

Trust Board Meeting: Wednesday 11 July 2018
TB2018.72

Title	Emergency Preparedness, Resilience and Response – Annual Report
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Status	For approval.
History	This is a regular report to Trust Board.

Board Lead(s)	Mrs Sara Randall, Acting Director of Clinical Services			
Key purpose	Strategy	Assurance	Policy	Performance

Executive Summary

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| 1. This paper provides a report on the Trust's preparedness for emergencies. |
| 2. It discusses the planning progress over the past year, looks at the training and exercising programme, and gives a summary of instances in which the Trust has had to respond to extraordinary circumstances. |
| 3. Recommendation

The Trust Board is asked to accept and endorse this report and approve the revised EPRR Policies. |

Emergency Preparedness, Resilience and Response – Annual Report July 2018

1. Introduction

- 1.1. This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.
- 1.2. The Trust has a mature suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with regional stakeholders to ensure cohesion with their plans.
- 1.3. The paper reports on the training and exercising programme, EPRR reporting programme, and details the developments of the emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

2. Background

- 2.1. The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level. As a category one responder, the Trust is subject to the following civil protection duties:
 - assess the risk of emergencies occurring and use this to inform contingency planning
 - put in place emergency plans
 - put in place business continuity management arrangements
 - put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
 - share information with other local responders to enhance co-ordination
 - cooperate with other local responders to enhance co-ordination and efficiency

3. Risk Assessment

- 3.1. The Civil Contingencies Act (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Local Resilience Forum Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, and that preparation arrangements are undertaken and response plans exist. The Trust's EPRR risk register mirrors the risks identified on the Community Risk Register that could impact on human health.

4. Assurance

- 4.1. Appendix 1 details the EPRR assurance logs for 2017/18 and 2018/19 YTD. These logs detail the publication dates of key EPRR documents and dates they are due for release or review.

5. Audits

- 5.1. In August 2017, SCAS undertook an audit of the Trust's CBRN(E)/HazMat (Chemical, Biological, Radiological and Nuclear (Explosive)/Hazardous Materials) incident preparedness. Feedback to the Trust noted that the Trust was well-prepared to manage a CBRN(E)/HazMat incident; however, further training and exercising would be beneficial. Following this audit, training for front-line staff has been increased and a rolling programme put in place. The audit is scheduled to be repeated in the summer of 2018.
- 5.2. In June 2017, Oxfordshire CCG and NHS England undertook an audit of our EPRR arrangements. This took the form of a self-assessment audit and a site visit. The report noted that planning was in line with the national core standards for EPRR. The audit highlighted four areas for improvement:
 - 5.2.1. Procurement department to ensure business continuity requirements are written into all contracts. This is an ongoing action.
 - 5.2.2. Training and exercising of plans could be improved. This is an ongoing action due to staff turnover.
 - 5.2.3. The Trust would benefit from having a Non-Executive lead to hold the portfolio for EPRR. This action is in progress.
 - 5.2.4. Attendance at the Local Health Resilience Partnership could be improved. This action has now been closed with a deputy identified if the Accountable Emergency Officer is unable to attend.

6. Partnership Working

- 6.1. The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Thames Valley Local Health Resilience Partnership (Executive and Business Groups), and the Oxfordshire Resilience Group. The Trust is also represented at a number of sub groups of the Thames Valley Local Resilience Forum. The purpose of these groups is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England.

7. Debriefing From Live Events and Exercises

- 7.1. Following live events and exercises, debriefs are undertaken in order to capture learning points. Lessons identified from live events and exercises are subsequently incorporated into major incident and business continuity plans, and are shared with partner organisations.

8. Communications

- 8.1. Communication is critical in dealing with any adverse incident. As part of the Trust's exercise programme, a series of communications exercises was held in the Thames Valley over the year. The exercise series, named 'Exercise Talk Talk', simulated a major incident communications cascade. Table 2 details these exercises and the learning gained from them.

9. Planning Sector Reports

9.1. The following sections provide an area-by-area report on developments over the past year and planning for next year.

9.2. Major Incident Policy

9.2.1. This Policy details the Trust's actions in the event of an external major incident (e.g., an air disaster, rail crash, floods, or a terrorist attack). Such an event will require the hospital to employ a different method of working in order to manage the situation. The Policy is supplemented with unit-level plans (held locally) that detail the actions required of individual units to ensure that the corporate plan is achieved. In addition to conventional incidents, the policy details how the Trust will manage CBRN(E)/HazMat incidents. The Policy plans for the management of mass casualties.

9.2.2. Version 9.5 of the Policy was released in July 2017.

9.3. Business Continuity Management Policy

9.3.1. Business Continuity Management is a management process that helps to manage the risks to the smooth running of an organisation or delivery of a service, or ensuring that the business can continue in the event of a disruption. These risks can be from the external environment (e.g., power failures or severe weather) or from within an organisation (e.g., systems failures or loss of key staff). A business continuity event is any incident requiring the implementation of special arrangements within an NHS organisation in order to maintain or restore services. For NHS organisations, there may be a long 'tail' to an emergency event, e.g., loss of facilities, provision of services to patients injured or affected in the event, etc.

9.3.2. The Policy is comprised of a corporate-level policy and supported by service-level plans. These service-level plans detail what would be required for the service to continue; which less-critical services or functions could be suspended and for how long in order to maintain critical services; which other services are required for that service to function; and which services rely on that service being operational.

9.3.3. The Policy has specific plans for the management of high likelihood incidents. These are:

- Fuel supply disruption
- Adverse weather
- On-site traffic management
- Pandemic influenza

9.3.4. Version 5.4.1 of the Policy was released in February 2018. The Policy aligns to British Standard ISO22301.

9.3.5. Table 1 shows the Division's progress on developing service continuity plans. It is recognised that planning in this area is not as thorough as it should be and a campaign to improve this is currently underway.

9.3.6. The criteria for RAG ratings is as follows:

- Plan review or test date over 2 years old or no plan/plan not tested = Red
- Plan not reviewed in past 12 months or plan not tested in past 12 months = Amber
- Plan ratified, tested and reviewed in past 12 months = Green

9.4. Hospital Evacuation Policy

9.4.1. This Policy details how the Trust would manage a scenario whereby it would need to evacuate a number of patients from the premises and potentially a whole block or site.

9.4.2. Version 5.4 of the Policy was released in July 2017.

10. Policy Review

10.1. The Trust Board is requested to approve the following policies as part of the annual review process. A summary of changes made to the documents is detailed below:

Major Incident Policy	<ul style="list-style-type: none"> • Updated throughout in line with national guidance. • Updated with NHS England Situation Report Pro Forma. • Paediatric Plans moved to separate document. • Hyperlinks to internal references added.
Business Continuity Management Policy	<ul style="list-style-type: none"> • Updated with NHS England Situation Report Pro Forma. • Fuel disruption planning checklist included. • Minor updates throughout. • Hyperlinks to internal references added.
Hospital Evacuation Policy	<ul style="list-style-type: none"> • Revised definitions and recovery sections aligning to recent national guidance.

10.2. Full versions of all of the above-mentioned policies can be found on the following link:

<http://ouh.oxnet.nhs.uk/EmergencyPlanning/Document%20Library/Forms/AllItems.aspx?RootFolder=%2fEmergencyPlanning%2fDocument%20Library%2fDRIFT%20PLANS%20FOR%20CONSULTATION&FolderCTID=0x010100B8D667E6D53D4008BD59E0D3C18CDFE0002AE606AEDB29F94AA21DD6A203BF9A8A&View=%7bB91A3C86%2dC9D8%2d41E8%2d985D%2dD44918773D05%7d>

11. Testing and Exercising

11.1. The Trust has a rolling programme of live, table-top, command post and communications exercises that are designed to test and develop our plans. The Trust is required to hold the following:

- Communications exercise – minimum frequency – every six months
- Table top exercise – minimum frequency – every 12 months
- Live play exercise – minimum frequency – every three years
- Command post exercise – minimum frequency – every three years

- 11.2. If an organisation activates their ICC in response to a live incident this replaces the need to run an exercise, providing lessons are identified and logged and an action plan developed.
- 11.3. Appendix 1 details our compliance against these standards.
- 11.4. Whenever possible, the Trust strives to ensure that our testing is held in a multi-agency context. This is to provide familiarisation with other organisations and to assist with benchmarking our response with our partners. Exercises provide invaluable insight into the operationalisation of our plans and important information regarding the areas of the plans that require further development. Table 2 details the training and exercises undertaken from April 2017 to June 2018. In addition to these, a rolling programme of service-level major incident and business continuity exercises has taken place (see Table 1 for details). Improvement in the level of service level training and exercising is recognised and a campaign to improve this is currently underway. A rolling programme of Decontamination Training for ED staff is in place. Finally, 9 Managing the Health Response to Incidents courses have been held for On Call Duty Executives, Duty Managers, General Managers, Operational Services Managers, and Matrons.
- 11.5. Further exercises are being planned for next year. These will include two communications cascade exercises (the first being scheduled for October 2018) and at least one table-top exercise (the first being scheduled for October 2018). The Trust holds bi-monthly command post exercises for Duty Executives, Duty Managers and Operational Managers.
- 11.6. At the regional level, a pandemic influenza table-top exercise is being planned for October 2018. The Trust is planning a bolt-on command post exercise to a regional exercise being held in October 2018.
- 11.7. As required by the EPRR Core Standards, all corporate-level training and exercising is based on and referenced to the National Occupation Standards for Civil Contingencies.

12. Live Events

- 12.1. During 2017/18, the OUH experienced a number of extraordinary incidents. These are detailed below:

- Over the year the Trust managed a number of suspected Highly Pathogenic Diseases presentations (3 suspected MERS cases and a case of suspected Lassa Fever). All cases were confirmed as negative.
- In October 2017, an external interruption to the water supply to the Churchill and NOC sites required the implementation of our business continuity plans.
- In December 2017, the Trust was required to undertake considerable planning to prepare for and manage the insolvency of Carillion PLC.
- The Trust was required to relocate inpatients from the Trauma block following issues raised over the fire safety arrangements in the block.
- During January and March 2018 severe weather required the Trust to enact its Business Continuity Plans.
- In March 2018, 10 people presented to the Trust with exposure to Palytoxin.

- Also in March 2018, the Trust was required to put plans in place should we receive any potentially contaminated people from the Salisbury Novichok incident. One suspected cases presented to the Trust who was not symptomatic and discharged home.

13. Summary

13.1. The past year has seen good developments in the Trust's resilience arrangements; however, more work is required at the service level to achieve full resilience.

13.2. The Trust should be undertaking a more detailed and comprehensive training and exercising programme; however, this requires resourcing.

14. Recommendations

14.1. It is recommended that the Trust Board accepts and endorses this report.

14.2. It is recommended the Trust Board approves the revised EPRR Policies.

Sara Randall, Acting Director of Clinical Services

David Smith, Emergency Planning Officer

June 2018

Appendix 1 – Emergency Preparedness, Resilience and Response Assurance Log – 2017/18 and 2018/19 YTD

Information as at 4/6/18.

2016/17

Group	Valid	Valid Period (Months)	Review Date	2015/16 Date	Date Approved/Sent											
					2016 Apr	2016 May	2016 Jun	2016 Jul	2016 Aug	2016 Sep	2016 Oct	2016 Nov	2016 Dec	2017 Jan	2017 Feb	2017 Mar
1 POLICIES																
Major Incident Policy	TIME/Trust Board	12	07/17	30/06/15						13/07/16						
Business Continuity Policy	TIME/Trust Board	12	07/17	30/06/15						13/07/16						
Hospital Evacuation Policy	TIME/Trust Board	12	07/17	30/06/15						13/07/16						
MERS Plan	TIME/OMD	12	01/18	30/11/15										01/01/17		
VHF Plan	TIME/OMD	13	02/18	30/01/16										01/01/17		
2 RISK REGISTER																
Risk Register Review		12	10/17	04/10/15									10/10/16			
3 REPORTING																
Annual TIME Report	TIME	12	07/17	01/06/15						13/07/16						
Annual Trust Board Report	Trust Board	12	07/17	01/06/15						13/07/16						
Directorate Board Report	Directorate Management Team	1	04/17	01/03/16	01/04/16	01/05/16	01/06/16	01/07/16	01/08/16	01/09/16	01/10/16	01/11/16	01/12/16	01/01/17		
Monthly Divisional Teams Report	Divisional Teams	1	04/17	01/03/16	01/04/16	01/05/16	01/06/16	01/07/16	01/08/16	01/09/16	01/10/16	01/11/16	01/12/16	01/01/17		
4 AUDITS																
EPRR Core Standards Self Assessment Audit	TIME and CCG	12	08/17	01/07/15						03/08/16						
National Capabilities Survey	DCS	24	11/16	12/11/14												
SCAS CDRN Audit	SCAS	12	05/17	15/02/15		18/05/16										
CDRN Equipment Audit	EPRR Group	3	08/17	15/06/16						29/09/16			05/12/16	30/04/17		
4 TRAINING																
Communications Exercise	EPRR Group	6	05/17	22/10/15		11/04/16							01/11/16			
Table Top Exercise	EPRR Group	12	10/17	22/10/15				07/06/16				21/10/16				
Live Exercise	EPRR Group	36	11/19	23/02/16								12/10/16				
Command Post Exercise	EPRR Group	36	11/19	23/02/16				14/06/16				11/10/16				
Front of House JESPIOR	EPO	12	01/01													
ED Staff JESPIOR	EPO	12	12/17	01/11/15									01/12/16			
ED Front of House JESPIOR	EPO	12	12/17	01/11/15									01/12/16			
Security Front of House JESPIOR	EPO	12	12/17	01/11/15									01/12/16			

2018/19

Group	Valid	Valid Period (Months)	Review Date	Date Approved/Sent												
				2017/18	2018	2018	2018	2018	2018	2018	2018	2018	2019	2019	2019	
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1 POLICIES																
Major Incident Policy	TME/Trust Board	12	07/2018	12/07/17												
Business Continuity Policy	TME/Trust Board	12	07/2018	12/07/17												
Hospital Evacuation Policy	TME/Trust Board	12	07/2018	12/07/17												
MERS Plan	TME/OXMD	12	01/2018	01/01/17												
VHF Plan	TME/OXMD	12	01/2018	01/01/17												
2 RISK REGISTER																
Risk Register Review		12	08/2018	19/08/17												
3 REPORTING																
Annual TME Report	TME	12	07/2018	12/07/17												
Annual Trust Board Report	Trust Board	12	07/2018	12/07/17												
Directorate Board Report	Directorate Management Team	1	07/2018	14/03/18	01/04/18	01/05/18	04/06/18									
Monthly Divisional Teams Report	Divisional Teams	1	07/2018	14/03/18	01/04/18	01/05/18	04/06/18									
4 AUDITS																
EPRR Core Standards Self-Assessment Audit	TME and CCG	12	09/2018	31/08/17												
National Capabilities Survey	DCS	24	05/2019	20/04/17												
SCAS CBRN Audit	SCAS	12	08/2018	14/08/17												
CBRN Equipment Audit	EPRR Group	3	07/2018	31/03/18												
4 TRAINING																
Communications Exercise	EPRR Group	6	05/2018	14/11/17												
Table Top Exercise	EPRR Group	12	05/2019	02/10/17	27/04/18											
Live Exercise	EPRR Group	36	12/2020	17/11/17												
Command Post Exercise	EPRR Group	36	01/2021	13/12/17												
Front of House JESIP IOR	EPO	12	01/1901													
ED Staff JESIP IOR	EPO	12	05/2019	13/03/18	22/05/18											
ED Front of House JESIP IOR	EPO	12	12/2017	01/12/16												
Security Front of House JESIP IOR	EPO	12	11/2018	15/11/17												

Table 2 – Testing and Exercising Programme 2016/17 and 2017/18 YTD

Year	Month	Exercise Name/Details	Type	Description	Led by	Target audience	Debrief Notes
2017	April	TVLRF Workshop	Workshop	Major Incidents and Business Continuity	TVLRF	TV LRF	N/A
2017	April	Command Post Exercise	Command Post Exercise	Major Incident	EPO	OUH Strategic and Tactical Officers	N/A
2017	April	Exercise Strontium IX	Table Top	Major Incident	EPO/ED	OUH ED Responders	N/A
2017	June	Exercise Salus	Table Top	Mass Casualty Recovery Exercise	PHE	NHS England South	<p>To demonstrate the NHS England-South Mass Casualty Framework for use in recovery from a MTFa incident resulting in mass casualties</p> <p>1 Amend the NHS England-South Mass Casualty Framework to include the NHS strategy in capacity management and a lead for critical care.</p> <p>2 NHS England to map and publish their response and coordinating role during the recovery from a Mass Casualty response, including clarifying decision making at regional and national levels.</p> <p>3 A process for regular contact between NHS England Incident Coordination Centres and clinical networks is necessary to avoid duplication and to ensure information sharing.</p> <p>To assess the Health and social care command, control and coordination arrangements in recovery from a mass casualty incident</p> <p>4 There is a need for a clear national guidance for NHS trusts with regard to financial arrangements during the recovery from a Mass Casualty response.</p> <p>5 The decision point and 'conditions' to re-activate elective procedures needs to be included in the Mass Casualty Framework and should be co-ordinated across regions.</p> <p>6 NHS England and Local Authority representatives should meet to gain understanding of the co-ordination needed to support NHS trusts and social care capabilities during the recovery from a Mass Casualty response.</p> <p>To assess the plans for the NHS and health partners to recover from a mass casualty incident involving traumatic injuries, including burns</p> <p>7 Develop a generic system to allow qualified staff to work in any NHS provider to provide mutual aid; the concept of a 'NHS Passport' was suggested.</p> <p>8 There is a need to consider a more detailed Mutual Aid Agreement(s) between health partners. Guidance on this from NHS England should be included in the regional Mass Casualty Framework.</p> <p>9 Management of foreign nationals should be included in the Mass Casualty Framework including responsibilities and embassy engagement.</p> <p>To inform the development of psychosocial response plans to a mass casualty incident</p> <p>10 The Mass Casualty Framework should include guidance on a standardised approach to the processes necessary for the effective onward care of patients; it was suggested that the term 'onward care' was a more accurate descriptor than "repatriation".</p> <p>11 Further training (such as TRIM) for all NHS staff to support their mental health would be</p>

Year	Month	Exercise Name/Details	Type	Description	Led by	Target audience	Debrief Notes
							beneficial. 12 Psychosocial support plans need to be developed that include all relevant agencies and organisations; such as NHS, police, local authority, voluntary groups etc. 13 It would be beneficial if psychosocial practitioners prepared a briefing for partner organisations to increase understanding. To evaluate the current processes for information sharing and improve methods for systems resilience for health and social care across the South region 14 There is a need to create a national directory of the capacity and capabilities of specialist clinical services, such as rehabilitation, Major Trauma Centres and Trauma Units. 15 Develop a system which enables an immediate online system sitrep to be generated to answer the information data set agreed at the time. 16 After the initial sitrep the sitrep should be combined with Winter sitrep (if seasonally appropriate) and gathered through Unify2. 17 Develop public health campaigns to raise awareness of the potential long term health implications of a Mass Casualty incident.
2017	June	Exercise Vanadium	Table Top	Major Incident and Business Continuity	EPO	Therapies	N/A
2017	July	Exercise Alamein	Table Top	Mass Casualty Recovery Exercise	PHE	NHS England Midlands and East of England	Report awaited
2017	July	Strategic Leadership in a Crisis	Workshop	Managing the Health Response to Incidents	NHS England South Central	NHS England South Central	N/A
2017	August	Plastic Surgery Clinicians Training	Presentation	Major Incidents and Business Continuity	EPO	Plastic Surgery Clinicians	N/A
2017	September	UHB Mass Casualty Conference	Conference	Mass Casualty Events	UHB	Acute Trusts	N/A
2017	September	Laboratory Haematology Training	Presentation	Major Incidents and Business Continuity	EPO	Laboratory Haematology Staff	N/A
2017	September	Exercise Tan for Theatres	Table Top	Major Incident and Business Continuity	EPO	Staff nurses (B7)	N/A
2017	October	Exercise Strontium XI	Table Top	Major Incident	EPO/ED	OUH ED Responders	The exercise highlighted and provided a training opportunity for staff and an environment where they could ask questions about major incidents and the Trust's preparedness. The exercise highlighted the following actions: <ul style="list-style-type: none"> • Paediatric Emergency Medicine and Paediatric Trauma Lead action cards • More copies of the Paediatric booklet for drug administration.

Year	Month	Exercise Name/Details	Type	Description	Led by	Target audience	Debrief Notes
2017	October	Exercise - Paediatric Emergo Exercise	Emergo Train	Major Incident	EPO	OUH Children's Services	<p>The exercise highlighted the following considerations for the development of the Children's Services Major Incident Plan:</p> <p>PICC Management.</p> <p>Consideration to move incumbent patients to PHDU to create capacity for all Major Incident patients in PICU.</p> <p>Consideration to utilise PICU as an extension of Resus for the ongoing evaluation of paediatric casualties from the incident.</p> <p>Consideration was needed on how New Born Care would link into a Major Incident response.</p> <p>Consideration of utilising CDU for minor's patients in a Major Incident.</p> <p>Consideration to bringing PICC staff to the ED to augment Paediatric Trauma Teams.</p> <p>Consideration to utilise TDA as an emergency discharge lounge.</p> <p>Consideration to utilise Day Case as a minors holding unit presuming elective care had been cancelled.</p> <p>Consideration to using play specialists, CSWs, Neonatal nursery nurses, and adult CSWs to help care for unattended children.</p> <p>Matrons to work with the Emergency Planning Officer to compile a list of key equipment and its location so it can be readily accessed should it be needed in a Major Incident.</p>
2017	October	Command Post Exercise	Command Post Exercise	Major Incident	EPO	OUH Strategic and Tactical Officers	N/A
2017	October	Major Incident Media and Comms Exercise	Hydra (Immersive)	Major Incident and Move to Critical	OCC	OCC	N/A
2017	October	ORICS Major Incident	Workshop	Oxford Region Intensive Care Society Major Incident Workshop	EPO/ED /ICU/SC AS	Oxford Regional ICU Clinicians	N/A
2017	November	Access to Headington Works Multi-Agency Table Top Exercise	Table Top	Business Continuity	OCC	Oxfordshire Car 1 and Cat 2 Responders	N/A
2017	November	Exercise Little Problem	Table Top	Mass Casualties	NHSE/OUH/PCC N	Acute Trusts - Thames Valley and Wessex	<p>Coordination of resources (Clinical Coordination Cell) would be critical and will require a paediatric specialist or somebody with paediatric expertise to ensure appropriate prioritisation and coordination of resources</p> <p>Clarify and produce a simple major incident overview document with what support and capabilities are available to the network and hospitals for paediatric care.</p> <p>Casualty tracking will be challenging and particularly with safeguarding of children. This must be confirmed in ambulance and hospital plans</p> <p>Local plans may need further work on the management and discharge of patients close to being medically fit to enable capacity within the Trust.</p> <p>Situation Reporting was a useful tool enabling a Trust to pause and gain overall status however the NHS England template is too complex to complete. This provided a barrier for</p>

Year	Month	Exercise Name/Details	Type	Description	Led by	Target audience	Debrief Notes
							<p>completion.</p> <p>A local hub approach with representatives from key stakeholders worked well.</p> <p>Identification of casualties will be problematic for unaccompanied minors and procedures must adhere to safeguarding and police protocols including management of consent.</p> <p>Consideration of language barriers for non-English speaking casualties and relatives.</p> <p>It may become necessary to enact decisions relating to care during a mass casualty incident to ensure the greatest number of survivors possible. This may include the decision to invoke the expectant triage category at the scene.</p> <p>The coordination of repatriating a large number of P3 paediatrics with their next of kin proved challenging and further work may be required to ensure the process adheres to safeguarding protocols and meets casualty identification protocols of the police.</p> <p>The management of unaccompanied P3s and keeping them occupied may prove challenging consideration of the use of outpatient departments and play specialists to support</p> <p>The management of parents / relatives will be even more challenging with a paediatric scenario. It is critical this is written into local plans – cohort, use of a safe place, staffing to monitor and providing practical and emotional/psychological support to next of kin while they wait for news.</p> <p>Consider the requirement for having a planning lead from the paediatric medical / clinical team to plan for major incident response and build in local plans on responding to a paediatric incident.</p> <p>Generate a hospital capacity matrix for Wessex Trauma network (to match the one in the Thames Valley Major Incident Plan).</p> <p>Role of police within casualty identification and tracking for a large scale paediatric incident at scene / hospital needs confirmation.</p> <p>Ensure there is sufficient resilience and capability within SORT to receive and manage a large volume of calls in the event of a paediatric incident.</p> <p>Ensure switchboard / reception desks are aware of the situation and also additional safeguarding around paediatric patients.</p> <p>Currently NHS Blood and Transplant do not receive notification of a major incident involving casualties with trauma injuries. The notification will come from the Trust when supplies are required. Trusts or NHS England should build in NHS Blood and Transport as part of their major incident cascade.</p> <p>Use of psychosocial support leaflets that are aimed at specific age groups would be helpful to hand to casualties.</p> <p>Media requests will be challenging for a paediatric incident, the nature of the incident, the numbers and ages will increase speculation and a relentless request for information. Plans must include how this will be managed for a paediatric scenario to ensure safeguarding etc. is in place.</p> <p>Potential shortage of the following:</p> <ul style="list-style-type: none"> -> Paediatric trolleys -> Paediatric transfer bags (consider appropriate locations) -> Paediatric monitoring kit -> Ventilators -> Kit on Ambulances – is it suitable for monitoring of paediatrics? -> Ambulance replenishing stock held on vehicle – needs to be scoped as this will vary across Ambulance Trusts (also access to

Year	Month	Exercise Name/Details	Type	Description	Led by	Target audience	Debrief Notes
							<p>replenishments) Consider -> Kit on Ambulances is suitable for monitoring paediatrics. -> Ambulance MCVs may replenish stock in Trusts. -> Trusts should have agreements in place with the Ambulance Service to enable this should it be required. Ensure timely thawing of FFP is built into local action cards Confirmation on the process and timings from NHS Blood and Transplant stock and supplies would be helpful to include in Trust plans and also what can be done to expedite stocks. Trusts need to review their supply chains and define what stock is from NHS Supply Chain and what is purchased outside of national arrangements. Sterile services will be critical to theatres and clinics with demand on limited equipment. Further guidance on clinical supplies that should be held is required from the national programme which is underway. Demand on staff with paediatric skills e.g. on call paediatric anaesthetist. Ratios of staffing per paediatric casualty needs to be confirmed and built in plans. At what point does SORT / Critical Care and trauma become a national challenge? It was noted that secondary transfers would be far more common for paediatrics than adults. Management of PTS contracts needs to be reviewed to include support in a major incident and mutual aid for neighbouring Trusts/Networks. Some hospitals are on a number of sites, movement of patients across those sites will prove challenging. Trusts should confirm whether adult general ITU could be used for paediatric casualties and whether they can care for young/small ventilated/unventilated patients. Contingency arrangements for restocking blood supplies, blood products and platelets must be built into local plans. Movement of blood components from the Trust's blood bank to clinical areas for increased demand may be an issue. Blood donors need to be redirected to the national call centre so a coordinated response to additional supplies is maintained. Staffing and shift rotas for the next 24 / 48 / 72 hours will require stringent planning and use of mutual aid / business continuity plans. Recognised that neonatal teams can often be used to support paediatrics, as can adult services. Hospital security and in particular casualty management will be challenging with paediatric casualties, requests from next of kin, media. If the Ambulance service has the contract for delivering PTS services this may be compromised in the event of a mass casualty incident. Explore protocols for Trusts on the edge of network and what pathways are in place to utilise key support such as SORT. Important to recognise that such Trusts should look outside the region in preference to within the region at times of regional incidents. Paediatric support will be required from other networks. This may be equipment, staff or bed space. Use of Ambulance, SORT, helimed, and coastguard should be considered in regional planning. Innovative use of facilities will be required to support P3 or A&E minors triage (Walk in centres, ETC etc.). Local arrangements should be built into plans to aid capacity.</p>

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2017	November	Exercise Talk Talk	Communications Cascade	Communications Cascade	SCAS (Amb) for region	All health agencies	<p>Welfare / crisis support for responders from scene to those involved at the hospital will be vital to have in place early on..</p> <p>Crisis support – emotional, psychological and practical will be required for families and next of kin for casualties and those of the deceased.</p> <p>The increased numbers of paediatrics in the hospital will require a staggered recovery in certain areas of the hospital.</p> <p>Consider replenishment of stock etc.</p> <p>Large incidents including a significant number of paediatrics will impact on the NHS – and will require recovery plans to include psycho-social support to staff as well as casualties.</p> <p>OUH: The internal cascade did not reach the Duty Executive on this occasion. This was resolved through the call back in from the CCG.</p> <p>In the 3 incidents that that Trust has dealt with since Dec 16 the communications cascade has not experienced any issues.</p> <p>The grouped noted that this provided a valuable training and exercising opportunity.</p> <p>It was noted that TVP would be the lead agency for media management in incidents of this nature.</p> <p>It was noted that all agencies would need to be rapidly managing the social media streams in such incidents.</p> <p>It was noted that messages would need to be given to Switchboard rapidly to help manage incoming calls to the Trust.</p> <p>During the exercise there were a number of artificialities in the scenario and execution of operations. E.g.</p> <ul style="list-style-type: none"> · Not normal Trauma team numbers or participants · Delays in patient processing · Simulated patient pathways <p>Whilst efforts had been made to separate the exercise from business as usual, just proximity to normal patient flow presented some challenges on the day.</p> <p>It was noted that communications cascade messages about the exercise a level of participation required could have been better in some departments.</p> <p>It was recognised that the exercise had overestimated the number of Subject Matter Experts and Observers/Evaluators needed for the exercise.</p> <p>Participating staff were not readily identified.</p> <p>It was noted that a live camera crew added to crowding in areas of exercise play, notably the Resus Room and Theatres.</p> <p>It was noted that cases with multi-specialty input would require an overseeing consultant to monitor the patient's physiology. This has been widely documented from other sources as best practice.</p> <p>It was noted that recruiting staff to take part in the exercise was difficult. Departmental resourcing of exercises is required to ensure a successful exercise.</p> <p>It was noted that there was some confusion on the numbers of patients expected during the pre-alert to ED. A system to ensure that SCAS staff give patient transport vehicle number and ED staff record patient transport vehicle number would eliminate possible duplication of patients.</p> <p>It was felt that not all staff were aware of the Trust Multiple Major Trauma Plan.</p> <p>It was felt that earlier activation of theatres would be beneficial in significant Trauma cases.</p> <p>The Trauma Consultant is on the second line of activation for Trauma calls and takes an</p>
2017	November	Exercise Crimson Rockface II	Live	Major Incident	EPO/ED	OUH ED Responders	<p>It was noted that communications cascade messages about the exercise a level of participation required could have been better in some departments.</p> <p>It was recognised that the exercise had overestimated the number of Subject Matter Experts and Observers/Evaluators needed for the exercise.</p> <p>Participating staff were not readily identified.</p> <p>It was noted that a live camera crew added to crowding in areas of exercise play, notably the Resus Room and Theatres.</p> <p>It was noted that cases with multi-specialty input would require an overseeing consultant to monitor the patient's physiology. This has been widely documented from other sources as best practice.</p> <p>It was noted that recruiting staff to take part in the exercise was difficult. Departmental resourcing of exercises is required to ensure a successful exercise.</p> <p>It was noted that there was some confusion on the numbers of patients expected during the pre-alert to ED. A system to ensure that SCAS staff give patient transport vehicle number and ED staff record patient transport vehicle number would eliminate possible duplication of patients.</p> <p>It was felt that not all staff were aware of the Trust Multiple Major Trauma Plan.</p> <p>It was felt that earlier activation of theatres would be beneficial in significant Trauma cases.</p> <p>The Trauma Consultant is on the second line of activation for Trauma calls and takes an</p>

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							<p>overseeing role.</p> <p>It was felt that Code Red Calls (pre-hospital administration of blood products) could be the trigger for theatres activation.</p> <p>In major trauma cases all care should be consultant delivered.</p> <p>It was noted that the identification of staff in Theatres was not always easy.</p> <p>The lockdown of the ED was effective and plans put in place to undertake zonal lockdown as required.</p>
2017	November	Exercise Tan for Theatres	Table Top	Major Incident and Business Continuity	EPO	Staff nurses (B6)	N/A
2017	November	TV LHRP Outbreak Incident Table Top Exercise	Table Top	Infectious Diseases	TV LHRP/PE	TV LHRP	Report was community focused.
2017	December	Command Post Exercise	Command Post Exercise	Major Incident	EPO	OUH Strategic and Tactical Officers	N/A
2018	January	Estates and Facilities FM/PFI Business Continuity Exercise	Table Top	Business Continuity Exercise	EPO	Estates and Facilities	<p>All: Portering Catering Domestic PFI: Helpdesk Estates Management Contact numbers for all staff needed. Data protection issues agreed. To be held in a secure central place. No access to information. Impossible to contact staff THC to arrange list and access. All: Portering Catering Domestic PFI: Helpdesk Estates Management, Reassurance messaging for staff. Provided in advance and approved. Time taken to get approval of message could result in staff anxiety/non-attendance. THC to furnish a draft message and get prior approval from all parties. All: Portering Catering Domestic PFI: Helpdesk Estates Management Who in the Trust will hold staff meetings if THC do not step in to do this. Individual support already identified. Could result in staff anxiety/non-attendance., Trust to discuss and agree. All services, Procurement supply chain if THC cannot maintain next day ordering. Loss of service/services. Trust to continue discussing and developing. All services, Lack of provision of IT systems. Particularly catering. Loss of menu analysis and same day ordering. THC to investigate and ensure plan in place. All services</p>

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							<p>Communications are complicated due to the number of issues and audiences. Mixed/delayed messaging. Media team to coordinate with relevant stakeholders to ensure pre-written messaging is agreed. Estates AP and CP for estates if Trust Estates is required to step in. No technical compliance. Trust to work up an orientation pack and arrange accreditation with support from THC.</p>
2018	January	Major Incident and Decontamination Training (Military Nurses)	Practical and Theory	Major Incidents and CBRN(E)/HazMat	EPO	ED Military Nurses	N/A
2018	February	NOC BC Exercise	Workshop	Business Continuity Exercise	EPO	NOC Site Staff	
2018	March	RCDM/OUH Major Incident Study Day	Lecture	Major Incidents and Blast and Ballistics	RCDM	TVTN	N/A
2018	April	Exercise Strontium XIII	Table Top	Major Incident	EPO	OUH ED Responders	N/A
2018	April	Cyber Crime Workshop	Workshop	Cyber Crime and Business Continuity	NHS England South	NHS England South	Report awaited
2018	April	Paediatrics Major Incident Exercise	Table Top	Major Incident	EPO	OUH Paediatric Staff (All Teams)	<p>To consider the development of a Paediatric CDU action card. To review PCC sedation/muscle relaxant drug supply. Review ED/PCC stocks of Children's Chest Drains Review who has Green Id badges across the Trust. Review Children's Hospital ICP monitoring supplies. Arrange further training and exercising for Paediatric SpRs Review levels of Cardiac Monitors and Fluid Pumps held across the Children's Hospital. Review endotracheal tubes in Green Bags – consider change to micro-cuff 3.0 to 4.5 cuffed. Consider adding bougies to Green Bags Consider welfare calls to patients discharged to create capacity in Major Incidents. Send link to Paediatric Major Incident Plan to attendees. Add Children's Psychological Medicine role to support parents, staff and patients. Review of patients under shared care. Ensure lead specialty is agreed and communicated (for normal business not just Major Incidents)</p>