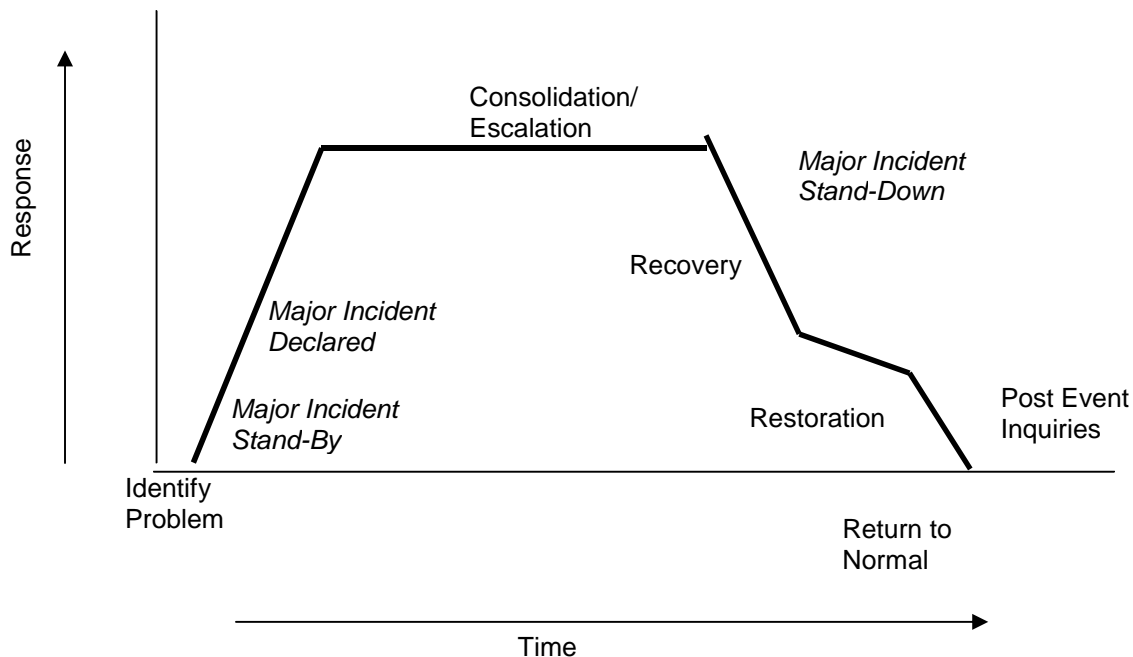
#### ***Level II Incidents – Potentially Hundreds of People and/or Persistent over Several Days:***

Larger scale events affecting potentially hundreds rather than tens of people, possibly also involving the closure or evacuation of a major facility (eg because of fire or contamination) or persistent disruption over many days; these will require a collective response by several or many neighbouring trusts;

#### ***Level III incidents - Potentially Catastrophic/Beyond the Collective Capabilities of NHS:***

Events of potentially catastrophic proportions that severely disrupt health and social care and other functions (power, water etc) and that exceed even collective capability within the NHS.

### 3.4. HOW LONG DOES IT LAST?



- **Major Incident Standby/Declared** – Stand-by and Declaring an Incident are two separate actions.
  - *Stand-by* highlights that the PCT needs to be ready to take action – as an incident may be about to occur, or has actually occurred but at this stage it is not clear that it is a major incident.
  - *Major Incident Declared* – a Major Incident has clearly occurred and the PCT takes action in response to that event.
- **Stand-Down of Major Incident Team** – The incident has finished or the scale has downsized and the PCT no longer needs to have a full Major Incident Team.
- **Recovery/Restoration** – Recovery and Restoration are two separate phases.
  - *Recovery* – the pressure eases off as the incident itself draws to a conclusion and the service starts to return to normal levels of service.
  - *Restoration* – the service needs to repair (eg restock, or make physical repairs) and regain lost ground (eg targets missed). This needs conscious actions to make good any damage to the service.
- **Post-Event Inquiry** - The work doesn't end when an incident ends, learning and improvement needs to take place, and trials/public enquiries/civil litigation may take place. Again, there needs to be conscious actions taken at the closing of an incident in anticipation of ongoing requirements.

## **4. WHO DOES WHAT?**

### **4.1. Primary Care Trust**

- Co-ordinate a local NHS response to a major incident including liaison with local authorities.
- Provide a 24-hour emergency management and clinical response, including co-ordinating the primary care, community and mental health response.
- Mobilise primary and community care resources to support acute trusts and non-acute trusts.
- Provide appropriate clinical settings for the treatment of people with minor injuries and conditions such as reception centres, minor injury centres, walk-in centres, community hospitals and general practice.
- Provide care and advice to evacuees, survivors and relatives, including replacement medication.
- Co-ordinate community hospital bed capacity in liaison with local acute hospitals and any available local bed management system.
- Assess the effects of an incident on vulnerable care groups, such as children, dialysis patients, elderly, medically dependent, or physically or mentally disabled.
- Establish with local authority facilities for mass distribution of counter-measures; for example, vaccinations and antibiotics.
- Administration of medications, prophylactics, vaccines and counter-measures.
- Provide support, advice and leadership to the local community on health aspects of an incident.
- Support screening, epidemiology and long-term assessment and management of the effects of an incident.
- Provide psychological and mental health support to staff, patients and relatives in conjunction with the appropriate provider.

**Details of who carries out these duties are contained in Section 5 – Handling An Incident and Resource Packs (see Appendices).**

### **4.2. Acute Trusts – Good Hope Hospital and Heart of England Foundation Trust**

- Receive and treat casualties.
- When not a receiving hospital – provides support eg a site medical incident officer and a mobile medical team, or provide back up to the receiving hospital.
- Provide specialist support at the scene of an incident.
- Identify casualties from the incident that require transfer to specialist centres.
- If necessary, decontaminate self-referrals.
- Provide isolation facilities.
- If necessary, through liaison with PCTs, to activate the early release procedure to surrounding community hospitals.
- Communicate with relatives and friends of existing patients, linking with police casualty bureaux, City Council-run friends/relatives centres).

#### **4.3. Community Hospitals / Facilities**

Depending on patients already placed in these units, the Community Hospitals may provide support in the event of severe pressure being placed on local resources, principally by accepting inpatients transferred from receiving and/or supporting hospitals for nursing care.

**The Primary & Community Care Lead will take the decision whether and how these facilities should be used, and will be supported by the Community Services Co-Ordinator. Details are contained in their Resources Packs (see Appendices).**

#### **4.4. General Practitioners & Pharmacists**

GPs can provide medical support (either triage or direct care) in support of an incident in a variety of locations, including:

- Opening the surgery outside of normal hours.
- Supporting higher dependency patients at home, Community Hospital, Nursing Homes, or Residential Homes.
- Providing care/triage at receiving hospitals.
- Providing Local Authority Rest Centres with medical support and advice.
- Providing support at the incident scene.

Pharmacists can provide support, including:

- Opening the pharmacy outside of normal hours for patients requiring urgent medication.
- Providing pharmacy service to groups of displaced patients (eg in temporary Rest Centres).
- Dispensing medication as a preventive, in accordance with directives.

**The Primary & Community Care Lead will take the decision on what services should be provided, and services will be mobilized via the Primary Care Co-Ordinator and Pharmacy Co-Ordinator. Details are held in their Resources Packs (see Appendices).**

#### **4.5. Nursing Care Homes and Private Hospitals**

Where bed requirements exceed normal availability, the PCT may utilize available beds at Nursing Care Homes and Private Hospitals.

**The Primary & Community Care Lead will take the decision on what facilities should be utilized, and these will be mobilized via the Community Services Co-Ordinator. Details are held in their Resource Packs (see Appendices).**

#### **4.6. Voluntary Groups**

Voluntary groups can provide significant support to health services during an incident, including:

- Refreshments at temporary facilities.
- Relative/patient accompaniment.
- Administrative/clerical support.
- Transport of individual relatives/carers.
- Interpretation.
- Religious and spiritual care.
- Co-ordination of international links, particularly for refugees and families of victims involved in overseas disasters.
- Clinical staffing contingencies (retired clinical staff only).
- Welfare services/victim support.
- Community/peer support.
- Post Traumatic Stress Disorder.

Arrangements for these services are either directly with the voluntary group themselves or via the Birmingham City Council who co-ordinate arrangements for a number of voluntary services.

**The Primary & Community Care Lead will take the decision on what services are required and these will be mobilized via the Community Services Co-Ordinator and Control Centre Co-Ordinator (see Resource Packs in the Appendices).**

#### **4.7. Birmingham and Solihull Mental Health Trust**

- Providing patients, relatives, and staff with counselling services/support.
- Support Acute Trusts in the transfer of casualties, and accessing additional resources (such as facilities and transport).

**The Primary & Community Care Lead will take the decision on what services are required and these will be mobilized via the Community Services Co-Ordinator and Control Centre Co-Ordinator (see Resource Packs in the Appendices).**

#### **4.8. West Midlands Ambulance Trust**

- Notify A&E departments, PCTs, and the local Health Protection Agency Team that an incident has occurred, and advise on the potential for self-presenting patients. (First Response Bed Bureau via the Chief Executives/Directors will notify PCTs.)
- Nominate and alert the receiving hospitals.
- Deploying the right healthcare resources to care for casualties either at the scene or at a hospital site.

- Provide treatment, stabilisation, care and transport of those injured at the scene.
- Establish an effective triage points and systems.
- Provide an incident control and communications point at the scene for all NHS and other medical resources (bronze control).
- Provide transport to the incident for any Medical Incident Officer (MIO), mobile medical/surgical teams, and their equipment.
- Decontamination in partnership with the Fire Brigade.
- Make PODS available at scene of incidents as appropriate.

#### **4.9. NHS West Midlands Strategic Health Authority**

- Strategic control of any incident that affects or seems likely to affect several hospitals or have a significant impact on primary care.
- Co-ordinate mutual aid across boundaries.

**The decision to contact the NHS West Midlands Strategic Health Authority will be taken by the PCT Major Incident Team Chair. This includes notifying the St HA of an incident (information only), or requesting assistance/escalation of the situation. Details are contained in the pack for the PCT Major Incident Team Chair (Resource Pack A1).**

#### **4.10. Health Protection Agency (HPA)**

- Provide specialist health emergency advice on communicable diseases, and chemical, biological, nuclear and radiological (CBRN) incidents.

**The PCT Public Health Lead will take the decision whether specialist advice is required from the HPA and will contact them accordingly. Details are contained in the pack for the PCT Public Health Lead (Resource Pack A2).**

#### **4.11. Birmingham City Council**

- Supporting the emergency services and those involved in the response to an incident including providing signage and barriers, and assisting Police with evacuations.
- Taking the lead in certain major emergencies, eg serious pollution, incidents involving schools, rabies and some other notifiable animal disease outbreaks.
- Using the resources of the local authority departments to mitigate the effects of the emergency on people, the environment, property and infrastructure.
- Providing and managing Rest Centres for the temporary accommodation of survivors/evacuees, Casualty Reception Centres, and to assist at Relatives and Friends Reception Centres.
- Providing a wide range of support services to the public.
- Activating the voluntary agencies and faith community, and co-ordinating their response.
- Providing and equipping temporary mortuary premises in emergencies involving multiple fatalities.

- Continuing normal support and care for the local and wider community affected by the incident and maintaining existing services in the locality.
- Leading the recovery phase and the return to normality.

The Emergency Planning Unit at Birmingham City Council is the central point for requests during an incident.

**The PCT Major Incident Team will take the decisions on what supporting services may be required and the Primary and Community Care Lead will be the lead for contacting the City Council. Details are contained in the pack for the Primary & Community Care Lead (Resource pack A3).**

#### **4.12. West Midlands Police**

- Saving life in conjunction with the other emergency services.
- Co-ordination of a multi-agency response, both at the scene of the incident and elsewhere.
- Securing, protecting and preserving the scene, and to control sightseers and traffic through the use of cordons.
- Ensuring access and egress for all Emergency Services.
- Investigating the incident, obtaining and securing evidence in conjunction with other investigative bodies where applicable.
- Collating and disseminate casualty information.
- Identifying the dead on behalf of HM Coroner.
- Preventing crime.
- Liaison with families.

#### **4.13. West Midlands Fire & Rescue Service**

- Life-saving through search and rescue.
- Fire fighting and fire prevention.
- Rendering humanitarian services.
- Provide and/or obtain specialist advice and assistance where hazardous materials are involved.
- Salvaging, damage control and environmental protection.
- The provision of specialist equipment eg pumps, rescue equipment and lighting.
- Safety management within the inner cordon (rescue zone).
- Decontamination in partnership with the Ambulance Service.

#### **4.14. HM Coroner**

- Determine who has died and how, when and where the death came about in relation to those bodies lying within the district who have met a violent or unnatural death, or a sudden death of unknown causes.
- Authorise the moving of a body at the scene of an incident.
- Authorise post-mortem and the release of a body to relatives.
- The Police act as the Coroner's Officers when dealing with fatalities arising from an incident.

#### **4.15. Water Agency**

- Respond to water pollution incidents, providing advice to health services and the public on action to take.

#### **4.16. Department of Health**

Level II to Level III Incidents - when more than one SHA is substantially affected or when an incident has a 'national' characteristic:

- National oversight and monitoring of all incidents that result in activation of a major incident plan. It will whenever necessary – either–
- Establish a national 'ops room' to support SHA management of incidents, to promote and encourage mutual aid and to act as focal point for links across Government. OR
- Take control of the deployment of NHS resources in the event of a complex and significant major incident, including those on a UK wide and international scale, through its Emergency Preparedness Division Coordination Centre.

**The liaison for the PCT will be via the Birmingham & Black Major Incident Response Team (BBC MIRT) based at NHS West Midlands SHA. The PCT Major Incident Team Chair will take the decision whether to contact the BBC MIRT and details are contained in the Resource Pack for the PCT Major Incident Team (Resource Pack A1).**

#### **4.17. West Midlands Regional Civil Contingencies Committee (WMRCC)**

Exceptional circumstances only (Level III – Catastrophic/Beyond NHS Capabilities):

- Provide a strategic picture of the situation within the region.
- Guide the deployment of resources across the region by identifying regional priorities.
- Target deployment of scarce resources across the region, facilitating mutual aid arrangements within the region and, where necessary, between regions to resolve such issues.
- Provide communication channels between local, regional and national levels.
- Co-ordinate reports to national level on the response and recovery efforts.
- Raise to a national level any issues that cannot be resolved at a local or regional level.
- Ensure that the national input to response and recovery is co-ordinated with the local and regional efforts.

Whilst the WMRCCC will observe local decisions, its role is to take a multi-agency overview and can also liaise on the deployment of national resources. It will only be activated if there is a need for it, either by request of central Government or by a member of a local Gold command.

- If needed, declare "State of Emergency" and grant Emergency Powers.
- Provide the "Regional Nominated Coordinator".

**The liaison for the PCT will be via the Birmingham & Black Country Major Incident Response Team (BBC MIRT). The PCT Major Incident Team Chair will take the decision whether to contact the BBC MIRT and details are contained in the Resource Pack for the PCT Major Incident Team (Resource Pack A1).**

## 5. HANDLING AN INCIDENT

### 5.1. Identifying the Problem and Going On Standby / Declaring an Incident

- Remember not all problems are immediately clear and may come in from a variety of sources.
- Only the PCT Chief Executive or Director can decide to set up the PCT Major Incident Team (even if a Major Incident is declared elsewhere)
- Notifying that there's an Incident and Declaring an Incident are two separate actions. Anyone can notify the Chief Executive/Executive Director/On-Call Manager of a potential/probable/actual incident, but only the Chief Executive or Director decide to set up the PCT Major Incident Team/place it on Standby in response to an event.

For avoidance of doubt, the following terms are used in this plan:

- PCT Major Incident Team (PCT MIT) – The PCT Incident Team dealing with incidents affecting the PCT.
- Birmingham MIRT Team (BBC MIRT) – Pan-Birmingham response to an incident, run by the NHS West Midlands Strategic Health Authority.

<b>Level</b>	<b>Event Occuring</b>	<b>Who Will Declare PCT MIT?</b>
Level I – Local Incident (NE Birmingham Economy)	Within PCT  Within Acute	PCT CE/Director  Acute CE/Director -> contact PCT CE/Director
Level II –Potentially Hundreds of People and/or Persistent over Several Days:	Within own health economy  Outside own health economy	PCT CE -> declares PCT MIT  Another MIT contacts -> CE/On-Call Director for support to neighbouring economy
Level II – Potentially Catastrophic/Beyond Collective Capabilities of NHS	Major Incident - health involvement  External to the NHS	BBC MIRT  External body contacts BBC MIRT who will contact PCT CE/On-Call Director

**Step 1** - Look out for problems before they happen

**Step 2** - Notify the Chief Executive or Director or On-Call Manager

**Step 3** - Chief Executive/Director/On-Call Manager agree whether to call a Major Incident

#### Key contact numbers

##### In-Hours:

Chief Executive 0121 380 9207  
Directors: 0121 333 4113

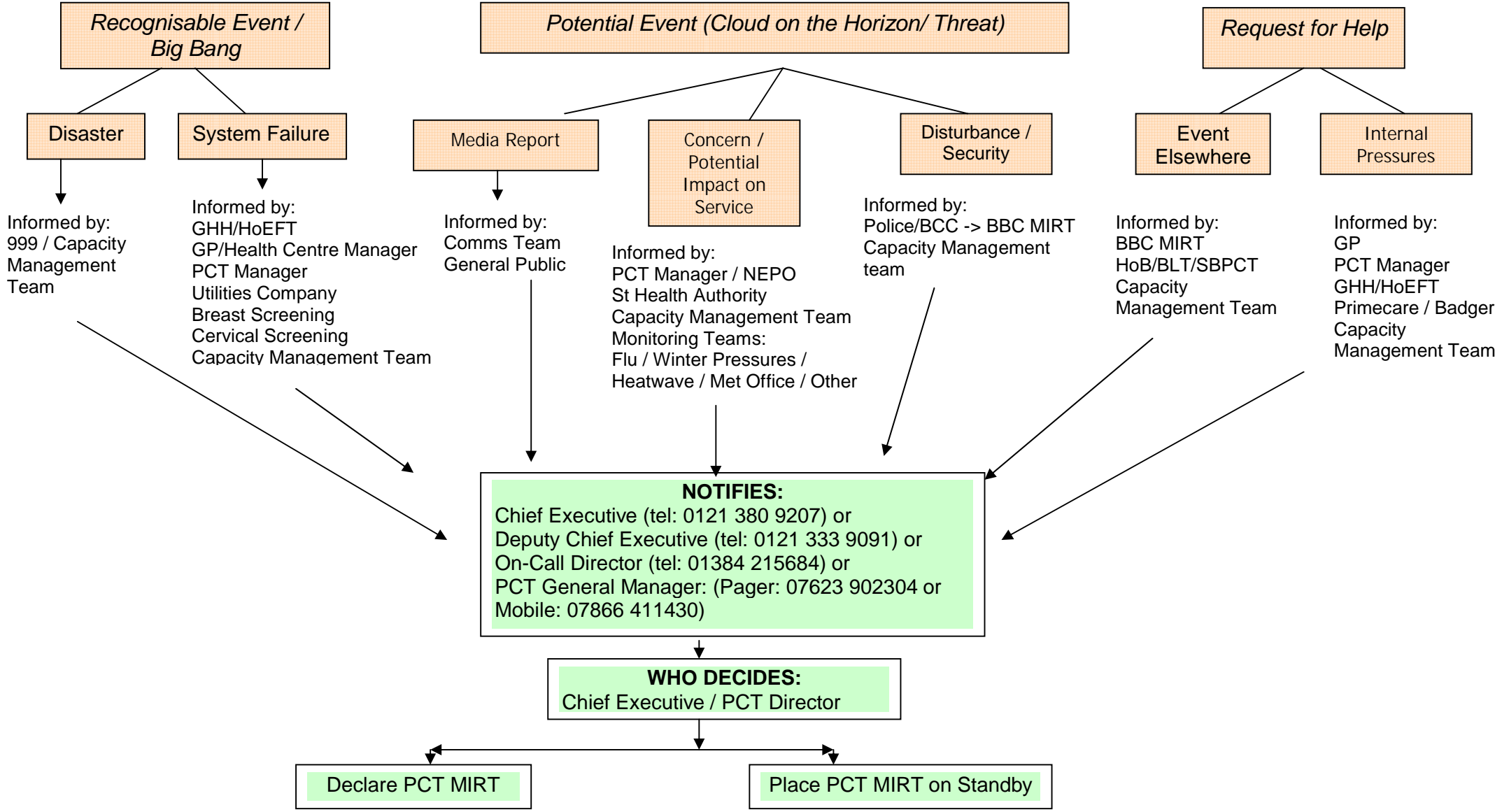
##### Out-of-Hours:

On-Call Director: via First Response: 01384 215684  
OR PCT General Manager:

- Pager: 07623 902304
- Mobile: 07866 411430

The decision-making tree is overleaf.

# DECLARING AN INCIDENT



## 5.2. Set Up an Incident Team:

**The Chief Executive/Deputy Chief Executive/On-Call Director will take the role of PCT Major Incident Team Chair and decide whether to activate the PCT MIT team or place it on stand-by. They will notify the Core Team listed below (using Emergency Wallet A1) and tell them which Control Centre to assemble at.**

**At the request of the PCT MIT Chair, the Control Centre Co-Ordinator will notify and call in the extended team (using Emergency Wallet A5).**

Team Roles	Who?	Summary Role	Resource Pack
Role of Team		Assess the situation Make Decisions. Allocate and deploy resources.	All "A" Packs
<b>Core Team:</b>			
Major Incident Team Chair	Chief Executive, BENPCT	Chair the Team Overall decision-taker. Assess the situation & action needed. Link to other agencies.	A1
Public Health Lead	Director of Public Health, BENPCT	Medical advice to team. Link to specialist medical advice. Assess health risk to public.	A2
Primary & Community Care Lead	Managing Director – Operations Directorate, BENPCT	Lead provision of care for patients and vulnerable groups. Mobilise community nursing resources & beds. Mobilise community resources, including independent contractors.	A3
Communications Lead	Head of Communications & Involvement, BENPCT	Deal with media enquiries. Press/Information releases. Set up hotlines.	A4
Control Centre Co-ordinator	Head of Core Business Processes & Strategy (Nominated Emergency Planning Officer), BENPCT	Set Up Control Room & resources. Manage flow of information in/out. Display situation reports/other info.	A5
<b>Extended Team:</b>			
Primary Care Co-ordinator	Head of Primary Care Commissioning, BEN PCT	Provide support to the Primary & Community Care lead. Mobilise Primary Care resources.	A6
Pharmacy Co-ordinator	Assistant Director - Medicines Management, BENPCT	Provide support to the Primary & Community Care lead. Mobilise Pharmacy support/resources.	A7
Community Services Co-Ordinator	Head – Adult Community Nursing, BENPCT	Provide support to the Primary & Community Care lead. Mobilise Community Services (including nursing staff and community beds)	A8
Logists	Exec Assistant to Chief Executive, BENPCT Head of Corporate Services, BENPCT	Document everything (information received, actions). Keep documentation together, useable and accessible.	A9
Information "Runners"	As available	Obtain information & situation reports for PCT Major Incident team.	A10

		Help team contact and mobilize resources.	
Co-Opted Members (dependent on incident): <ul style="list-style-type: none"> <li>▪ Nurse</li> <li>▪ Medical Director</li> <li>▪ Estates</li> <li>▪ ICT</li> <li>▪ Acute Trust</li> <li>▪ Social Services</li>   <li>▪ Utility</li> </ul>	Executive Nurse Medical Director Director of Estates, Director of ICT Director of Ops Social Services Quadrant Director Emergency Planning Officer	Provide specialist advice to PCT Major Incident Team. Contribute to decision-making process. Provide two-way communication between PCT & their own organization on situation reports and action taken. Mobilise services of their own services as requested by PCT Major Incident Team.	A11

- Roles, Action Cards, and Contact Details are contained in the Resource Packs located in each of the Control Rooms.
- Emergency Wallets will be held by each member of the Core Team with initial contact numbers, and emergency access details.
- A full Telephone Directory (Resource Pack B) is also held in each of the Control Rooms.

If members of the Core Team are unavailable (eg annual leave, sick, out-of-hours) or need relieving during a prolonged incident, the 1<sup>st</sup> and 2<sup>nd</sup> replacements are:

Team Roles	Designated Team	1 <sup>st</sup> Replacement	Out-of Hours/2 <sup>nd</sup> Replacement
<b>Core Team:</b>			
PCT Major Incident Team Chair	Chief Executive, BENPCT	Deputy Chief Executive (Director of Redesign & Commissioning), BENPCT	On-Call Director
Public Health Lead	Director of Public Health, BENPCT	Deputy Director – Health Improvement, BENPCT	On-Call Public Health
Primary & Community Care Lead	Managing Director – Operations Directorate, BENPCT	Service Director – Long-Term Conditions, BENPCT / Service Director Children & Families OR Service Director - Rehabilitation	On-Call Operational Manager
Communications Lead	Head of Communications & Involvement, BENPCT	Communications Manager, BENPCT	LTA Communications
Control Centre Co-Ordinator	Head of Core Business Processes & Strategy (Nominated Emergency Planning Officer), BENPCT	Director of Performance & OD (executive lead – emergency planning), BEN PCT	PCT General Manager On-Call, BENPCT
Primary Care Co-ordinator	Head of Primary Care Commissioning, BEN PCT	Senior Commissioning Manager, BENPCT	
Pharmacy Co-ordinator	Assistant Director - Medicines Management,	Senior Prescribing Advisor, BENPCT	

	BENPCT		
Community Services Co-Ordinator	Head – Adult Community Nursing, BENPCT	Head of Intermediate Care, BENPCT	
Loggists	Exec Assistant to Chief Executive, BENPCT Head of Corporate Services, BENPCT	Executive Assistant to Director of Performance & OD (lead executive – emergency planning)  Board Committee Administrator	
Information “Runners”	As available	As available	
<b>Co-Opted Members:</b>			
Nursing Advice	Executive Nurse, BENPCT	Head of Nursing Development / Deputy Executive Nurse, BENPCT	
Medical Advice	Medical Director, BENPCT	PEC Chair, BENPCT	
Estates	Director of Estates, BPCSSA	Deputy Director of Estates, BPCSSA	On-Call Estates Manager
IM&T	Director of ICT, BPCSSA		
Acute Representative	Director of Ops	Medical Director	On-Call Director
Social Services	Social Services Quadrant Director		
Utilities rep (or Birmingham City Council)	Emergency Planning Officer	Emergency Planning Officer	Via switchboard

### 5.3. Set Up Command and Control

**On declaring activation of the PCT Major Incident Plan team, the PCT MIT Chair will establish clear Command and Control functions and designate staff to those functions.**

#### 5.3.1. What Is Command & Control?

There needs to be clear distinction between command and control, particularly where different organizations and agencies are involved:

- *Command* - The authority for an agency to direct the actions of its own resources (both personnel and equipment).
- *Control* - The authority to direct strategic and tactical operations in order to complete an assigned function (includes the ability to direct the activities of other Agencies engaged in the completion of that function).

Within these two functions, are levels to reflect the different levels at which an incident is managed:

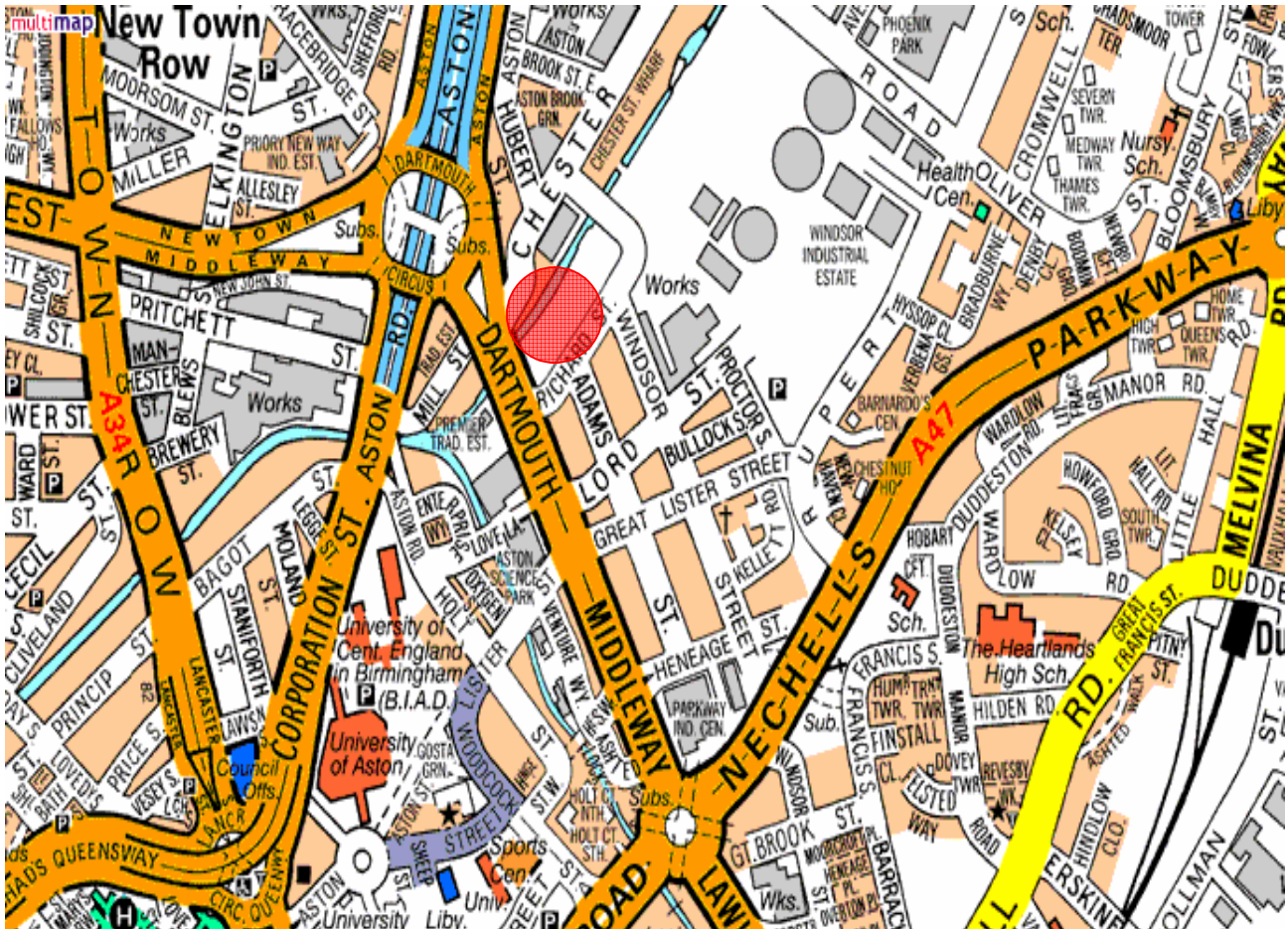
<b>Gold:</b>	Overall <b>strategic</b> control of the incident	Formulate overall Policies. Provide resources. Prioritise demands. Determine media policy. Consider the future
<b>Silver</b>	<b>Tactical</b> control	Determine priorities in allocating resources. Plan & co-ordinate tasks and overall response.

		Obtain resources.
<b>Bronze</b>	<b>Operational</b> control/response	The 'doers' managing front line operations

Not all these command levels are necessarily activated - depending on the scale of incident and response. The general approach is to escalate the levels with the increasing size and complexity of the response required. The Police will normally co-ordinate any interagency response to a major incident. In some major incidents the combined tasks of strategic and tactical control may be combined at single police silver.

### 5.3.2. Where are the Control Centres?

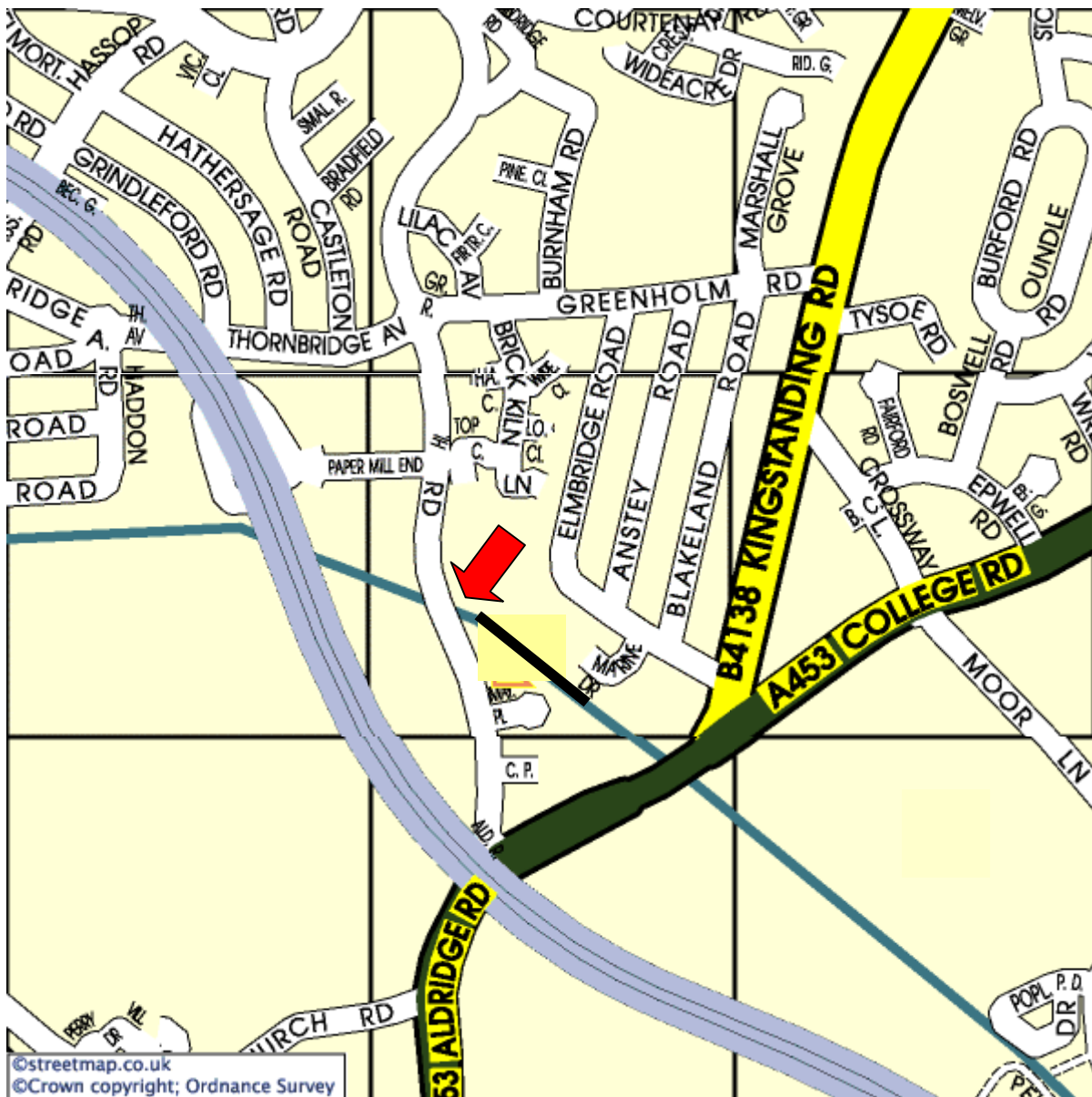
The PCT Major Incident Team will meet at Control Room A (Board Room, 4<sup>th</sup> Floor, Waterlinks House, Richard Street, Aston)



Prior to establishing the team, the PCT Major Incident Team Chair will decide if the Team should meet at one of the alternate Control Rooms. Consideration may be given:

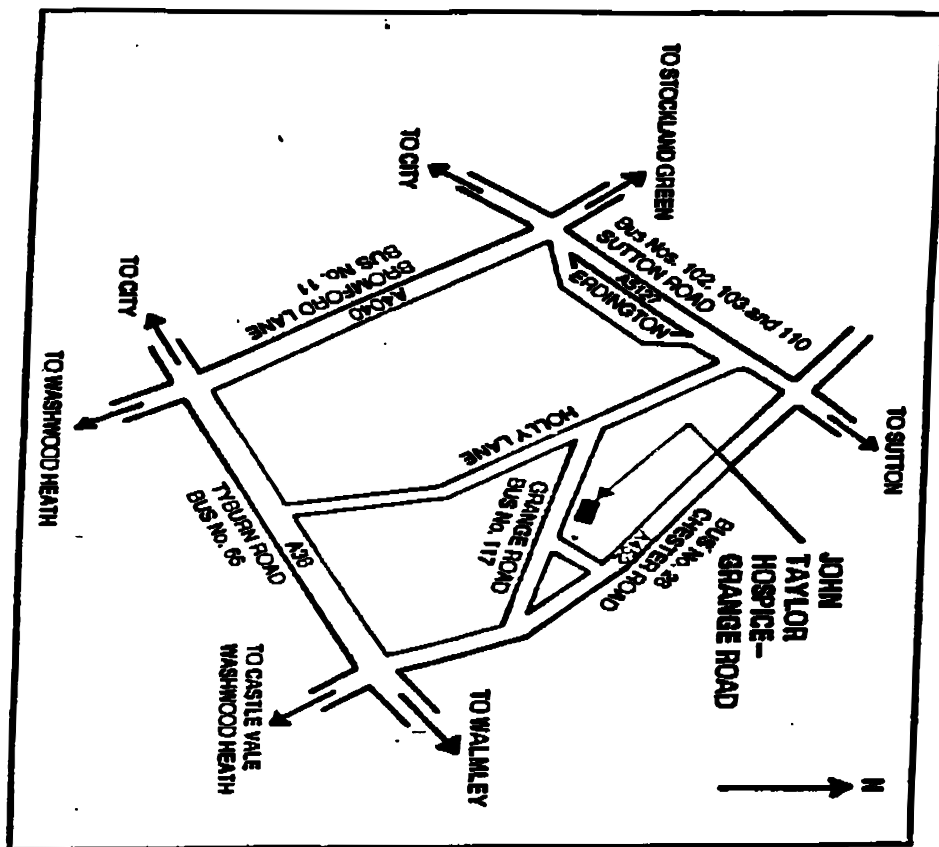
- IF the incident (or consequences of the incident) are causing congestion on the surrounding roads, making it difficult for the PCT Incident Team to get to Control Room A.
- IF the incident has (or is likely to) involve evacuation of the City Centre / closure of central roads.
- IF the incident has the potential to spread geographically in the direction of Control Room A (eg crowds, or chemical cloud).
- IF power supplies fail, rendering the main Control Room unusable (Control Room C has an independent power supply).

If Control Centre A is unavailable, the PCT Major Incident Team Chair will notify PCT MIT members to meet at Control Centre B (Board Room, Blakelands House, Aldridge Road, Perry Barr, B44 8BH)



IF Control Centres A and B are unavailable, the PCT Major Incident Team Chair will notify PCT MIT members to meet at Control Centre C (John Taylor Hospice, 76 Grange Road, Erdington, B24 0DF – resources kept in cupboard opposite education room, 1<sup>st</sup> floor)

Control Centre C (John Taylor Hospice) has an independent power source



**IF the incident goes beyond PCT services, the PCT MIT Chair will:**

- Clarify what other agencies/organisations are involved and which is in overall control,
- clarify what control levels are/have been activated in response to the incident (in addition to the PCT Command) and,
- designate appropriate senior PCT staff to man or liaise with those control centres.

**Likely locations will be determined by the incident, but may include:**

	<b>Bronze</b>	<b>Silver</b>	<b>Gold</b>
<b>Level I Incident (local):</b>			
PCT Incident	Scene of incident	None	PCT Control Room A (Waterlinks)
Acute-based Incident	Scene of incident	PCT Control Room A (Waterlinks)	Acute
<b>Level II Incident (100+ involved or persistent over several days):</b>			
BBC MIRT	Scene of incident	PCT Control Room A (Waterlinks)	St Chads
Multi-agency	Scene of incident	St Chads	Police HQ, Lloyd House
<b>Level III Incident (potentially catastrophic or beyond NHS):</b>			
Catastrophic – Multi-agency + regional & national co-ordination	Scene of Incident	For NHS – BBC MIRT Room (St Chads)	Regional or national base depending on incident

**Maps, directions, keys, and access codes in the Resource Pack for each Team Member.**

### 5.3.3. Role of Team Members on Arrival at the Control Centre

On arrival at the PCT Control Centre, the:

- **PCT MIT Chair** will establish Command and Control, assess the likely scale of the situation and whether escalation is required, and link with other organizations (eg Good Hope Hospital / Heart of England Foundation Trust, Strategic Health Authority).

**See Resource Pack A1**

- **Public Health Lead** will assess the health implications of the situation and advise the PCT MIT Chair and decide whether to obtain specialist medical advice.

**See Resource Pack A2**

- **Primary & Community Care Lead** will assess patient requirements and likely availability of community & primary resources and advise the PCT MIT Chair.

**See Resource Pack A3**

- **Communications Lead** will assess the level of information already available to the press and their likely interests, and prepare to set up the supplementary media resources (including back-up communications and helplines).

**See Resource Pack A4**

- **Control Centre Co-ordinator** will set up the control centre and contact the Extended Team (if not contacted already) and assign support staff to the Core Team.

**See Resource pack A5**

- **Primary Care Co-ordinator** will meet with the Primary & Community Care Lead, assess the availability of primary care resources and prepare to mobilize those resources.

**See Resource Pack A6**

- **Pharmacy Co-Ordinator** will meet with the Public Health Lead, and Primary & Community Care Lead and assess the likely medication needs of patients and availability of resources.

**See Resource Pack A7**

- **Community Services Co-Ordinator** will meet with the Primary & Community Care Lead, assess the availability of resources, and prepare to mobilize community nursing and beds.

**See Resource Pack A8**

- **Loggists** will report to the Control Centre Co-Ordinator, and set up access to faxes, telephones, e-mails, and prepare supporting documentation.

**See Resource Pack A9**

- **Information “Runners”** will report to the Control Centre Co-Ordinator and be assigned to support designated Core Team members.

**See Resource Pack A10**

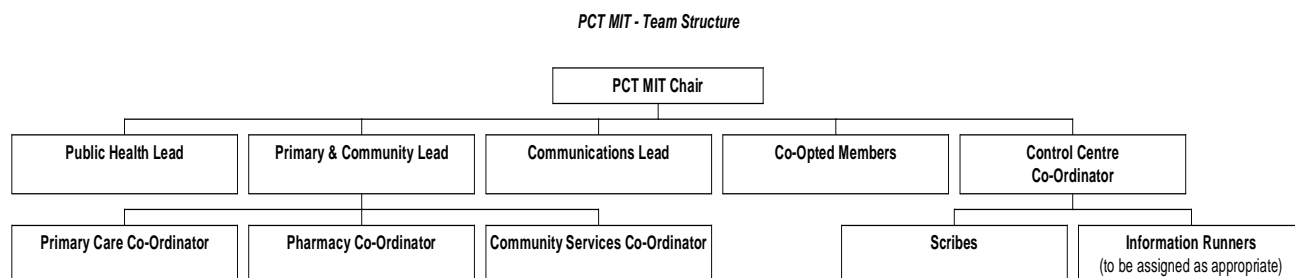
- **Co-Opted Member** will report to the PCT MIT Chair and advise them on the requirements of the situation and availability of resources within their own organizations.

**See Resource Pack A11**

#### **5.4. Assessing the Incident & Getting Advice**

When an incident first happens, there will be an initial stage of lack of information, confused position, and uncertainty about what has happened/the extent of the problem. So the Team's first responsibility is to assess what has/is happening, and the extent of the problem in order to decide what (proportionate) response is needed.

The flow of information in/out of the Team needs to be controlled through the Core Team:



In assessing an incident, the overall responsibilities are:

<b>RESPONSIBILITY</b>	<b>WHO?</b>	<b>ASSESSING THE SITUATION</b>
Overview & accuracy of position & required action	PCT MIT Chair	Is this a real incident? What's the state of the information (opinion, partial fact, or clarified fact)? What has actually happened? Where has the information come from (is it confirmed)? What's the Scale of the Incident? Does it need to be escalated and/or do higher bodies need to be informed? Do external organisations need to be involved?
Clinical position	Public Health Lead	What's the nature of the incident (eg trauma, chemical, infectious, etc)? Will it spread or is it contained? Are special considerations needed (eg decontamination)? Is what's being reported accurate/what clinically needs to be done? Will specialist clinical advice be needed (eg biological)?
Patient needs & what's available?	Primary & Community Lead	Number of patients involved Type of injuries and requirements. State of current services (eg how many beds are <u>currently</u> available, where are staff, what resources <u>could</u> be made available).
What do the public/press know?	Communications Lead	Has the press picked up on it? What is being said on TV/SKY/CNN/ local radio, etc. Do staff know anything?

## **Getting Advice & Information**

In assessing the situation, the Core Team can get advice from a number of sources, including:

- Major Incident Team Chair:
  - First Response
  - Military/Security
  - Police
  - Utilities
- Clinical Advice – The Public Health lead can access specialist advice from:
  - Health Protection Agency (HPA)
  - Consultant – Communicable Disease (CCDC)
  - Health Advisory Team (HAT)
- Primary & Community Care Lead:
  - Receiving Trust
- Communications Lead:
  - Press contacts

### **AT THIS INITIAL STAGE, THE TEAM:**

- **GATHER INFORMATION**
- **CHECK IT'S ACCURACY**
- **REPORT BACK TO THE PCT MIT CHAIR**
- **GET READY TO MAKE DECISIONS TO ACT ON.**

**Responsibilities and contacts are outlined in individual Resource Packs**

## **5.5. TAKING ACTION**

The PCT MIT will decide on the appropriate course of action to take, including the following steps:

### **5.5.1. Escalation**

**THE PCT MIT CHAIR WILL DECIDE WHETHER ESCALATION IS REQUIRED AND WILL ENACT:**

- **MUTUAL AID FROM NEIGHBOURING ORGANISATIONS.**
- **BEYOND LOCAL HEALTH ECONOMY CAPABILITIES (IN WHICH CASE, NOTIFY BBC MIRT)**

**CONTACT DETAILS ARE CONTAINED IN RESOURCE PACK A**

### **5.5.2. Alerting staff**

**THE PRIMARY & COMMUNITY SERVICES LEAD WILL DECIDE WHETHER TO ALERT THE FOLLOWING STAFF GROUPS:**

- GPs
- Community Nurses
- Pharmaceutical Support
- Social Services
- Retired Staff
- Volunteers/Voluntary Agencies

**A CLEAR MESSAGE WILL BE GIVEN TO STAFF ON ACTIVATION:**

- MAJOR INCIDENT PLAN ON STANDBY OR
- MAJOR INCIDENT PLAN ACTIVATED, PLEASE GO TO ...

### **5.5.3. Mobilising & Deploying Staff**

Staff will be asked to undertake a range of actions, including:

- Providing triage and/or assessment services.
- Providing emergency care.
- Providing emergency medication.
- Receive patients and provide an Increased level of care in current settings.
- Decant or discharge patients to another setting.
- Provide a service (eg vaccination) within their capability, but not normally within their usual duties.

**THE PRIMARY & COMMUNITY SERVICES LEAD WILL DESIGNATE MOBILISATION OF STAFF (as appropriate) TO:**

**PRIMARY CARE CO-ORDINATOR will mobilise -**

- GPs

**PHARMACY CO-ORDINATOR will mobilise -**

- Pharmaceutical Support

**COMMUNITY SERVICES CO-ORDINATOR will mobilise -**

- Community Nurses
- Social Services
- Retired Staff
- Volunteers/Voluntary Agencies

**A CLEAR MESSAGE WILL BE GIVEN TO STAFF ON ACTIVATION:**

- MAJOR INCIDENT PLAN ACTIVATED, PLEASE GO TO ...
- YOU ARE ASKED TO.....

**CONTACT DETAILS ARE CONTAINED IN RESOURCE PACK A6, A7, AND A8 RESPECTIVELY**

#### 5.5.4. Facilities

In responding to an incident, the PCT MIT may use facilities in a way different to its usual use, including:

- **Role of Sutton Cottage Community Hospital / Berwood Court / Grange Road / John Taylor Hospice / Nursing & Residential Homes / Intermediate Care**
  - Early discharge of patients.
  - Scaling up range of patients taken.
  - Temporary, increased capacity.
  
- **Health Clinics:**
  - Assessment and treatment of patients.
  - Temporary holding area for displaced patients.
  
- **Triage Centres/Vaccination Centres:**
  - Triage and assessment of patients.
  - Provision of basic care to patients.
  - Provision of preventative measures (eg vaccinations).

Such centres may be Health-based centres, or Non health-based centres (eg leisure centres) which can be accessed via Birmingham City Council.
  
- **Walk-In Centres/Urgent Care Centres/Out of Hours Centres**
  - Diversion of patients away from acute hospitals.
  - Provision of increased level of care in community setting.
  - Capacity to cope with sudden increased number of patients.
  
- **Emergency Management Service Rest Centres**

Birmingham City Council has responsibility for setting up Rest & Reception Centres, and the PCT has responsibility for ensuring health needs of people at those centres, and linking with the police on the co-ordination of survivor/relatives/carers details.

#### Scenarios Requiring Rest Centres:

Possible Scenarios	EG	Likely Implications for PCT
Evacuation due to a threat.	Security threat	<ul style="list-style-type: none"> <li>▪ Access to medication.</li> <li>▪ Ongoing medical assessment –likely increased stress-related conditions (eg respiratory).</li> <li>▪ Needs of vulnerable people.</li> </ul>
Evacuation due to a disaster.	Building collapse. Weather.	Triage & medical help.
Evacuation due to system/building failure	Fire.	<ul style="list-style-type: none"> <li>▪ Access to medication.</li> <li>▪ Ongoing medical assessment –likely increased stress-related conditions (eg respiratory).</li> <li>▪ Needs of vulnerable people.</li> </ul>

### **Types of Rest/Reception Centres**

- *Rest Centres* - For people who are temporarily displaced but not injured (ie not injured in the initial incident).
- *Casualty Reception Centres* - For people requiring primary care assessment / triage and treatment.
- *Friends and Relatives Reception Centres* - Co-ordinating point for people seeking information on/finding relatives and friends.

**The Primary & Community Care Lead will take the decision as to what facilities are required, services required, and what staffing is needed to man them. In mobilising these services, the Primary & Community Care Lead will designate duties to the Primary Care Co-Ordinator, Pharmacy Co-Ordinator, and Community Services Co-Ordinator.**

**Details of facilities, staffing, and contact numbers are held in Resource Packs:**

<b>Primary &amp; Community care lead</b>	<b>Resource Pack A3</b>
<b>Primary care Co-Ordinator</b>	<b>Resource Pack A6</b>
<b>Pharmacy Co-Ordinator</b>	<b>Resource Pack A7</b>
<b>Community Services Co-Ordinator</b>	<b>Resource Pack A8</b>

**IN DETERMINING REQUIREMENTS, THE PRIMARY & COMMUNITY CARE LEAD WILL TAKE INTO CONSIDERATION:**

- **Possible contamination of patients – alternate treatment areas, use of PODS (including modesty pods).**
- **Accessing & recording patient details.**
- **Dealing with Children, Vulnerable People & Persons with Special Needs**
- **Needs of religious and ethnic groups.**
- **Movement restriction – of staff and patients (eg transport problems, security issues, lockdown).**
- **Emergency supplies (eg heating, blankets, food, medication, power).**

**Resource Pack A3  
(and supporting A6, A7, A8)**

**The Communications Lead will take into account:**

- **Likely level of interest from the press and where they will congregate.**
- **Facilities for the media to minimize the impact on patient care.**
- **Level of Public interest/confidence and messages needed.**
- **Establishment of helplines.**
- **Staff Briefings/Communications (including what's happening, latest positions, who to contact for concerns eg childcare).**

**Resource Pack A4**

## **5.6. Consolidating/Reviewing the Situation**

### **5.6.1. Prolonged Incident**

During the early stages of an incident, directors/managers must be aware of staffing levels and seek information regarding the length of time the incident may be expected to last. This may be difficult to assess and the worse case scenario should be planned for. This may require a shift system to be implemented and managed. Certain situations may be very demanding and stress levels will also need to be considered.

**The Control Centre Co-Ordinator will identify the effects of a prolonged incident, including:**

- **Identifying rest periods and facilities.**
- **Ensuring that refreshments have been provided to the PCT Control Rooms (including Gold, Silver, and Bronze), Triage Centres, Community health facilities, Health Clinics.**
- **Monitoring overall length of the incident and need for staff shifts.**
- **Stress levels and support needed (eg additional resources).**
- **Prompt the Core (and Extended) Team to take rest periods, and identify hand-over.**
- **Family support / childcare / carer support.**
- **Prompt the PCT MIT Chair to initiate Business Recovery Plans**

**Resource Pack A5**

### **5.6.2. Initiate Business Recovery Plans**

Because it is impossible to predict the cause of every single event, Integrated Emergency Management focuses on the consequences. In the event of an incident, the Major Incident Team Chair will allocate to a member of the team one or more of the Business Recovery Plans:

- **Human resources, including:**
  - Staff shortages
  - Redeployment of staff
  - Use of retired staff
  - Use of volunteers
  - Policies
- **Buildings:**
  - Alternate locations
- **Supply chains:**
  - Food
  - Linen
  - Drugs
- **Utilities, including communications:**
  - Alternates to communications (electronic and phone)
  - Water supply
  - Electricity supply

- Service capacity:
  - Flexible use of beds
  - Alternate
  - Discanting
  - Care of patients at home
  - Temporary suspension of work/targets.

## **5.7. Standing Down the Incident Team**

### **5.7.1. Authority & Procedure**

When an incident is close to ending/has ended, there must be clarity about the state of the incident (eg has it ended or is it simply past the worst), decisions at that point in time, the position of the PCT MIT Team (is it fully enacted, partially enacted, etc) and how to re-assign designated resources (eg if staff have been redeployed, when do they return to their normal duties).

**The PCT MIT Chair will decide whether to stand down the team and will clearly state either:**

- **Full stand-down of the Team OR**
- **Partial stand-down - stating which Team members need to continue to monitor/deal with the situation, and who is in charge of the team.**

### **5.7.2. Preparing to Stand Down**

Before the Incident Team is fully stood down:

- **The PCT MIT Chair will:**
  - **Clearly state and record the current position of the incident (including final decisions made/at that point).**
  - **Agree arrangements for suspending targets.**
  - **Ensure that Business Recovery Plans have been allocated and initiated.**
  - **Clearly communicate to the Strategic Health Authority and other bodies that the Team is being stood down.**

- **All Team members will:**
  - **Ensure that all documentation in their control has been gathered and handed to the Control Room co-ordinator.**
  - **The message to stand down is clearly communicated to staff supporting them in the incident.**
  - **Assess whether staff supporting them in the incident need to rest, and the arrangements for covering their work.**

- **Public Health lead will:**
  - **Assess the need for (and where appropriate Initiate arrangements for) surveillance and monitoring of staff involved in the incident and affected population.**
  - **Assess the need for counseling for staff.**

- **Control Room Co-Ordinator will:**
  - **Gather all documentation together (including flip charts, information listed on white boards, etc).**
  - **Assess whether information for audit trails/legal documentation, etc is outstanding.**
  - **Replenish stocks of the Control Incident Room.**
  - **Liaise with the PCT MIT Chair to agree arrangements for follow-up of staff involved in the incident (eg ongoing situation, appreciation of staff).**
  - **Identify arrangements for debriefing staff involved in the Incident (at all levels, including the Incident Team).**
  - **Initiate “After the Event: Evaluation and Review” process.**
  - **Secure the Control Incident Room.**

This document is followed by “After the Event: Evaluation & Review” and will be enacted by the Control Centre Co-Ordinator (PCT Nominated Emergency Planning Officer)