NHS
Wessex Trauma Network

Incident Response Plan

April 2021

Wessex Trauma Network Incident Response Framework	Version: 1.6
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Amendments log

Version	Amendments	Page No.	Date
V1.1	Input from SCAS Update abbreviations Update Incident Management Plan Update to Mass Casualty	 5 8 12-15	 16/3/21
V1.2	Update to Casualty numbers	19 & 20	08/04/21
V1.3	Nomenclature Change to "Incident Response plan"	Throughout	14/4/21
V1.4	Update to HEMs responsibilities in Mass casualty section	14	20/04/21
V1.5	Update to Mass Casualty definition (6.1.9)	7	02/06/21
V1.6	Updated casualty dispersal plan	19/20	14/12/22

Executive Summary

This framework outlines the response of the Wessex Trauma Network (WTN) to any incident across its Area of Responsibility (AOR) It will define the various incidents, the response of the WTN Major Trauma Centre (MTC) and each of its Trauma Units (TU) and Local Emergency Hospitals (LEH) it will also illustrate the communication pathways that should exist to ensure notification of all organisations affected.

1. Scope and Purpose

The purpose of this framework is to ensure that any Incident, which has, or the potential to have an impact on the Wessex Trauma Network service delivery, can be managed, within a recognised structure.

The framework **does not** replace Major Incident arrangements at a local level.

It is primarily designed to supplement the existing multi agency emergency preparedness arrangements across the WTN, NHS SE and NHS SW regions.

It considers responses to Critical Incidents, Major Incidents and Mass Casualty Incidents.

2. Definitions

2.1. Business continuity/internal incidents [1]

Fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime

2.2. Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special

[1] NHS England Emergency Preparedness, Resilience and Response Incident Response Plan (National) 2017

measures and support from other agencies, to restore normal operating functions.

2.3. Major Incident

Any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented[2].

2.4. Major Trauma Centre (MTC):

Manages all types of trauma but specifically has the lead for managing major trauma patients, providing consultant-level care and access to tertiary and specialised level services. Within the Trauma Network the MTC:

• Is optimised for the definitive care of injured patients. In particular it has an active, effective trauma programme. It also provides a managed transition to rehabilitation and the community.

- The WTN MTC is University Hospital Southampton (UHS)

2.5. Major Trauma Network (MTN)

There are 23 Major Trauma Networks (Operational Delivery Networks) that cover England and Wales. Each has at least one MTC and several TU's that can deliver trauma care to their local populations.

2.6. Mass casualty event

An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage. Usually caused by sudden onset events (big bang) and exclude casualties as a result of infectious events such as pandemic influenza[2].

2.7. P1 / P1 Paeds

Casualties requiring immediate lifesaving intervention;

2.8. P2 / P2 Paeds

Casualties requiring intervention that can be delayed;

2.9. P3 / P3 Paeds

Casualties walking wounded or minor injuries;

2.10. Pre hospital Services

The WTN works alongside multiple Air Ambulance and Ambulance trusts. The main providers of air assets are:

- Dorset and Somerset Air Ambulance (DSAA)
- Hampshire and Isle of Wight Air Ambulance (HIOWAA)
- Kent and Surrey Air Ambulance (KSAA)

The 3 ambulance trusts

- South Central Ambulance Service (SCAS)
- South West Ambulance Service (SWASfT)
- South East Coast Ambulance Service (SECAMB)

2.11. Standard Operating Procedure (SOP):

[2] Major Incident and Mass Casualty guidelines, NHS England (2018)

An SOP is a set of instructions to be followed in carrying out a given operation, or in a given situation, which lend themselves to a definite or standardised procedure without loss of effectiveness.

2.12. Trauma Unit (TU)

A Trauma Unit is to accept and manage, at any time, arrival of patients from the following two groups:

- Those considered having injuries not requiring expertise of MTC
- Those critically injured for whom direct transfer to MTC could adversely affect outcome (with subsequent plans to transfer).

2.13. WTN

Wessex Trauma Network is an Operational Delivery Network encompassing

- UHS as Major Trauma Centre,
- Basingstoke and North Hampshire Hospital, Basingstoke; Dorset county hospital, Dorchester; Portsmouth Hospital University, St Mary's Hospital, Isle of Wight; Salisbury District Hospital, Poole General Hospital as Trauma Units and
- Royal Hampshire County Hospital, Winchester and Royal Bournemouth Hospital as local emergency hospitals.
- Local ambulance and air ambulance Trusts

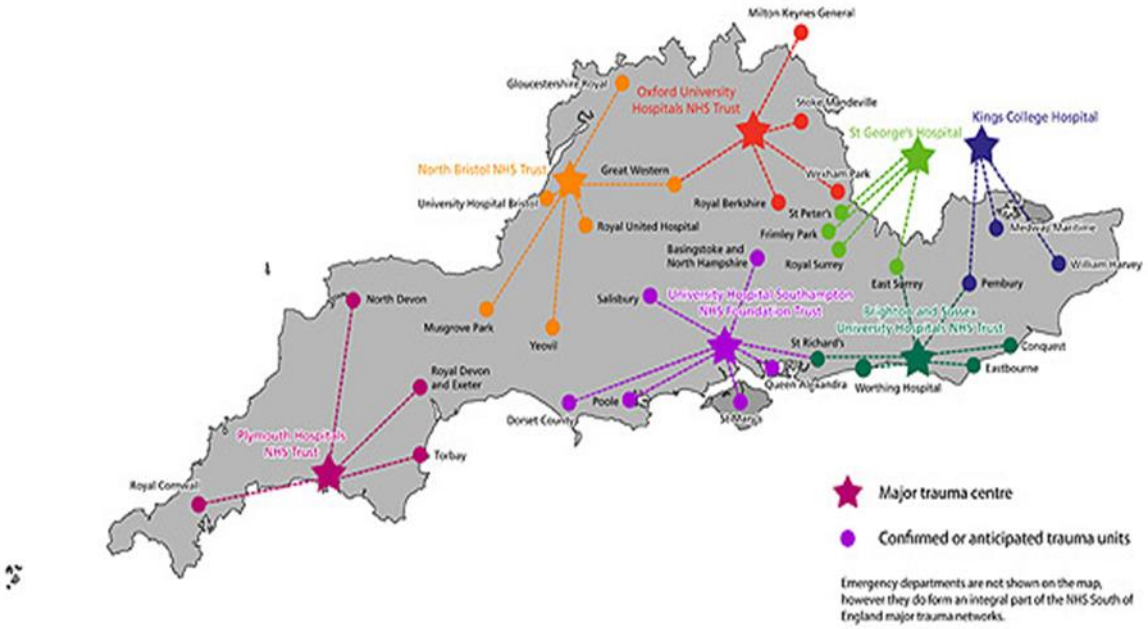
3. Acronyms

CCG	Clinical Commissioning Group
DCH	Dorset County Hospital
DSAA	Dorset and Somerset Air Ambulance
HALO	Hospital Ambulance Liaison Officer
HHFT	Hampshire Hospitals NHS Foundation Trust
HIOWAA	Hampshire and Isle of Wight Air Ambulance
HLO	Hospital Liaison officer
ICC	Incident Coordination Centre
ICS	Integrated Care System
IOW	Isle of Wight
LHRP	Local Health Resilience Partnership
MTC	Major Trauma Centre
MTN	Major Trauma Network
METHANE	Mneumonic for declaring a Major Incident
NHSE (SE)	National Health Service England South East Region
NHSE (SW)	National Health Service England South West Region
NHH	North Hampshire Hospital, Basingstoke
NIHP	National Institute for Health Protection
ODN	Operational Delivery Network
OPEL	Operational Pressures Escalation Levels
PH	Poole Hospital
PHU	Portsmouth Hospital University
RBH	Royal Bournemouth Hospital
RHCH	Royal Hampshire County Hospital, Winchester
SCAS	South Central Ambulance Service NHS Foundation Trust
SDH	Salisbury District Hospital
SECamb	South East Coast Air Ambulance
SWASfT	South West Ambulance Service NHS Foundation Trust
STP	System Transformation Partnership

T&O COW	Trauma and Orthopaedic Consultant Of the Week
TUB	Trauma Unit Bypass
TU	Trauma Unit
UHS	University Hospital Southampton NHS Foundation Trust
WTN	Wessex Trauma Network

4. South MTN's and Wessex

The WTN is one of five Trauma Networks that cover the South of England (excluding London). The following map indicates WTN in purple, with its associated TU's:



4.1. Within each network hospitals will support each other.

4.2. During any incident inter MTN cooperation maybe required and this would be coordinated by the regional ICC.

5. Incident levels

5.1. The following table describes the incident levels in use across the NHS

Incident Levels	
1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England and NHS Improvement - South East (HTV).

3	An incident that requires the response of a number of health organisations across geographical areas within an NHS England and NHS Improvement - South East. NHS England and NHS Improvement - South East to coordinate the NHS response in collaboration with local commissioners at the tactical level.
4	An incident that requires NHS England and NHS Improvement - National Command and Control to support the NHS response. NHS England and NHS Improvement - South East (HTV) to coordinate the local NHS response in collaboration with local commissioners at the tactical level.

Note: Any Terrorism related incident will be a Level 4 and therefore coordinated nationally.

6. Types of Incident[3]

6.1. The following list provides commonly used classifications of types of incident. This list is not exhaustive and other classifications may be used as appropriate. The nature and scale of an incident will determine the appropriate Incident Level.

6.1.1. Business continuity/internal incidents – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime

6.1.2. Sudden Onset – a serious transport accident, explosion, or series of smaller incidents

6.1.3. Rising tide – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action

6.1.4. Cloud on the horizon – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action

6.1.5. Headline news – public or media alarm about an impending situation, reputation management issues

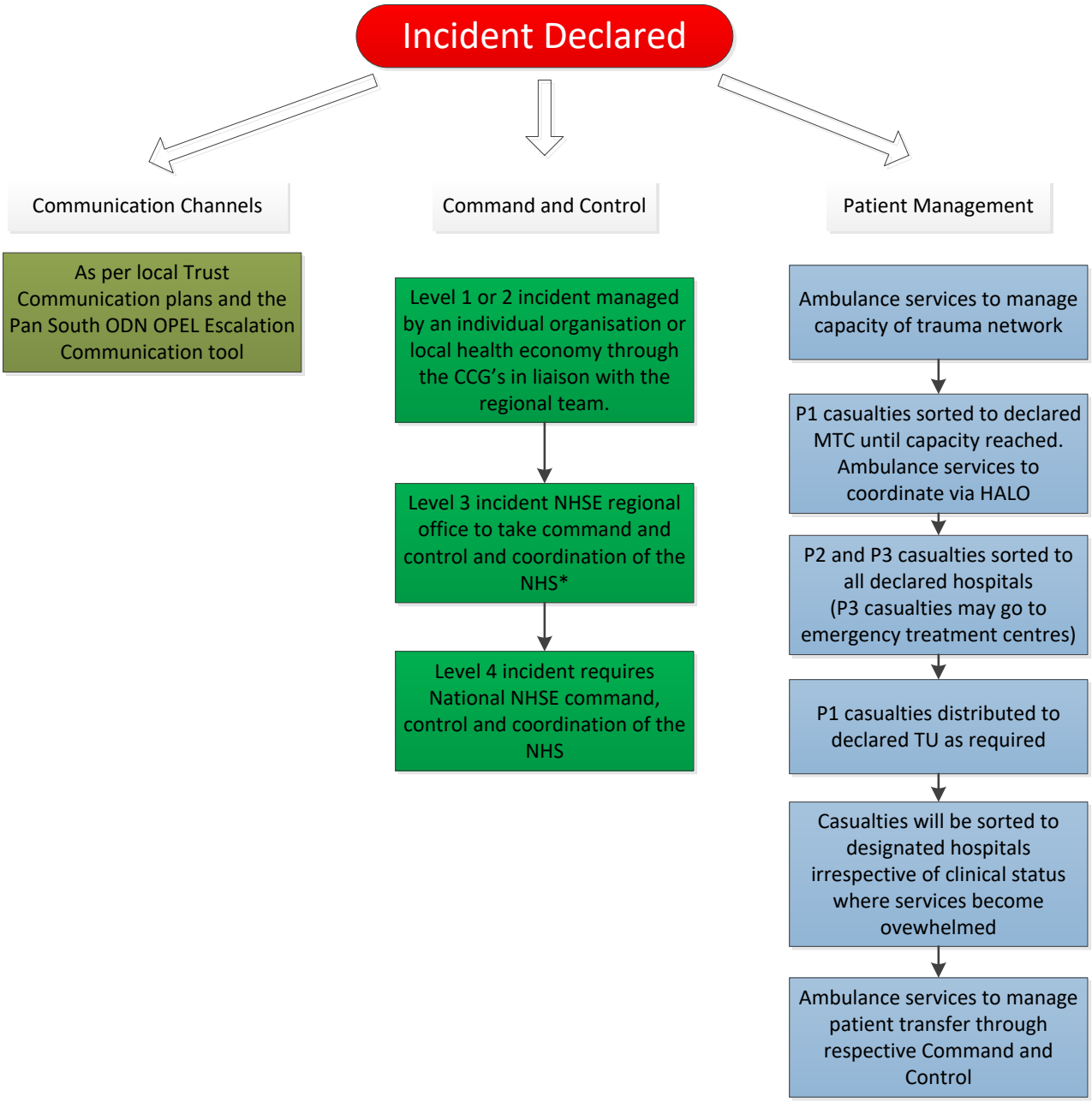
6.1.6. Chemical, biological, radiological, nuclear and explosives (CBRNE) – CBRNE terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent

6.1.7. Hazardous materials (HAZMAT) – accidental incident involving hazardous materials

6.1.8. Cyber-attacks – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality

6.1.9. Mass casualty – dependent on the type of incident, type of casualties and number of casualties involved. The response must be augmented with extraordinary measures

7. Incident Management Framework[3]



More detail on roles and responsibilities can be found in section 13.

8. Pan south Adult Major Trauma Operational Delivery Networks (ODN) Escalation Framework (2020)

8.1. This framework includes the OPEL tool for determining the level of escalation a Major Trauma Network is at dependent on the pressure being felt across the Network.

8.2. It contains a communication tool for escalation both within and external to the MTN and a tool to aid the MTN manager / MTC Trust on call manager to aid with de-escalation.

[3] SW London Major Incident Framework

8.3. It describes when mutual aid should be sought and how this will be accessed.

9. Burns Mass casualty incident

9.1. Although there are over 220 Emergency Departments, there are comparatively few places where patients with severe burns may be cared for by clinical specialists. This is the case particularly for children. Therefore, a mass casualty incident for burns is likely to involve significantly fewer casualties than other mass casualty incidents. It has been estimated that an incident involving more than 20 patients with Level 3 burn injuries (Burn Intensive Care Unit) is likely to lead to activation of the Burns Annex[4].

9.2. Management of a Burns Mass Casualty incident should be managed as laid out in the Burns Annex.

10. Business Continuity Incident Management

10.1. Any business continuity Incident that prevents a TU from functioning as a Trauma Unit will require a level 2 response and notification of the MTC and WTN as soon as possible. Communication for this type of incident is addressed in the Pan South ODN OPEL escalation plan.[5]

10.2. Closure of 50% or more TU's across the WTN would lead to WTN enacting OPEL 3 of the Pan South ODN OPEL escalation plan

10.3. Any Critical Incident that prevents the MTC from functioning as the Major Trauma Centre will require a level 3 response.

10.4. Closure of the MTC would lead to WTN enacting OPEL 4 of the Pan South OPEL escalation plan

10.5. If UHS is unable to operate an MTC surrounding MTC's should be notified to expect MTC level patients. The following MTC diverts have been identified:

10.5.1. Adult Patients **-** The following matrix indicates the closest – 5th closest MTC for ADULT patients for each of the Trauma Units and the within the WTN:

WTN Hospital & area / Divert hospital	Divert 1	2	3	4	5
Southampton	John Radcliffe	Royal Sussex	St Georges	Southmead (Bristol)	Cardiff / Other London MTC
Basingstoke and Winchester	John Radcliffe	St Georges	Southmead (Bristol)	Royal Sussex	Cardiff / Other London MTC
Portsmouth & IOW	Royal Sussex	St Georges	John Radcliffe	Southmead (Bristol)	Cardiff / other London MTC
Salisbury	John Radcliffe	Southmead (Bristol)	Royal Sussex	St Georges	Cardiff / other London MTC
Dorset County Hosp	Southmead (Bristol)	Derriford	John Radcliffe	Cardiff	ST Georges / other London MTC
Poole / B'mouth	John Radcliffe	Southmead (Bristol)	St Georges	Royal Sussex	Derriford / Other London MTC's

10.5.2. Paediatric Patients **-** The matrix below indicates the closest – 4th closest MTC for PAEDIATRIC patients for each of the Trauma Units and

[4] Concept of Operations for the management of Mass Casualties: Burns Annex (2020)

[5] Pan South Supra regional ADULT MT ODN Escalation Framework (2020)

the within the WTN:

WTN Hospital & area / Divert hospital	Divert 1	2	3	4
Southampton	John Radcliffe	St Georges	Bristol Childrens	Cardiff / Other London MTC
Basingstoke and Winchester	John Radcliffe	St Georges	Bristol Childrens	Cardiff / Other London MTC
Portsmouth & IOW	St Georges	John Radcliffe	Bristol Childrens	Cardiff / other London MTC
Salisbury	John Radcliffe	Bristol Childrens	St Georges	Cardiff / other London MTC
Royal Dorset	Bristol Childrens	Derriford	John Radcliffe	Cardiff / other London MTC
Poole / B'mouth	John Radcliffe	Bristol Childrens	St Georges	Derriford / Other London MTC's

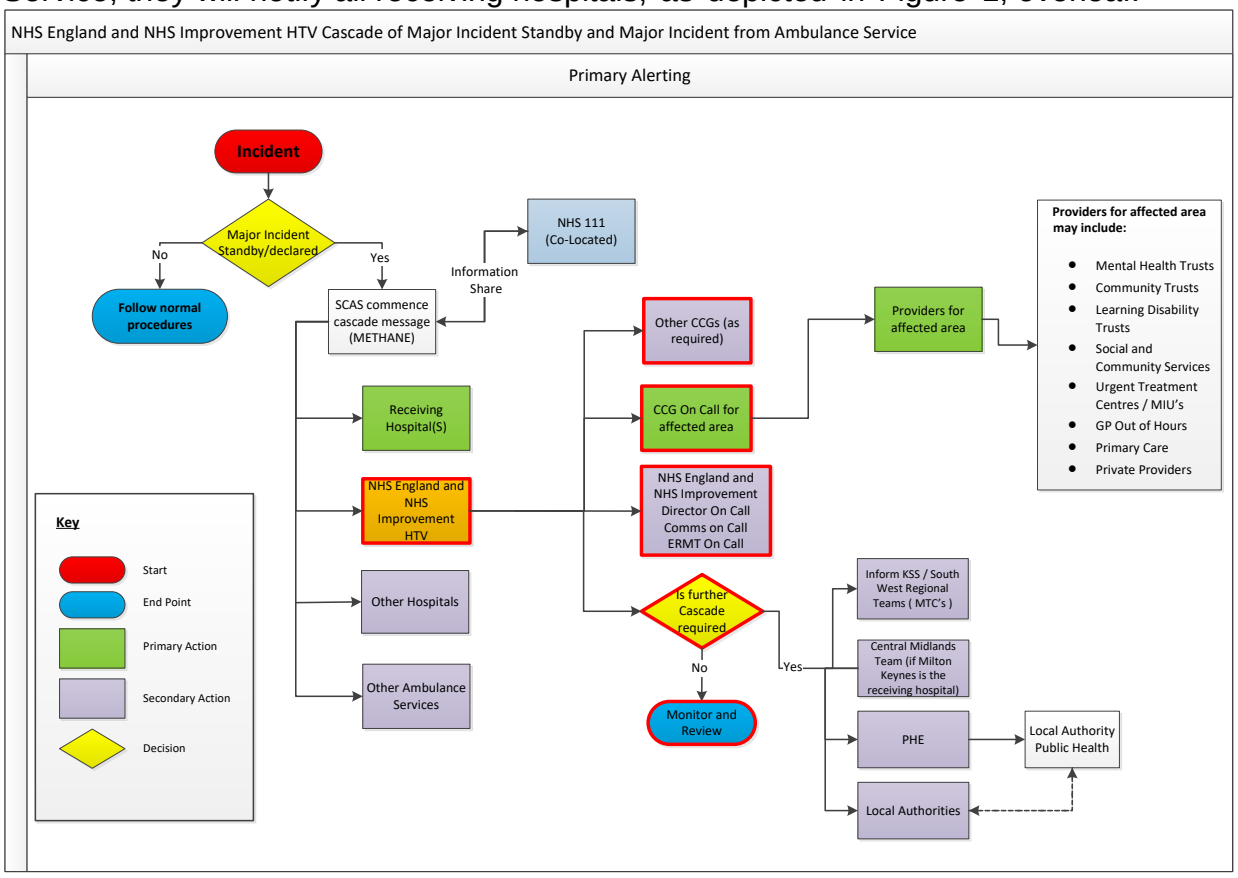
Contact numbers for these hospitals are available in appendix 1

10.5.3. The WTN automatic acceptance and secondary transfer tool and the Trauma Unit Bypass tool will be deactivated and the TU's will be expected to stabilise critically ill patients for transfer to a divert MTC.

11. Major Incident

11.1. South Central Ambulance Service (SCAS)

If a major incident occurs within the area covered by the South Centre Ambulance Service, they will notify all receiving hospitals; as depicted in Figure 1, overleaf.



11.2. South West Ambulance Service (SWASfT)

If a major incident occurs within the area covered by the South West Ambulance Service, they will notify all receiving hospitals; as depicted in Figure 2, below.

INSERT SWASfT Comms flow

11.3. Trauma Units will be required to take P1, P2 and P3 casualties as per the Ambulance Services dispersal plans.

11.4. All acute providers will have a background level of activity at initiation of the plan.

11.5. Repatriation of patients from the MTC to TU during a major incident

11.5.1. Repatriations from the MTC to a TU will follow the process outlined in the WTN repatriation procedures.

11.5.2. In a major incident, at the point of receiving notification that UHS MTC is declared for a major incident, all WTN TUs are required to be prepared to receive patients who may need to be repatriated to increase capacity at the MTC. It is expected that the TU will provide a bed for repatriation at the time of a major incident without delay or repeated requests. It is recognised that transporting patients for repatriations may be challenging.

11.5.3. All requests for repatriations from the MTC to a TU should be directed through UHS Tactical (Silver) and UHS Silver Medical commander at the MTC and respective TU who will agree on the need to repatriate patient. The priority of the transfer must be clear and agreed as it will remove a resource from the primary scene. Only when a transfer is agreed should the MTC contact the appropriate ambulance service

11.6. Secondary transfer of patients from a TU to MTC during a major incident

11.6.1. During a major incident, there may not be capacity at the MTC to accept patients who during normal business would be transferred under the WTN Automatic Acceptance / Secondary Transfer tool. Also, it is unlikely that SCAS or SWASfT will have resources available to facilitate the secondary transfer of under-triaged patients transferred from scene to a TU, those patients who deteriorate following admission to a TU, or those who self-present to the TU.

11.6.2. All requests for secondary transfers to the MTC should be directed through UHS Silver Medical Command who will be able to advise on UHS ED, Critical Care and anaesthetic availability. They will log all requests for transfer and agreed transfers, ensuring a view of where patients are and the clinical needs of those awaiting transfer.

11.6.3. Only when a transfer is agreed should a TU contact the appropriate ambulance service (SCAS or SWASfT) to request conveyance. The priority of the transfer must be clear and agreed as it will remove a resource from the primary scene. Priority must be given to sending any images undertaken at the TU via the image exchange portal (IEP) as early as possible to enable these images to be available to the receiving team at

the MTC.

11.7. Capacity and capabilities of the WTN MTC, TU's and LEH's can be found in sections 12 and 13 respectively

12. Mass Casualty Incident

A Mass Casualty Incident is a type of major incident and the involved ambulance service (SCAS or SWASfT) will notify all receiving hospitals; as depicted previously

12.1. As in a Major Incident, patients with traumatic injuries should be triaged to the Major Trauma Centre, where possible, as per usual WTN Trauma Unit Bypass (TUB) tool. On scene clinical assessment will be made by the incident commander dependent on nature and size of incident.

12.2. In mass casualty events, the usual WTN Secondary transfer / automatic acceptance protocols are switched off.

12.3. The need for national direction i.e. COBR (Cabinet Office Briefing Room) exists in a mass casualty event from an early stage. This is likely to be no later than 1 hour.

12.4. The Mass Casualty plan for the MTC includes receipt of 8 P1 major trauma patients in the first hour. This would have a large impact on the Major Trauma Centre infrastructure. In a TU this number is likely to be considerably lower. For information on each hospitals' capacity and capabilities please see capacity and capabilities sections 14 and 15 respectively

12.5. In a multisite incident or one where terrorist activity is involved, access to some MTCs or TUs may be restricted.

12.6. All healthcare providers (public, private, independent and voluntary) will have a supporting role in mass casualty situations. They should review local operating policy and infrastructure.

12.7. In a mass casualty event a proportion of significantly injured patients may require transport to hospitals other than an MTC. Plans need to be in place for those receiving hospitals to adopt a "stabilise and treat" process that is different to that of normal business. If patients are deemed to need transfer for specialist intervention this may be delayed, or facilitated by a patient transport provider (PTS).

12.8. Where the number of children overwhelms the MTC capacity children may present at hospitals which are not used to dealing with seriously injured children, therefore hospitals must cater for children and young people in their Major Incident / Mass Casualty Plan.

13. Roles and Responsibilities in the event of a Major Incident or Mass Casualty Incident

The WTN is not responsible for the coordination of individual patients and bed management across / within the Network. Individual Trust Incident Response Plans will outline the roles and responsibilities of individuals providing the command and control structure within these organisations: strategic (gold), tactical (silver), and operational (bronze) command.

13.1. Ambulance Service

13.1.1. In normal major incident business, the MTC will receive P1, P2 and P3 patients as triaged and transported by the on-scene services.

13.1.2. In mass casualty events, there may be a requirement for P1s, P2s and P3s to go to TUs, and MTCs. P1's requiring immediate life saving treatment should be transferred to their closest TU or LEH for this prior to transfer to MTC (as per TUB tool) It is not desirable to send P2s to LEHs, or children to LEHs unless they are triaged as P3.

13.1.3. The decision to distribute patients across the Trauma Network will be made by the Ambulance Incident Commander (in liaison with a Medical Incident Advisor).

13.1.4. The management of mass casualty event should ensure all patients, either directly affected by the incident or those with non-incident related urgent and emergency care needs continue to receive safe and high quality standards of care.

13.1.5. In the event of a Wessex based mass casualty incident the ambulance service has responsibility for coordinating all movements and transportation of casualties from scene to hospital.

13.1.6. The ambulance service will establish an Incident Command Centre to manage the incident.

13.1.7. Nominated hospitals will be advised of the incident in the standard format.

13.1.8. The ambulance service will provide a Hospital Ambulance Liaison Officer (HALO) at the MTC and at all TU's involved

13.1.9. The ambulance service will continue to monitor capacity at all nominated hospitals and across the Network, and liaise with the ICS and NHS England (South East or South West) as required.

<u>Secondary Transfers</u>

13.1.10. Patient transfer requests received during and immediately after the incident phase are likely to incur significant waiting times. All hospitals will be expected to provide first line management to patients from the incident. WTN secondary transfer / automatic acceptance protocol will be suspended.

13.1.11. Transfers during the incident phase will have to be agreed by the Silver Medical Command at the MTC and the priority of transfer will also be agreed allowing appropriate communication / triaging of this tasking by the ambulance service. Movement of non-trauma patients to alternative sites should only be considered as a last resort when all surge capacity is exceeded.

13.1.12. Networks should consider the use of hospital-based patient transport services. For children this should include CATS, SORT and STRS (paediatric retrieval services). For adults the Adult Critical Care transport service should be considered, with consideration of HEMS for long distance transfers.

13.1.13. These services will not be able to offer their usual level of response and alternative plans should be formulated i.e. local escort/transfer.

13.2. Helicopter Emergency Medical services (HEMS)

During a mass casualty incident air ambulance aircraft and personnel can fulfil multiple roles. Deployment and tasking will be via the ambulance service control/HEMS desk.

13.2.1. Deployment of helicopter crew to scene (difficult or remote access)

Initial command from the Ambulance Service (Forward Incident Officer / Bronze Command) can be established in any remote location and effective communication links can also be set up directly from the scene. Rapid situation reports can allow Ambulance Control to send appropriate resources, including external agency resources such as Fire Service, Police, Urban Search and Rescue and Mountain Rescue personnel.

13.2.2. Delivery of medical equipment/supplies to scene

The aircraft can be effectively used to transport medical equipment and supplies to the scene if required.

13.2.3. Rapid transportation of time-critical patients to designated hospitals

Due to the speed of the aircraft, patients can be transferred to appropriate receiving hospitals capable of delivering specialist definitive care. In addition, the flexibility of the aircraft also means that patients do not necessarily have to be transferred to the nearest receiving hospital, but can be flown further afield to ease the pressure on these hospitals.

13.2.4. Response Co-ordination

Due to the nature of mass casualty incidents and recent experience; it is highly probable that multiple air assets from multiple agencies will be required to respond.

Co-ordination of this response will be determined by the level of incident:

- Level 1 Incidents

  Involve 2 air assets from two different agencies. Coordination will be conducted between the respective tasking authorities using normal processes.

- Level 2 Incidents

  Involve 3 or more air assets from two or more agencies attending enduring incidents where tactical command has been established.

  In such circumstances a Combined Tactical Air Cell (CTAC) will be formed in accordance with the Integrated Emergency Air Response Operations doctrine to prioritise air tasking in accordance with the Strategic Commander's intent and the Tactical Commander's objectives. This will be coordinated by the National Police Air Service in liaison with the Air Rescue Coordination Centre based at HMCoastGuard.

13.3. Major Trauma Centre

13.3.1. UHS as the MTC host, has a Major Incident Plan that would be enacted on declaration by the ambulance service.

13.3.2. In addition to the Major Incident plan there is a supplementary plan regarding the arrangements required in a Mass Casualty Event.

13.3.3. Consideration should be given by the MTC of going to Major Incident Standby if any Trauma Unit in the WTN is similarly stood up. This allows for rapid escalation to activation to accept severely injured casualties directly from the scene.

13.3.4. Primary role is to deal with **all** presentations across all triage categories and ensuring appropriate triage and treatment.

13.3.5. Accept P1, P2 and P3 patients who arrive via pre-hospital care providers and by other means.

13.3.6. The MTC cannot refuse any patients resulting from the incident or other patients.

13.3.7. Effective reporting back to the ambulance service to advise on capacity and need for support will occur via the MTC Ops to the HALO.

13.3.8. There should be the facility for additional Critical Care, Holding and Treatment areas to allow for local increase in capacity, as per the UHS Major Incident plan.

13.3.9. Requests for secondary transfer to the MTC should be directed to the Silver Medical Commander at UHS. They will log all requests for transfer and agreed transfers, ensuring a view of where patients are and clinical needs of those awaiting transfer. Patients are not to transfer to the MTC until agreement has been obtained from Silver Medical Command at MTC.

13.3.10. Daily contact will be made with the ambulance service to ascertain the number of patients who will require transfer across the trauma network.

13.3.11. This will continue until all incident patients have clear plans for ongoing management or transfer. This may take several days to achieve depending on the nature of the incident and volume of casualties.

MTC transition stand down

13.3.12. The MTC will not stand down until all TUs in their network have been stood down.

13.3.13. The MTC will work with the TU's to accept any patients remaining at TU's that still require secondary transfer to the MTC

13.3.14. The MTC will work with the TUs to provide, where necessary, staff to accompany patients being repatriated to them for on-going care.

13.3.15. Work with the TUs and Network to assist in repatriating patients back to their nearest hospital within an acceptable timeframe.

13.3.16. There may be an ongoing workload for several days to weeks that may impact on normal business.

13.4. Trauma Units

13.4.1. Each Trauma Unit Trust of the WTN has an incident Response Plan specifying their internal processes in the event of a Major Incident.

13.4.2. In addition to the Incident Response plan each trust will have a supplementary plan regarding the arrangements required in a Mass Casualty Event.

13.4.3. They will also activate business continuity plans for elements such as patient capacity and patient transport where normal services are disrupted due to the incident.

13.4.4. Primary role is to deal with **all** presentations across all triage categories and ensuring appropriate triage, treatment and transfer

13.4.5. No Trauma Unit can refuse any patients resulting from the incident or other patients.

13.4.6. Accept P1, P2 and P3 patients who arrive via pre-hospital care providers and by other means.

13.4.7. Requests for secondary transfer to the MTC should be directed to the Silver Medical Commander at UHS.

13.4.8. Where directed by NHS England and NHS Improvement, or the T&O COW liaise with a specified out of area MTC with regards to the best care for patients, which may include agreeing transfer arrangements to that or another MTC.

TU Stand Down

13.4.9. Work with the MTC and other TUs to provide, where necessary, staff to accompany patients being repatriated to them for on-going care.

13.4.10. Work with the MTC and Network to assist in repatriating patients back to their nearest hospital within an acceptable timeframe.

13.5. Local Emergency Hospitals

13.5.1. During an incident a LEH may be utilised to support appropriate patients as designated by the responsible organisation.

13.5.2. LEHs should not receive paediatric patients resulting from the incident, unless they are triaged as P3.

LEH transition back to normal business

13.5.3. Work with the MTC and other TUs to provide, where necessary, staff to accompany patients being repatriated to them for on-going care.

13.5.4. Work with the MTC and Network to assist in repatriating patients back to their nearest hospital within an acceptable timeframe.

13.6. NHS England and NHS Improvement (South East or South West) - in event of Level 3 Major Incident or Mass casualty event

13.6.1. Activate the NHS England NHS Improvement SE Mass casualty framework 2020 / 2021.

13.7. NHS Provider Organisations

13.7.1. NHS Providers prepare to take discharges to support acute capacity.

13.7.2. Transport Providers

Prepare to support patient movement outside of emergency vehicles at the request of responding emergency services.

13.7.3. National Institute for Health Protection (NIHP)

Commission appropriate monitoring of patients and survivors health outcomes.

13.7.4. Local Authorities

Assist health organisations in the rapid discharge of patients.

14. Capacity at a glance across WTN

Trust	ED Resus Spaces	ED Majors Spaces	No. CT Scanners	No. In hours Theatres	No. OOH Theatres	Number G&A beds	Trauma Ward Capacity	ICU Capacity
UHS (Southampton)	**6**	**15**	**4**	**22-24**	**4 - 5**	**1061**	**32**	**90 (50 L3 & 40 L2)**
BNHH (Basingstoke)	**4**	**22**	**2**	**7 4 day case 2 Maternity 1 x local cases only**	**1 (ortho or Surgery) +1 Mat.**	**454**	**53**	**18 (+10)**
PHU (Portsmouth)	**4**	**25**	**3**	**20 +7day case +2Maternity**	**2 + 1 Maternity**	**998**	**n/a**	**24 Care spaces (19 L3)**
St Mary's (Isle of Wight)	**3**	**8**	**2**	**4**	**1**	**246**	**30**	**6**
Poole	**3**	**14**	**3**	**7**	**1**	**436**	**87**	**11 (+10)**
DCH (Dorchester)	**4**	**16**	**2**	**6 +2 emergency + 1 maternity + 2 day case**	**1 + 1 mat**	**301 (Adult)**	**n/a**	**8 (+8)**
SDH (Salisbury)	**3**	**10**	**2**	**10 + 6 DSU**	**3 + 1 mat**	**402**	**n/a**	**10**
RBCH (Bournemouth)	**5**	**12**	**2**	**13**	**2**	**569**	**n/a**	**11**
RHCH (Winchester)	**3**	**10**	**2**	**5 + 3 day case 2 Womens 2 Maternity 1 x Local cases only**	**1 for Gen Surg (no – Ortho)**	**329**	**n/a**	**7 (+5)**

15. Capabilities across WTN (updated May 2022)

Trust	P1		P2		P3		Orthopaedic Trauma	Gen Surg	Neuro. (Incl ICU)	Vascular	IR	Cardio Thoracic	HPB	Pelvic	Spines	Burns	Plastics	Maternity	Critical Care	Sp.Paeds (incl PICU)
	1st hr.	**2nd Hr.**	**1st Hr.**	**2nd Hr.**	**1st Hr.**	**2nd Hr**														
UHS (Southampton) (Mass casualty incident)	**5** **10**	**5** **10**	**9** **10**	**6** **10**	**30** **25**	**20** **25**	✓	✓	✓	✓	✓	✓	x	✓	✓	x	x	✓	✓	✓
BNHH (Basingstoke)	**4**	**3**	**6**	**3**	**20**	**10**	✓	✓	x	✓*	✓*	x	✓	x	x	x	x	✓	✓	x
PHU (Portsmouth)	**4**	**10**	**6**	**8**	**40**		✓	✓	x	✓*	✓*	x	x	x	x	x	✓*	✓	✓	x
St Mary's (Isle of Wight)	**3**	**3**	**10**		**20**		✓	✓	x	x	x	x	x	x	x	x	x	x	✓	x
Poole	**4**		**18** **(15 night)**		**30** **15 night)**		✓	✓	x	x	x	x	x	x	x	x	x	✓	✓	x
DCH (Dorchester)	**5 (day) / 3 (night)**		**5 / 3**		**20 / 10**		✓	✓	x	x	✓*	x	x	x	x	X	x			x

NHS
Wessex Trauma Network

Trust	P1		P2		P3		Orthopaedic Trauma	Gen Surg	Neuro. (Incl ICU)	Vascular	IR	Cardio Thoracic	HPB	Pelvic	Spines	Burns	Plastics	Maternity	Critical Care	Sp.Paeds (incl PICU)
	1st hr.	**2nd Hr.**	**1st Hr.**	**2nd Hr.**	**1st Hr.**	**2nd Hr**														
SDH (Salisbury)	**6 (3 night)**		**10 (6 night)**		**22 (12 night)**		✓	✓	x	x	x	x	x	x	x	✓	✓	✓	✓	x

Local Emergency hospitals

Trust	**P1**		**P2**		**P3**		Orthopaedic Trauma	Gen Surg	Neuro. (incl ICU)	Vascular	IR	Cardio Thoracic	HPB	Pelvic	Spines	Burns	Plastics	Maternity	Critical Care	Sp.Paeds (incl PICU)
	1st hr.	**2nd Hr.**	**1st Hr.**	**2nd Hr.**	**1st Hr.**	**2nd Hr.**														
RBH (Bournemouth)	**4**		**15 (5 night)**		**30 (10 night)**		✓	✓	x	✓	x	x	✓	x	x	x	x	x	✓	x
RHCH (Winchester)	**3**	**3**	**5**	**3**	**15**	**10**	**X**		✓*	✓*	x	x	x	x	x	x	x			x

16. Ratification of this plan

16.1. Development and formulation of this plan via TU and MTC EPRR leads

16.2. Feedback to be gathered from all WTN hospitals and agreement from Accountable Emergency officers in each Trust.

16.3. Each WTN Trust to ensure that this plan reflected in their own EPRR's

16.4. To be presented at LHRP / local EPRR committee

17. Process for Monitoring Compliance/Effectiveness

The purpose of monitoring is to provide assurance that the agreed approach is being followed – this ensures we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

17.1. Exercising

Plans cannot be considered reliable until they are exercised and have proved to be workable. Exercising should involve: validating plans; rehearsing key staff; and testing systems which are relied upon to deliver resilience (e.g. uninterrupted power supply). Exercises must have defined aims and objectives that may include:

- affirmation that everyone understands their role and that there is an overall appreciation of the plan
- checking that the invocation procedures and callout communications work
- ensuring that the accommodation, equipment, systems and services provided are appropriate and operational
- testing the key services can be recovered within the RTO and to the levels required.

The network must be cognisant of capacity at the MTC and TUs to support the ambulance service in their role in casualty distribution.

It is anticipated that Wessex Trauma Network will be exercised as part of individual organisations' exercises and as part of EPRR exercises as and when appropriate. Wessex Trauma Network may also decide to exercise its plans in its own right.

18. Arrangements for Review of the Policy

This SOP will be reviewed 3 years after ratification or earlier if required.

Appendix 1 –Contact details

- South West Ambulance service
  - Senior Clinician On call 03003690008
- South East Coast Ambulance Service
  - CCD – 03001231252
- South Central Ambulance Service:
  -
- Chichester: 01243788122 (Switchboard)
- Salisbury: 01722 336262 (Switchboard)
- Bournemouth: 01202 303626 (Switchboard)
- Poole: 01202 665511 (Switchboard)
- Dorchester: 01305 251150 (Switchboard)
- Basingstoke North Hampshire Hospital: 01256 473202
- Royal Hampshire County Hospital: 01962 863535
- University Hospital Southampton: 023 8077 7222
  - Silver Medical Command: 023 8120 6849
- Divert MTC's:

	Switchboard	ED reception	ED coordinator
John Radcliffe	0300 304 7777	01865 220208	01865 857717
Royal Sussex (Brighton)	01273 696955	x 63502	
North Bristol (Southmead)	0117 9505050	0117 414 4102	0117 414 4100
Bristol Royal Childrens hospital	0117 9230000		
Derriford (Plymouth)	01752 202082	01752 439091	
St Georges (London)	020 8672 1255	020 8725 1279	020 8725 1222

WTN Incident Management plan	Version: 1

Document Monitoring Information	
Approval Committee:	WTN Governance committee
Date of Approval:	11th May 2021
Ratification Committee:	WTN Board
Date of Ratification:	11th Maya 2021
Signature of ratifying Committee Group/Chair:	Insert Signature or name (Chair of PRG if Level 1 document)
Lead Name and Job Title of originator/author or responsible committee/individual:	Emma Bowyer Wessex Trauma Network Manager
Policy Monitoring (Section 6) Completion and Presentation to Approval Committee:	
Target audience:	All MTC and TU trauma Leads EPRR of TU's and MTC
Key words:	Incident Response Plan
Main areas affected:	
Summary of most recent changes if applicable:	New document
Number of pages:	23
Type of document:	SOP
Does this document replace or revise an existing document	No
Should this document be made available on the public website?	No
Is this document to be published in any other format?	No