NHS
Oxfordshire
Clinical Commissioning Group

Incident Response Operational Manual

This manual has been designed to be used by the OCCG On Call Director. The document summarises the practical steps that need to be taken and includes action cards.

Lead Director:	**Catherine Mountford, Director of Governance and Accountable Emergency Officer**
Date:	**September 2018**
Version:	**V5.1**
Author:	**Rachel Jeacock, Governance Manager**
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Approved by:	**Executive Committee**

Document Control

Date	Author	Reason
19.12.2013	Julie Dandridge	Addition of point 2.5
19.12.2013	Julie Dandridge	Update to Communications on call action card
02.11.2015	Rachel Jeacock	Comprehensive review. Change to correct name for NHS England, Oxford University Hospitals NHS Foundation Trust and South, Central and West Commissioning Support Unit. Update of Action Cards A, B, C and H.
19.11.2015	Rachel Jeacock	Update to NHS England Incident Levels in line with Emergency Preparedness, Resilience and Response Framework dated 10 November 2015
01.08.18	Rachel Jeacock	Change title to Incident Response Operational Manual; Change name to NHS England; OCCG to contact Primary Care instead of NHSE; S.8 Director on Call may be required to assist NHSE set up ICC and obtain cupboard code from them. Appendices : Action Cards A & B updated to reflect METHANE and JESIP; Removal of Southern Health; Update Planning Structure; Update SCAS Cascade flow diagram; AgendaTemplates for teleconference/meeting; 'National' SITREP template
26.07.19	Linda Adhana	U[date Action Cards

Contents

PART ONE: MANUAL

1. Introduction

1.1. This document details the actions to be taken by Oxfordshire Clinical Commissioning Group (OCCG) in the event of an incident.

1.2. It is for use by OCCG staff and sets out the response to a significant health related incident. It also describes command and control arrangements for the local NHS.

1.3. This Incident Response Operational Manual will also assist the Director on Call in their duties as being the single point of contact in the organisation for any escalation or major emergency.

2. Roles and Responsibilities

2.1. Within the NHS architecture, different organisations have different responsibilities in relation to emergency planning and response (see Incident Response Plan for full list).

2.2. OCCG may need to lead a response to a local issue but in all cases NHS England should be informed and may take over leadership (see Escalation, p10).

2.3. The responsibilities of OCCG are to respond to reasonable requests to assist and cooperate during an emergency. NHS England may decide to include CCG members in the formal command and control structure and to assist in any response to a major incident. CCGs may assist and support NHS England to undertake the following tasks:

- Mobilising resources from locally commissioned services;
- Providing local NHS leadership if required;
- Liaising with relevant partner organisations;
- Cascading information to relevant service level providers;
- Informing and maintaining dialogue with neighbouring CCGs when appropriate
- Supporting CCG commissioned organisations with any local demand, capacity and systems resilience issues.

2.4. The OCCG Director on Call will become the responsible lead in the case of an incident.

2.5. The Emergency Accountable Officer is responsible for ensuring that this manual is regularly updated and tested.

3. Receiving the Alert

3.1. The Director on Call will be alerted to an incident by NHS England Team or via the Oxford University Hospitals NHS Foundation Trust as the receiving hospital. It is, however, possible that an alert could come via a different route; for example the Public Health England Centre, other NHS organisation, or an individual CCG staff member.

3.2. Appendix 1 details NHS England cascade of 'major incident standby' or 'major incident declared - activate the plan'.

3.3. The standard alerting messages are:

Major Incident – standby

This alerts staff members that a major incident may need to be declared. Preparatory arrangements are then made appropriate to the incident.

Major Incident declared – activate plan

This alerts staff members that the plan should be activated and additional resources mobilised.

Major Incident – cancelled

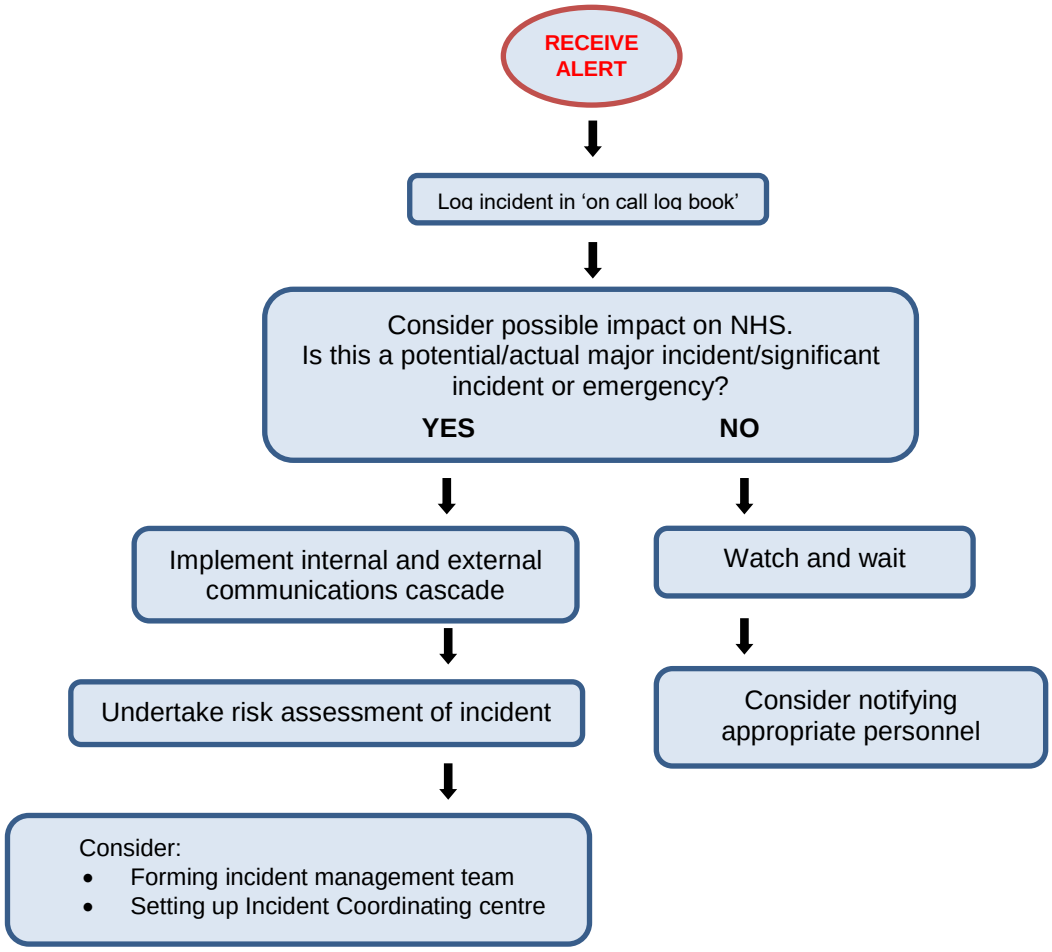
This alert cancels any previous messages.

Major Incident – stand down

All receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible the Ambulance Incident Commander will make it clear whether any casualties are still en-route. The CCG will then assess its own appropriateness to stand down.

3.4. As soon as alerted, the Director on Call takes the role of OCCG Executive Lead (until this role is passed on to another colleague) and may therefore activate the Incident Response Plan.

Figure 1: process to follow on receiving an alert message.



4. Begin a log and record

4.1. The OCCG Director on Call should record in the Director on Call log book:

- the time of the call;
- the name and contact details of the caller;
- the nature of the incident, e.g. type of incident, location, number of casualties;
- when the incident occurred;
- organisations involved, e.g. NHS Trusts;
- current action being taken and by whom;
- any plans made or expectations of what may happen next (e.g. evacuation plans);

- what actions are being requested of OCCG.

5. Cascading the Alert

5.1. The CCG Director on call is responsible for initiating the communications cascade both in hours and out of hours to ensure all relevant individuals are aware of the alert.

5.2. The CCG Director on Call will need to decide whether the internal communications cascade should also be initiated. This will depend on the type of incident and those services/organisations likely to be affected.

Figure 2: Oxfordshire CCG Communications Cascade

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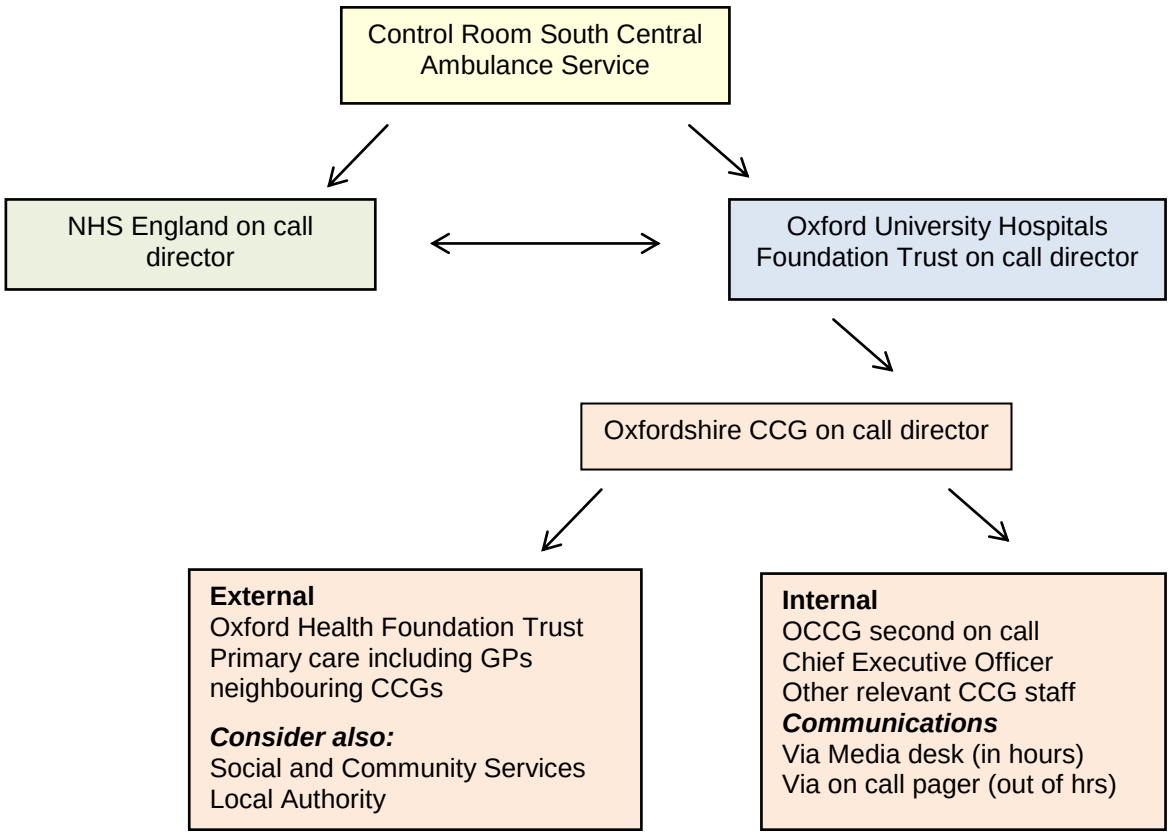


6. Risk Assessment

6.1. An initial risk assessment should be under taken as soon as possible. This will determine the next steps to be taken.

6.2. The risk assessment template on page 7 should be used as a guide.

6.3. In making this assessment, it is important to distinguish between:

- Events that can be dealt with using normal day to day arrangements;
- Events that can be dealt with within the resources and emergency planning arrangements of the OCCG and local NHS commissioned services;
- Events that require a joint co-ordinated response from the organisations across the Thames Valley;
- Events that require a strategic level co-ordinated multi-agency response across the Thames Valley (or wider) health community;
- Events that need regional co-ordination.

Figure 3: Template to be used when undertaking a risk assessment on a recently declared incident

Questions to consider	Information Collected?*
What is the size and nature of the incident?	
Area and population likely to be affected - restricted or widespread	
Level and immediacy of potential danger - to public and response personnel	
Timing - has the incident already occurred or is it likely to happen?	
What is the status of the incident?	
Under control	
Contained but possibility of escalation	
Out of control and threatening	
Unknown and undetermined	
What is the likely impact?	
On people involved, the surrounding area	
On property, the environment, transport, communications	
On external interests - media, relatives, adjacent areas and partner organisations	
What specific assistance is being requested from the NHS?	
Increased capacity - hospital, primary care, community	
Treatment - serious casualties, minor casualties, worried well	
Public information	
Support for rest centres, evacuees	
Expert advice, environmental sampling, laboratory testing, disease control	
Social/psychological care	
How urgently is assistance required?	
Immediate Within a few hours Standby situation	
***Key √ = Yes X = no ? = Information awaited N/A = Not applicable**	

7. The Incident Management Team

7.1. The size and seriousness of the incident will need to be considered when deciding on the extent of response needed. It may be appropriate to manage certain incidents off site (e.g. from home) using the telephone to coordinate the response. Other incidents may require full use of office facilities and staff support, making it necessary to form the Incident Management Team.

7.2. Depending on the incident the Incident Management team could consist of:

- Director on Call – would chair and co-ordinate the Incident Management Team;
- Second on call – if support is needed;
- Administration support – to ensure key actions are logged;
- South, Central and West Commissioning Support Unit (SCW CSU) Communication Manager – to lead internal and external communications;

- Locality link – (if incident is in one locality);
- Lead Commissioner – (if only one service is affected by the incident);
- IT Lead – (if IT is involved in the incident).

7.3. Where possible, and where incidents dictate, the OCCG Incident Management Team may work alongside the NHS England Major Incident team and share resources and information. If this happens Conference Room B in Jubilee House will be designated as the Incident Coordination Centre.

7.4. Out of Hours: The Director on Call will need to use their discretion when deciding to form a complete incident team out of hours. The out of hours Incident Management Team consists of:

- On call Director (Chair);
- SCW CSU Communications Manager on call
- Senior staff called in (if required).

7.5. A standard agenda template for Incident Management Team meeting can be found in Appendix 2.

7.6. There is no duty on OCCG to have a Loggist to document decision making but it is good practice to ensure that all actions are clearly recorded. Some members of OCCG have been trained by NHS England and may be called to assist in their incident co-ordinating centre

7.7. METHANE : The Joint Emergency Services Interoperability Principles (JESIP) identifies METHANE as the preferred model to share information to promote a shared situational awareness.
Major incident declared?
Exact location
Type of incident
Hazards present or suspected
Access - routes that are safe to use
Number, type, severity of casualties
Emergency services present and those required

7.8. National Decision Making Model : JESIP (Joint Emergency Services Interoperability Programme Decision Making Model) : This model is suitable for all decisions and can be applied to spontaneous incidents or planned operations. See Appendix 2.

8. The Incident Coordination Centre (ICC)

8.1. NHS England may establish an Incident Coordination Centre (ICC) from which the incident can be managed. OCCG Director On Call may be required to assist.

8.2. The ICC for OCCG is based in Conference Room B, Jubilee House, Oxford Business Park South, Oxford OX4 2LH

8.3. The role of the ICC is to:

- Manage the operational response to the incident;
- Co-ordinate response across the local health economy;
- Report to the NHS England;
- Handle media issues/enquiries;
- Coordinate with district councils and unitary authorities;
- Manage the return to normality;
- Ensure liaison with other key partners as required.

8.4. The ICC will act as a focal point for all liaisons with NHS and partner organisations regarding the incident. It will have robust and resilient IT and telecommunications capability. The ICC will be staffed by the Incident Management Team.

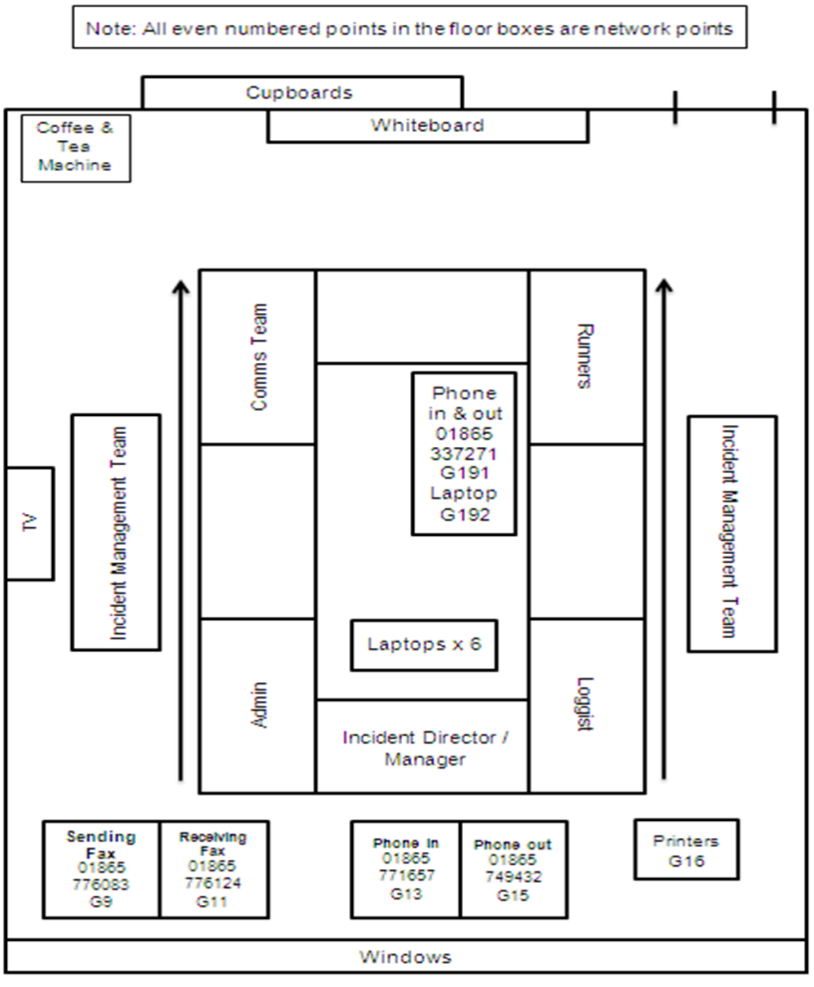
8.5. The Incident Coordination Centre will be set up by NHS England according to *Figure 4.* In the unlikely event that the OCCG Director on Call needs to assist to set up the control room they should obtain the cupboard code from the NHS England on call Director.

8.6. NHS England, SCW CSU and OCCG have agreed to release Conference Room B from any bookings in the case of a major incident requiring an ICC.

8.7. Access arrangements to Jubilee House are as follows:

- 09:00hrs – 17:00hrs Open access
- 06:00hrs – 09:00hrs and 17:00hrs – 21:00hrs Photo ID Card access
- Out of Hours: To access Jubilee House outside of the above hours contact Security 08447255568 and state 030452. Security will come to Jubilee House and open the building when presented with an OCCG photo identification card.

8.8. Equipment for the ICC is stored in the emergency planning cupboards 1 and 7 on the ground floor of Jubilee House. It is likely that the Incident Room Manager from NHS England will set up the centre, but in the unlikely event that the OCCG Director on Call needs to assist to set up the control room they should obtain the cupboard code from the NHS England Central on call Director. (See *Figure 4 below*: Layout of Incident Coordinating Centre)



Incident Control Centre Floor Layout – Jubilee House Conference Room B

9. Full assessment and action phase

9.1. The role of OCCG Director on Call is to direct and coordinate the management of the incident. In particular OCCG Director on Call will:

- form the Incident Management Team (if necessary);
- remain available for consultation throughout the incident;
- obtain input from all relevant sources of expertise and convene quickly, even if some areas cannot be represented immediately;
- check the representation and expertise available to the group and ensure that all members of the Incident Management Team understand their roles and responsibilities;
- ensure that meetings, investigations and actions are properly documented;
- ensure (with communications managers) that the media are briefed;
- ensure communication with NHS England;
- consider, recommend and implement measures to protect the public;
- if required, coordinate the Oxfordshire Health NHS Foundation Trust response to the incident by convening an Oxfordshire Health Emergency Response Group with representatives from all NHS Trusts in Oxfordshire;
- take executive decisions in the light of the best available information.

10. Escalation

10.1. *Figure 5* describes the four broad levels of escalation and provides broad parameters for decision making. It is the responsibility of the senior manager leading the NHS response at any particular time to decide, in conjunction with colleagues, what level of command is appropriate for the local NHS.

Figure 5: NHS England incident alert and response levels

Alert	Activity	Action	NHS England Incident levels	
Alert	Dynamic Risk Assessment	Declaration of Incident level	1	An incident that can be responded to and managed by a local health provider within their business as usual capabilities and business continuity plans in liaison with the local commissioners
			2	An incident that requires the response of a number of health provider organisations across the local health economy and will require NHS coordination by the local commissioners with NHS England local office
			3	An incident that requires the response of a number of health organisations across the geographical area within the NHS England region. NHS England to coordinate the response in collaboration with local commissioners at the tactical level
			4	An incident that require 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 tastical level

*Adapted from NHS England Emergency Preparedness, Resilience and Response Framework

10.2. Multi-agency Command and Control

There are three commonly accepted levels within emergency management command and control (*Figure 6*) and adherence to these by all organisations ensures a coordinated response to a major incident.

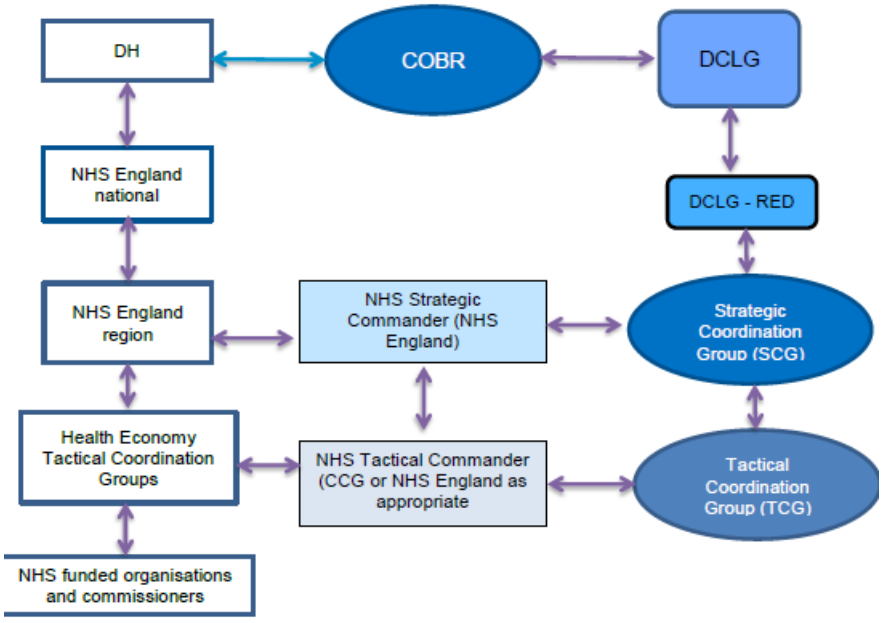
Figure 6: Levels within command and control structures

Level	Role	Colour
Strategic	Establish strategic objectives and overall management framework. Ensure long-term resourcing/expertise.	**Gold**
Tactical	Determine priorities in obtaining and allocating resources. Plan and coordinate overall response.	**Silver**
Operational	Manage front line operations.	**Bronze**

10.3. The multi-agency response to a major incident, significant incident or emergency is described below:

- The Department of Health & Social Care (DHSC) will be the source of information regarding the NHS for the Cabinet Office Briefing Room (COBR) at national level;
- NHS England –will represent the NHS at regional level;
- NHS England will attend the Strategic Coordinating Group (Gold) led by Thames Valley Police;
- Public Health England Centre will provide the Public Health Consultant to attend and may chair the Scientific and Technical Advice Cell (STAC);
- NHS England may attend multi-agency silver and interact at a bronze level;
- Local CCGs may attend county wide silver and interact at a local bronze level.

10.4. National response model



11. Communications

11.1. Managing communications including receiving and providing information to staff, public and the media is a key part of a major incident response.

11.2. Media: This will be coordinated by the SCW CSU on call Communications Manager. Thames Valley Police will have a Press Liaison Officer available through Silver/Gold who will be responsible for briefing and coordinating press/media enquiries regarding the incident. It is essential that this person be given all the relevant information to ensure a coordinated response to the media. The NHS England will also have access to their Communication team as will other NHS organisations. Any communication needs to be coordinated.

11.3. General notes regarding communication:

- Effective communications are the key to good public relations;
- A response to a press enquiry of 'no comment' or the giving of inaccurate or unverified information should be avoided at all costs;
- Initial response statements, particularly during the early stages when the total picture has not fully emerged, should be positive and concentrate on the actions the organisation is undertaking and information that is known;
- Communications Managers must ensure that they are kept fully informed whether at the scene or based in the ICC. Armed with officially cleared facts, spokespersons can respond confidently to media enquiries with the assurance that further details will be given in due course;
- The spokesperson will normally be the Director on Call;
- To avoid confusion it is essential that all press enquiries are channeled through the SCW CSU Communication Managers;
- If communicating directly with GP practices then it is essential that the Local Medical Committee is kept informed. Normally it will be the role of OCCG to communicate with primary care.

12. Creating Capacity

In a major incident it might be necessary for the Oxfordshire providers to create capacity across the system. The Director on Call may be able to assist and the NHS England Escalation Framework may be useful.

12.1. Use of Minor Injuries Units/First Aid Centres

Diversion of patients to Minor Injuries Units and First Aid Centres can provide support to acute hospitals. Oxford Health NHS Foundation Trust Director on Call should be contacted to discuss creating capacity to receive patients in a major incident.

12.2. Use of Community Hospitals

The OCCG Director on Call should contact the Director on Call for Oxford Health NHS Foundation Trust who will coordinate the emergency response at the community hospital sites. Their role in responding to a major incident that is external to a community hospital is:

- to act as a focal point for the coordination of the community hospitals response;
- to assess bed states and capabilities for the accelerated discharge of inpatients;
- to advise the receiving hospital(s) of capability to accept transferred in-patients;
- to coordinate the notification of relatives, GPs and as appropriate social services in the event of accelerated discharge/relocation of in-patients;
- to maintain liaison with OCCG Director on Call about the hospitals response to the incident;
- to determine the appropriate time for the declaration of hospitals' 'stand down' following notification of the release of the hospital from their incident response role;

- to notify OCCG Director on Call of all matters of importance relating to the incident response and submit a post incident report, including recommendations for follow up action.

12.3 Consider Support from Primary Care

13. Reporting

13.1. A key responsibility of OCCG during a major incident is the collation and reporting of local situation reports (SITREP).

13.2. In most major incidents the report frequency and mechanism will be defined and agreed by NHS England.

13.3. In most major incidents Oxfordshire providers will provide the SITREP directly to NHS England although sometimes they will ask that this is collated by OCCG. In all instances, providers should copy their local SITREP to commissioners.

13.4. In some cases OCCG may require providers to produce a local SITREP. An example of the national SITREP form can be found in *Appendix 5.*

13.5. It is the responsibility of the Director on Call to ensure that SITREPs from OCCG are reported as required. However, they may delegate the coordination to another competent member of staff.

13.6. In a multi-agency major incident the Thames Valley Local Resilience Forum may require a SITREP to be completed. This should be done using an online reporting tool, which may be via Resilience Direct

13.7. Resilience Direct : The information sharing, data storage and mapping system designed and managed by the Civil Contingencies Secretariat. It offers Local Resilience Forums and individual agencies tools to improve data and information sharing for planning and response.

14. Finance and resources

14.1. The CCG Director on Call may assist and support NHS England South Central mobilise resources from locally commissioned services.

14.2. If necessary a separate cost centre will be set up with a budget in agreement with the Director of Finance. The Scheme of Delegation will apply.

15. Extended Incident

15.1. Extended incidents present a serious human resources challenge. The OCCG Director on Call will:

- regularly review the number of people committed to the incident and their energy levels
- establish shift periods which have clearly defined hand over procedures and adequate rest periods

16. End of an Incident

16.1. Standing down an Incident

As the incident diminishes the emergency services will declare stand down of the incident. A decision should then be made by OCCG Director on Call, when it is appropriate to stand down the Incident Management Team. This is because OCCG is likely to have a continuing role after emergency services have stood down. Before the Incident Management Team is disbanded arrangements should be made to review the incident via a structured debrief. This is to ensure outcomes for review are captured and incorporated in revised major incident plans.

16.2. Managing the aftermath of an Incident

16.2.1. In many incidents, the aftermath of a major incident becomes another role and involves facilitating the restoration of normal health services.

16.2.2. Provision of care and support to staff that may have been personally affected is also likely to be required.

16.2.3. Consideration should also be given to the legal and financial risks that might ensue.

16.3. Legal Framework

Following a major incident, significant incident or emergency a number of legal investigations and challenges can and will be made. These may include Coroners Inquests, Public enquiries, Corporate Manslaughter and Civil Action. Normal processes should be followed and legal advice can be sought from Oxford University Hospitals NHS Foundation Trust Legal Services. Any legal queries should be reported to NHS England

16.4. Debriefing

16.4.1. In order to identify lessons learned, a series of debriefs post incident are seen as good practice.

- **Hot debrief:** Immediately after incident with incident responders (at each location);
- **Organisational debrief:** 48-72 hours post incident;
- **Multi-agency debrief:** within one month of incident;
- **Post incident reports:** within six weeks of incident.

16.4.2. These will be supported by action plans and recommendations in order to update OCCG plans and provide any training and further exercising required.

16.4.3. OCCG may also contribute to multi-agency debriefing and actions from incident reports.

16.4.4. The Incident Management team and Director on Call will be involved in the debriefing.

17. Recovery

17.1. Recovery and the return to normal working is an important part of the management of all major incidents. In many incidents, the aftermath of the major incident becomes another phase, taking stock of the overall impact and facilitating the restoration of normal health services. OCCG has an important role as a system leader.

17.2. OCCGs role in recovery might include:

- renegotiating priorities with commissioned services
- assessing and arranging for the continuing need of primary and community health services such as psychological support and counselling
- provision of care and support to staff that may have been personally affected
- consideration of legal and financial risks that might ensue.

17.3. ACTION CARDS

A. CCG Director on call – MAJOR INCIDENT - STANDBY

B. CCG Director on call – MAJOR INCIDENT DECLARED - ACTIVATE THE PLAN

C. CCG Director on call – MAJOR INCIDENT - STANDDOWN

H. South, Central & West Commissioning Support Unit Communications Manager

Additional Action Cards specific to tasks and certain situations can be found in the Director on Call pack.

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A : Major Incident – ON STANDBY

For Action by OCCG Director on Call

Scope

If a major incident is declared or an acute hospital is put on standby the OCCG Director on Call will be informed by both the NHS England Director on Call and the receiving hospital (most likely to be the OUHFT).

The CCG Director on Call may then need to manage the situation. NB – it is likely that in the case of a Major Incident this will be managed by NHS England and the OCCG Director on Call will assist with this.

Major Incident – STAND BY

This alerts staff members that a major incident may need to be declared. Preparatory arrangements are then made appropriate to the incident.

<table>
<tr><th>Number</th><th>Actions:</th><th>Time Completed</th></tr>
<tr><td>1</td><td>In the event of a potential or actual significant /Major event, the Director on Call will normally be notified by:
• Oxford University Hospitals NHS Foundation Trust (OUHFT) Duty Executive
• NHS England</td><td></td></tr>
<tr><td>2</td><td>Document all details, decisions and actions in the on call log book or electronically.</td><td></td></tr>
<tr><td>3</td><td>Obtain as much information about the incident as possible, including any specific or urgent actions for the NHS and OCCG. Use the JESIP model for shared situational awareness following METHANE .Clarify which organisation is leading/coordinating the incident. Record :

<u>METHANE :</u>

<table>
<tr><td>M</td><td>MAJOR INCIDENT</td><td>Has a major incident or standby been declared? (Yes/No)</td></tr>
<tr><td>E</td><td>EXACT LOCATION</td><td>What is the exact location or geographical area of the incident?</td></tr>
</table>
</td><td></td></tr>
</table>

	T	**TYPE OF INCIDENT**	What kind of incident is it?
	H	**HAZARDS**	What hazards or potential hazards can be identified
	A	**ACCESS**	What are the best routes for access and egress?
	N	**NUMBER OF CASUALTIES**	How many casualties are there and what condition are they in?
	E	**EMERGENCY SERVICES**	Which and how many emergency responder assets/personnel are required or are already on-scene?
4	Inform NHS England Director on Call (unless they have informed you of the major incident)		
5	Inform (if relevant) • Oxford Health NHS Foundation Trust (OHFT) via on call Director • OUHFT via Duty Executive (unless they have informed you that they are a receiving hospital)		
6	Inform OCCG Communications Team a. Out of hours – via communications on call b. In hours (M-F 9-5pm) – contact media desk		
7	Consider internal communication cascade to: • Chief Executive Officer • Executive Directors • Heads of Service • Business Continuity Leads		
8	Consider contacting • Adult and Social Care through Out of Hours Emergency Duty Team (if relevant) • Public Health England on call (if relevant) • Local Authority on call (if relevant)		
9	Undertake an initial risk assessment of the incident (see template in Operational Response manual)		
10	Provide support to NHS England On Call Director as required		
11	If it is NOT a potential or actual major incident: • If no further action is required, ensure the log is completed and signed off • If it can be dealt with using normal resources, notify the appropriate personnel and maintain a watching brief • Continue to reassess the situation as further information becomes available and determine if any additional action is required • In the event of any increase in the scale / impact of the incident reassess the risk and re escalate as needed		

Information

Appendix A : Aide Memoire Information Log

Relevant Plans
Incident Response Operational Manual

Version Control

Version No	Date	Reason
Version 4 (JD)	21 November 2013	Change of OUHT Director on call to Duty Executive
Version 5 (RJ)	11 May2015	Update to NHS England South (South Central)
Version 6 (LA)	04 November 2015	Comprehensive Review. Change of names to OUHFT and South, Central and West CSU
Version 7 (RK)	February 2017	Review – minor changes
Version 8 (LA)	12 July 2017	Removal of Southern Health
Version 9 (LA)	19 December 2017	Include reminder to log decisions as well as details and actions. Include METHANE and Appendix A (Aid Memoire). Change of name for NHSE
Version 10 (LA)	September 2018	Change to name of NHSE' inclusion of 'Which organisation is leading/coordinating the incident' in Section 3. Include JESIP in S3. Change of name to Incident Response Operational Manual
Version 11 (LA)	June 2019	Item 6 change name of Communications team to OCCG

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B : Major Incident Declared – ACTIVATE THE PLAN

For Action by OCCG Director on Call

Scope

If a major incident is declared or an acute hospital is identified as the receiving hospital then the OCCG Director on call will be informed by both the NHS England Director on Call and the receiving hospital (most likely to be the OUHFT).

The CCG Director on Call may then need to manage the situation. NB – it is likely that in the case of a Major Incident this will be managed by NHS England and the OCCG Director on Call will assist with this.

Definitions

Major Incident Declared – ACTIVATE THE PLAN : This alerts staff members that the plan should be activated and additional resources mobilised.

<table>
<tr><th>Number</th><th>Actions:</th><th>Time Completed</th></tr>
<tr><td>1</td><td>In the event of a potential or actual significant /major event, the Director on call will normally be notified by:
• Oxford University Hospitals (OUHFT) Duty Executive
• NHS England South (South Central)</td><td></td></tr>
<tr><td>2</td><td>Document all details, decisions and actions in the on call log book.</td><td></td></tr>
<tr><td>3</td><td>Obtain as much information about the incident as possible, including any specific or urgent actions for the NHS and OCCG. Use the JESIP model for shared situational awareness following METHANE .Clarify which organisation is leading/coordinating the incident. Record :

METHANE :

<table>
<tr><td>M</td><td>MAJOR INCIDENT</td><td>Has a major incident or standby been declared? (Yes/No)</td></tr>
<tr><td>E</td><td>EXACT LOCATION</td><td>What is the exact location or geographical area of the incident?</td></tr>
<tr><td>T</td><td>TYPE OF INCIDENT</td><td>What kind of incident is it?</td></tr>
</table>
</td><td></td></tr>
</table>

		H	**HAZARDS**	What hazards or potential hazards can be identified
		A	**ACCESS**	What are the best routes for access and egress?
		N	**NUMBER OF CASUALTIES**	How many casualties are there and what condition are they in?
		E	**EMERGENCY SERVICES**	Which and how many emergency responder assets/personnel are required or are already on-scene?
4	Inform NHS England Director on Call (unless they have informed you of the major incident)			
5	Inform (if relevant) • Oxford Health Foundation Trust via on call director • Oxford University Hospital Foundation Trust via Duty Executive (unless already contacted) • Adult and Social Care through Out of Hours Emergency Duty Team (if relevant) • Public Health England on call (if relevant) • Local Authority on call (if relevant)			
6	Inform OCCG Communications Team a) Out of hours – via communications on call b) In hours (M-F 9-5pm) – contact media desk			
7	Consider internal communication cascade to: • Chief Executive Officer • Executive Directors • Heads of Service • Business Continuity Leads			
8	Undertake an initial risk assessment of the incident (see template in Operational Response Manual)			
9	Consider use of JESIP Aid Memoire : • Joint Decision Model • Principles for Joint Working • Shared Situational Awareness : METHANE • De-Briefing			
10	Consider holding an Incident Management Team meeting with key personnel (see standard agenda in Operational Response manual).			
11	Consider holding a teleconference with partners in order to coordinate response (see on-call pack for details)			
12	Use the Emergency planning nhs.net email address wherever possible: occg.emergencycontrol@nhs.net (see on-call pack for details)			
13	Resilience Direct may be used for some information (see On Call pack for details)			
14	Identify an incident rhythm dependent on • Reporting requirements • NHS England requirements			

	This will determine when certain actions need to take place	
15	Establish an Incident Co-ordinating centre, if indicated, tasking specific staff	
16	Ensure Communication Manager is appropriately linked in	
17	In consultation with the NHS England South East Director on Call, determine when the stand down should be declared	

Information
Appendix A : Aide Memoire Information Log
Appendix B : JESIP

Relevant Plans
Incident Response Operational Manual

Version Control

Version No	**Date**	**Reason**
Version 4 (JD)	21 November 2013	Change of OUHT Director on call to Duty Executive
Version 5 (RJ)	11 May 2015	Update to NHS England South (South Central)
Version 6 (LA)	04 November 2015	Comprehensive review. Change of names to OUHFT and South, Central and West CSU
Version 7	12 July 2017	Removal of Southern Health
Version 8	19 December 2017	Include reminder to log decisions as well as details and actions. Include METHANE and Appendix A (Aid Memoire Information log), and Appendix B JESIP Model Aid Memoire. Include reminder for Resilience Direct use. Change of name for NHSE.
Version 9	September 2018	Change to name of NHSE' inclusion of 'Which organisation is leading/coordinating the incident' in Section 3. Include JESIP in S3. Change name to Incident Response Operational Manual
Version 10	June 2019	Change name Comunications team to OCCG

Oxfordshire
Clinical Commissioning Group

C : Major Incident \ STAND DOWN

For Action by OCCG Director on Call

Scope

Following a Major incident the response will need to be formally stood down. This direction may come from NHS England or maybe decided by the OCCG Director on Call when systems are returning to normal. It should be noted that it is possible to 'stand down' organisations at different times depending on their response.

Definitions : Major Incident – Stand Down

All receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible the Ambulance Incident Commander will make it clear whether any casualties are still en-route. OCCG will then assess its own appropriateness to stand down

Number	Actions:	Time Completed
When the 'Stand down' command is given from NHS England or agreed within OCCG the OCCG Director on Call will		
1	Ensure that all stakeholders are aware the Major Incident is stood down. The CCG Director on Call should ensure the following are aware (if relevant): • NHS England (unless they have informed you of the stand down) • Oxford University Hospital NHS Foundation Trust (OUHFT) Duty Executive (unless already contacted) • Oxford Health NHS Foundation Trust (OHFT) Director on Call (unless already contacted) • Adult and Social Care through Out of Hours Emergency Duty Team (if relevant) • Public Health England on call (if relevant) • OCCG Communications team (Out of hours – via communications on call, In hours (M-F 9-5pm) – contact media desk)	
2	Ensure that a process is in place for an appropriate return to business as usual internally and externally across the local NHS	
3	Support the multi-agency recovery phase if required	
4	Agree when staff involved in the incident should return to their normal duties	
5	Debrief the staff working in the incident room ('hot debrief'). Consider : • What worked well	

	• What didn't work well? • Lessons Learned	
6	Complete and sign off the incident log and ensure all relevant documentation is secured.	
7	Contribute to multiagency debriefs as required	
8	Ensure a formal report is prepared, highlighting any good practice or issues identified.	
9	Ensure report and learning is passed to the member of staff responsible for updating the Major Incident Plan, Incident Response Manual and Director on Call packs	

Information
None

Relevant Plans
Incident Response Operational Manual

Version Control

Version No	Date	Reason
Version 2 (JD)	21 November 2013	Change of OUHT Director on call to Duty Executive
Version 3 (RJ)	11 May 2015	Update to NHS England South (South Central)
Version 4 (LA)	04 November 2015	Comprehensive review. Change names to OUHFT and South, Central and West CSU. Additional organisations added to section 1
Version 5 (LA)	12 July 2017	Removal of Southern Health
Version 6 (LA)	19.12.2017	Addition of de-brief points. Change of name for NHSE
Version 7 (LA)	September 2018	Change of name for NHSE and Incident Response Operational Manual
Version 8 (LA)	June 2019	Change name of Communications team to OCCG

Oxfordshire
Clinical Commissioning Group

H : Communications On Call

For Action by OCCG Communications Manager

Scope

Communications are key in any major incident and the OCCG Director on Call will ensure that the OCCG Communications Manager on call is informed of any major incident (whether declared or standby).

In hours contact will be made via the media desk (01865 334640) which will identify an appropriate Communication Manager to link with the OCCG Director on Call. Out of hours the Communications on call can be contacted via 0300 123 4465 on the emergency card.

Number	Actions:	Time Completed
The role of the Communication Manager on call will be to provide communication co-ordination, advice and support to the OCCG Director on Call		
1	Confirm with the Director on Call that an incident is taking place	
2	Contact the NHS England Communications Lead and agree who will be leading on communications for the incident	
3	Commence a personal log	
4	Obtain all available information about the incident and liaise with communication colleagues in local trusts and neighbouring CCGs, the Local Authority and Police and any other stakeholders	
5	Issue pre-arranged public health/safety messages in conjunction with Public Health England within the first hour of becoming aware of the incident if leading on communications.	
6	Assume responsibility for managing OCCG staff communications and link with the NHS England Communications Lead regarding public information and media communications. Note that if the Strategic Coordinating Group (SCG) is established all media responses are controlled and coordinated by them so communications input/feedback should be fed upwards into the SCG	
7	Identify a health spokesman for media response– if an OCCG spokesperson is required this would normally be the Director on Call or another Director.	
8	Alert communications network of incident and advice of media handling strategy.	
9	Deal with all media enquiries/draft statement/organise press conferences and interviews as agreed in media handling	

	strategy	
10	Identify communications administration support to log media calls and develop rolling question and answer brief	
11	On stand down, ensure that all original documentation (including notes, flip charts, emails etc.) are kept. Close personal log	
12	Attend hot and formal debriefs	
13	Manage any on-going media interest in the NHS response, including social media	

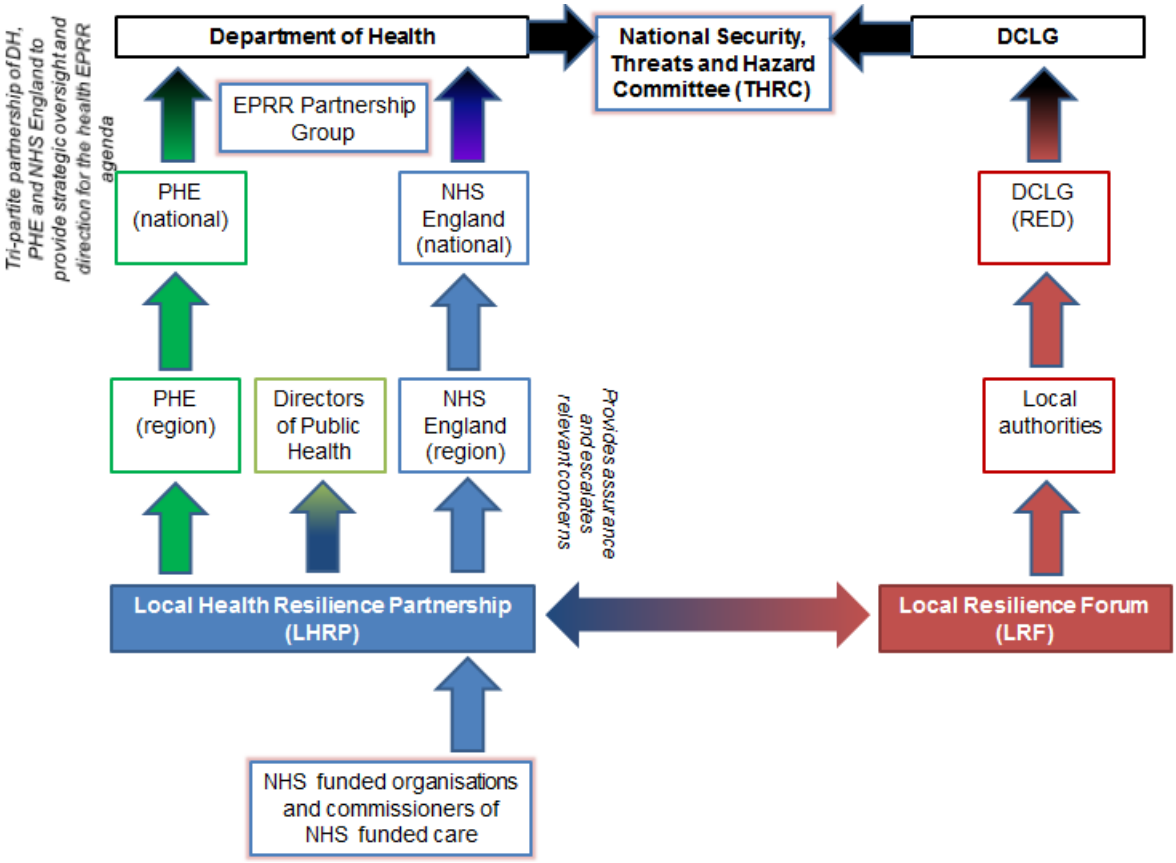
Information

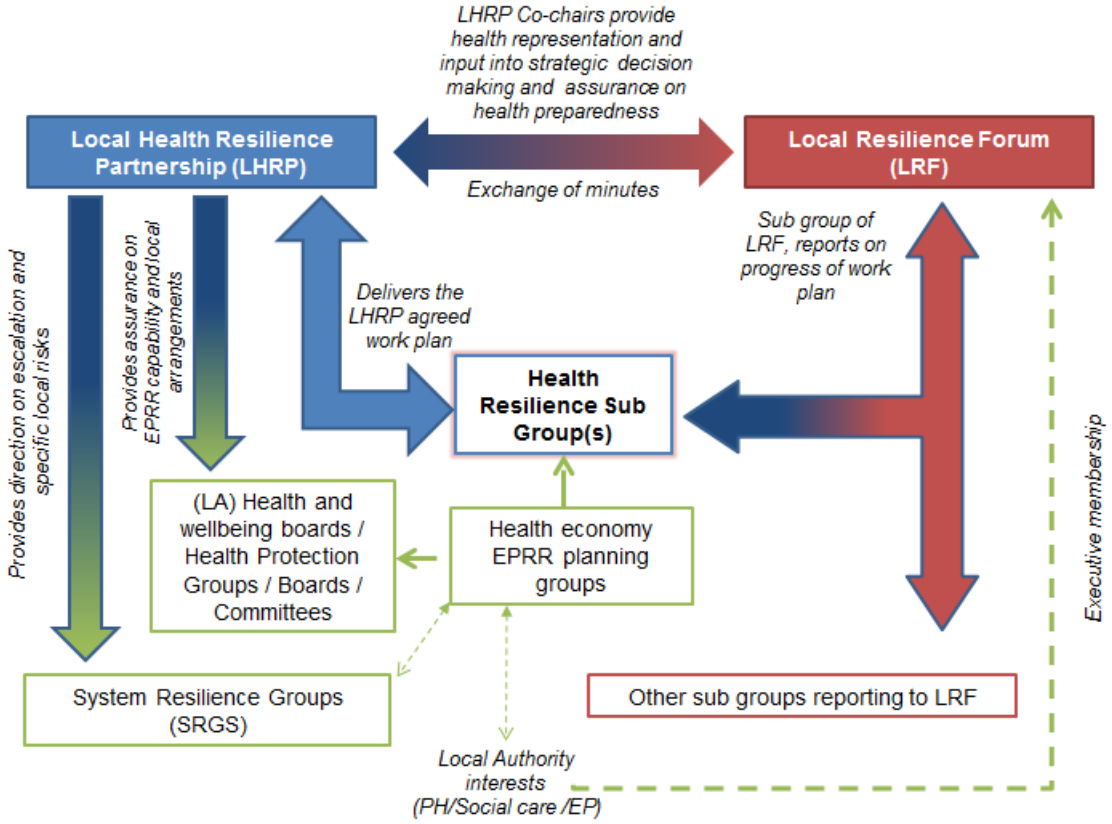
Relevant Plans

Version Control

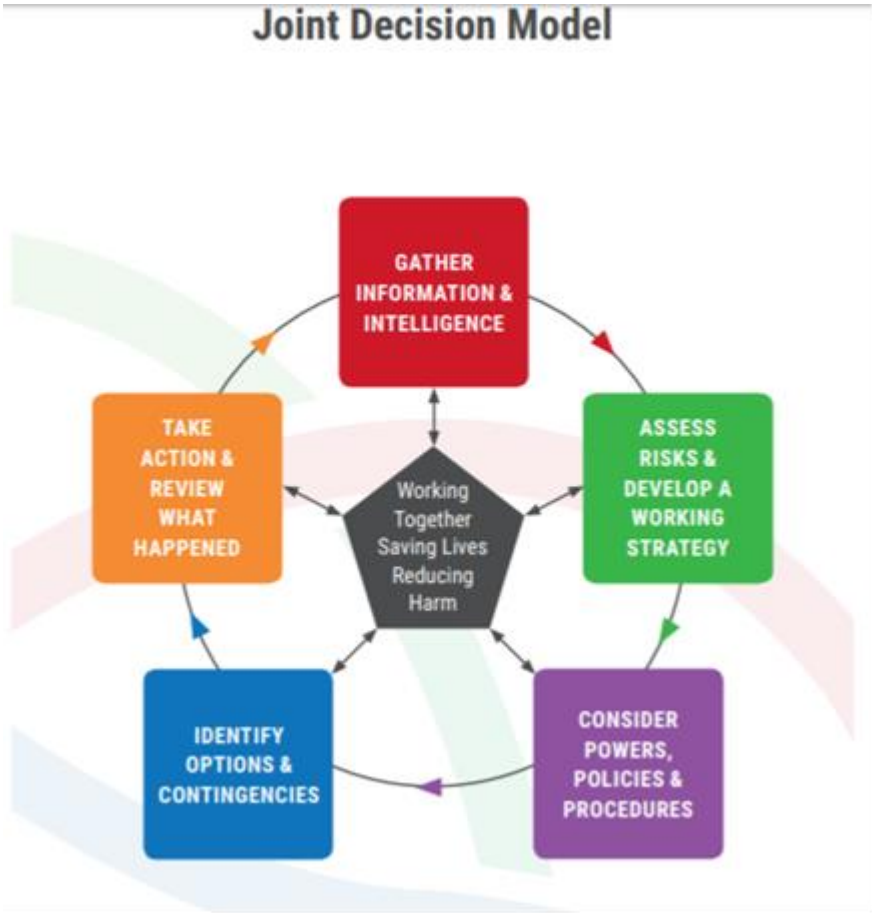
Version No	**Date**	**Reason**
Version 2 (JD)	19 December 2013	
Version 3 (RJ)	11 May 2015	Update to NHS England South (South Central)
Version 4 (LA)	04.11.15	Comprehensive review. Change of name to South, Central and Southern CSU
Version 5 (LA)	September 2018	Change name of NHSE. Update pager number
Version 6 9LA)	June 2019	Change name of Communications Team to OCCG

Appendix 1 Planning Structure

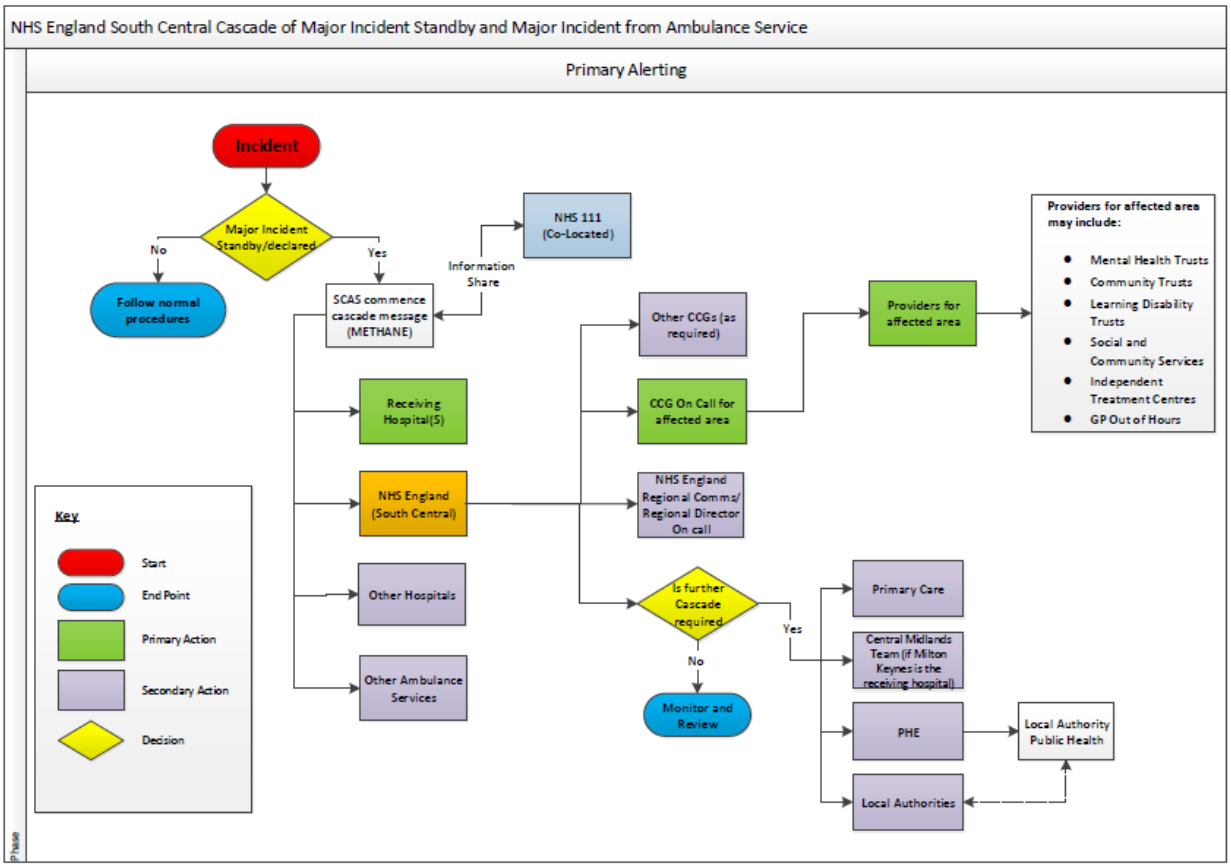




Appendix 2 JESIP



Appendix 3 SCAS Cascade



Appendix 4 -

Agenda for Health Teleconference – Initial Meeting

This agenda is flexible and scalable depending on the nature of the incident ** Based on NHSE Agendas	
Note to chair : Ensure actions, rationales and decisions are contemporaneously recorded throughout the meeting	
Note to organisations : Organisations should document their respective decisions and rationale Ensure you have considered your own powers, policies and procedures	
No	Item
1	Confirm chair and minute taker
2	Record attendance and agree membership
3	Purpose of the meeting
4	Confirm Health Strategic Objectives * Use JESIP as a guide
5	Gather information and intelligence • METHANE report (sitrep) from the responding Ambulance Service • Updates from organisations • Existing command structures in place (single organisation and multi-agency) • Review actions already taken – response required from each participating organisation. Confirm if any organisations have declared ‘major incident’ for their organisation
6	Health community actions and associated impacts • Identify actions • Develop a working strategy and assess risks • Forward look and possibility of deterioration in the situation • Timelines and lead
7	Communications Strategy • Assign communications lead and confirm teleconference scheduled • Highlight any immediate concerns (eg reactive/holding statements, social media)
8	Formal situation reports (SITREPs) from organisations if scale of the response requires
9	Agree next meeting • If scale of the incident requires complete Cycle of command
Circulate Risk Assessment, Action Log and Cycle of Command to the group	

October 2017 NHSE

Agenda – Standard Meeting Teleconference

Health Community Teleconference Agenda – Standard Meeting (If this is the initial meeting please use the 'Initial Meeting agenda' ** Based on NHSE Agenda	
This agenda is flexible and scalable depending on the nature of the incident	
Note to Chair : Ensure actions are contemporaneously recorded throughout the meeting Be clear what the actions are for the person recording them for you Use an action log Note to Organisations : • Organisations are encouraged to document their respective decisions and rationale • Ensure you have considered your own powers, policies and procedures	
No	Item
1	Confirm Chair and identify loggist and or minute taker
2	Attendance/apologies • Check for any additional members required
3	Opportunity for urgent updates from organisations • High impact situational changes since last teleconference by exception
4	Review of Action Log • Actions completed • Actions outstanding • Matters arising
5	Situation update • New information/intelligence/data – review what happened • Organisational updates • Service disruption • Multiagency update/information required • Notify of any changes to command and control structures
6	Health community actions and associated impacts • Update as required • Review risk assessment (by exception) • Forward look and possibility of deterioration pf situation • Inform decision to stand down the response • Identify options and contingencies • Timelines and lead
7	Communications Strategy • Update from the Communications lead
8	Next meeting
Circulate Risk Assessment, Action Log and Cycle of Command to the group	

Appendix 5 – Incident Situation Reports

NHS Incident Situation Report (SitRep)

Note: Please complete all fields. If there is nothing to report, or the information requested is not applicable, please insert NIL or N/A
Instructions for completion are provided at the end of the template
This template will be customised by NHS England as soon as practicable for use during an incident however initial reporting should be done on the generic template
For second and subsequent SitRep reports highlight new information in yellow

The source, time and assessed quality of information should be reported. Uncertainties and working assumptions must be clearly identified

Organisation Name:				
	NHS England Region (DCO Team) ☐	NHS England Regional Team ☐	CCG ☐	Provider ☐
For Provider Organisations **Services Provided:** [1]	Acute Services ☐	Community Services ☐	Mental Health ☐	
	Ambulance (Emergency) Services ☐	Ambulance (Non-emergency) ☐	Urgent Care Services ☐	
	Minor Injuries Unit Services ☐	Walk-in-Centre Services ☐	NHS 111 ☐	
	General Practice ☐	Out of Hours GP Service ☐		
	Other ☐ (specify)			

Date:		dd/month/yyyy	**Time:**	hh:mm
Completed by:	Name			
	Title			
Telephone number:				
Email address:				
Authorised for release by:	Name			
	Title			

Exact location of Incident/s [2]				
NHS Incident [3]	Business Continuity Incident ☐	Critical Incident ☐	Major Incident ☐	
Type of Incident/s [3]	Big Bang ☐	Rising Tide ☐	Cloud on the Horizon ☐	Headline News ☐
	Internal Incident ☐	CBRNe ☐	HAZMAT ☐	Mass Casualties ☐
	Extreme Weather ☐	Flooding ☐	Infectious Disease ☐	Other ☐
	Specify Other			
Description of Incident [4]				
Resources Deployed [5]				

NHS Ambulance Service

Incident Scene Casualties [6]	Location	**P1/P2:**		**P3:**		**P1 Hold:**		**Discharge on scene**		**Dead on scene**	
		Adult	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**
Scene # 1											
Scene # 2											

Receiving Facilities Initial Report

Receiving Hospitals / Provider [7]	Location/Site	**T1:**		**T2:**		**T3:**		**T4:**		**Admit**		**Discharge**		**Dead**	
		Adult	**Child**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
Trust/Provider (Name) # 1															
Trust/Provider (Name) # 2															
Trust/Provider (Name) # 3															
Trust/Provider (Name) # 4															
Total at Receiving Hospitals															

Receiving Facilities Subsequent Report

Receiving Hospitals / Provider	Location/ Site	Total number attended		Total number currently admitted		Total number currently in critical care (Level 3 and Level 2)		Total number discharged home		Total number discharged/transferred to another provider (specify where for each patient)		Total Died in Hospital	
		Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child
Trust/Provider (Name) #1													
Trust/Provider (Name) #2													
Trust/Prov													

ider (Name) #3													
Trust/Provider (Name) #4													
Total at receiving facilities													

If any of the patients above is normally resident in Scotland, Wales or Northern Ireland or is a foreign national then complete the following table

Receiving Hospitals / Provider	Nationality	Total number attended		Total number currently admitted		Total number currently in critical care (Level 3 and Level 2)		Total number discharged home		Total number discharged/transferred to another provider (specify where for each patient)		Total Died in Hospital	
		Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child
Trust/Provider (Name) #1													
Total at receiving facilities													

Actual impact on Critical Functions and/or services and/or patients [8]	
Potential impact on Critical Functions and/or services and/or patients	
Capacity Issues [9a]	
Capability Issues [9b] (e.g. major trauma, burns)	
Impact on business as normal [10]	
Mitigating actions taken/planned	

Mutual Aid Request Made [11]	Yes ☐ No ☐ Details

Current media interest and messages [12]	
Potential media interest and messages	
Media lead (Name) **Email** **Telephone number**	

Other Information/Context [13] Other Key information that you as Incident Director (Strategic Commander) deem relevant for NHS England to be aware of	
Key risks and mitigating actions [14]	
Key risks for escalation [15]	

Incident Specific Information and Questions [16]	*Insert any specific information/questions related to the incident*

Forward Look [17]	Next 12 hours Next 24 hours Next 48 hours Next week

Recovery Actions [18] Including any issues	

Next SitRep Due [19] **Battle Rhythm**	**Date:** dd/month/yyyy **Time:** hh:mm

Return to [20]	**Email:**	**england.tv-icc@nhs.net**
	Contact Telephone Number	**On Call Pager 07623 505519**

NHS Incident Situation Report (SitRep)

Notes to aid completion of SitRep

1. Services Provided

Tick all appropriate boxes for types of service provided by your organisation. If 'other' specify service(s) provided. In subsequent information provide information appropriate to the services affected. If it is easier for clarity please complete a separate template for each type of service provided

2. Exact Location of Incident/s

Provide information relating to the location of incident/s including, where possible, address Indicate if this is an NHS site (this is the incident scene)

3. Type of Incident/s

Tick appropriate box(s) for type of incident, if 'other' specify

4. Description of Incident

Provide as much detail as possible regarding the type of incident and extent

5. Resources Deployed: *Delete if not required*

- Resources deployed at scene of/to incident e.g. Hazardous Area Response Team (HART), Special Operations Response Team (SORT), Medical Advisers or teams, Number of double crewed ambulances (DCA's)/Rapid Response Vehicles (RRV's), Decontamination, Air Ambulance

6. Incident Scene Casualties: *Delete if not required*

Insert name of each scene in the first column, under location add address of scene. Insert additional rows as required

Provide numbers (where possible provide adult and paediatric numbers separately, combine if not known) based on triage sieve:

P1: Immediate - Casualties who require immediate life-saving procedures **P2: Urgent - Casualties who require surgical or medical intervention within 2-4 hours.** For initial reports the numbers of P1 and P2 may be combined
P3: Delayed – Less serious cases whose treatment can safely be delayed beyond 4 hours
Discharge at scene – number of patients seen, treated and discharged at scene
Dead – number of patients 'recognition of life extinct' at scene

7. Receiving Units, Admissions and Fatalities in Hospital: *Delete if not required*

Insert name of each Trust/provider/receiving unit in the first column. Insert site/hospital address under location. Add additional rows as required

Provide numbers (where possible provide adult and paediatric numbers separately,

combine if not known), include self-presenters: (T- Triage Sort)

T1: Immediate - Casualties who require immediate life-saving procedures

T2: Urgent - Casualties who require surgical or medical intervention within 2-4 hours

T3: Delayed – Less serious cases whose treatment can safely be delayed beyond 4 hours

T4: Expectant – Casualties whose condition is so severe that they cannot survive despite the best available care and whose treatment would divert medical resources from salvageable patients who may then be compromised

Confirm if invoked and who by

Admit - Number of patients arriving at hospital and subsequently admitted
Discharge – Number of patients arriving at hospital and subsequently discharged
Dead - Number of patients arriving at hospital and subsequently dying at/or in hospital

Please expand with a level of appropriate detail for these points below

The second table is to be used on subsequent reports for all incident patients

Total number attended – the total number, including self-presenters, who have attended at each facility as a result of the incident, split by adult and child (cumulative total)

Total number currently admitted – the total number of incident patients currently admitted as an in-patient at the time of reporting, split by adult and child

Total number currently in critical care (Level 3 and Level 2) – the total number of incident patients currently receiving level 3 or level 2 critical care, split by adult and child

Total number discharged home – the total number of incident patients discharge home (cumulative total), split by adult and child

Total number discharge/transferred to another provider – the total number of incident patients discharged and transferred to another provider for ongoing care (cumulative total). Split by adult and child. Specify destination for each patient

Total died in hospital – the number of incident patients who have died following attendance/admission at the facility, split by adult and child (cumulative total)

If any of the patients identified in receiving facilities are normally resident in Scotland, Wales or Northern Ireland (the devolved administrations) or is a foreign national then these are to be identified by nationality at each provider

8. Impact on Critical Functions e.g.:

Separate actual and potential impacts

- Implications on Ambulance Red 1 and Red 2 response times
- Critical Care, ECMO, burns beds, acute admissions capacity. Split by adult and paediatric
- Primary, community services and mental health

9. Capacity/Capability Issues:

a) Capacity – e.g. bed availability, theatre availability, primary and community services, double crewed ambulances
b) Capability – e.g. adequate numbers of competent staff, Paramedic staff availability

10. Impact on Business as Normal and Mitigating Actions:

- Cancellation of elective activity should be covered here
- Any other service reduction as consequence of incident
- Staffing issues
- Supply chain issues
- Include actions taken or planned to mitigate impact on patients
- Business continuity issues

11. Mutual aid request:

- Confirm details of mutual aid requested, by whom and from who requested
- Confirm whether or not the request was granted and the extend of mutual aid provided

12. Media:

- Indicate media interest shown/reported, including social media
- Provide key messages for media; also provide details of lead media contact
- Indicate any potential media interest and any proactive messages

13. Context

- For the incident director/strategic commander to put context to the overall situation report emphasising the strategic dimensions and issues arising
- Other key information e.g.
    - **Fuel disruption** – use of NHS bunkered fuel including estimate of current stock levels (number of days supply) and which organisations are accessing bunkered fuel stocks

14. Key Risks and Mitigating Actions

Provide a summary of the key risks from the incident and the mitigating actions

15. Key Risks for Escalation

Provide details of all key risks where escalation is required to mitigate the effects. Include details of who the risks have been escalated to

16. Incident Specific Information and Questions

This section can be used to request specific information relating to an incident

17. Forward Look

- Provide an update regarding anticipated impacts/actions required in the next 12, 24, 48 hours and the next week
- Adjust timescales as appropriate
- This will summarise emerging risks and critical uncertainties that have potential strategic implications for the response and recovery effort

18. Recovery Actions

- Include any information available regarding recovery actions that will/may be required in the short, medium and long term
- Indicate areas where additional external support may/will be required

19. Next SitRep Due/Battle Rhythm

- Insert date/time next SitRep is due to be submitted (realistic to when updated information will be available)
- If known insert applicable Battle Rhythm

20. Return to

- NHS England national and regional teams to amend as appropriate BEFORE sending SitRep to providers for completion
- If using the SitRep to report an incident prior to formal request for SitRep then return to NHS England via normal incident reporting procedures

Appendix 6 - GLOSSARY

CCG	Clinical Commissioning Group
COBR	Cabinet Office Briefing Room
SCW CSU	South, Central and West Commissioning Support Unit
ICC	Incident Control Centre
OCCG	Oxfordshire Clinical Commissioning Group
PHE	Public Health England
SAGE	Scientific Advisory Group for Emergencies
SCG	Strategic Coordinating Group
SITREP	Situation Report
STAC	Scientific and Technical Advice Cell