NHS England

Emergency Preparedness, Resilience and Response

Concept of Operations for managing Mass Casualties

Preparing for Emergencies in the NHS in England

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Concept of Operations for managing Mass Casualties

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

This plan should be read in conjunction with the following documents:

- NHS England Emergency Preparedness, Resilience and Response Framework
- NHS England Incident Response Plan (National)
- Regional Mass Casualty arrangements
- National Ambulance Resilience Unit Guidance

The web version of this plan is available on the NHS England website

Contents

1 Introduction

This document describes the NHS England strategic intentions on how to respond to a Mass Casualty incident and should be read in conjunction with the NHS England Incident Response Plan (National) (IRP(N)) and Regional Mass Casualty arrangements.

1.1 Purpose

To define a framework of response in which NHS England may direct NHS resources in the event of a Mass Casualty incident occurring within England. This Concept of Operations is likely to be needed where local and regional health economies require external support to manage the number of casualties, or specialist resources are needed to treat casualties and national coordination of assets is required.

Elements of this concept of operations may be used to support the response to a Mass Casualty incident occurring within the United Kingdom, where the NHS in England is needed to support the NHS in Wales, Scotland or Northern Ireland.

1.2 Definitions

NHS England defines a Mass Casualty incident for the health services as 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.

A Mass Casualty incident may involve hundreds or thousands of casualties with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures to cope and require further measures to appropriately deal with the casualty numbers.

Examples of previous mass casualty events can be found in section 7.2.

For the purposes of this document, Mass Casualty incidents are usually caused by sudden onset events (big bang), and exclude casualties as a result of infectious diseases such as pandemic influenza.

However several smaller incidents may combine to become a larger response, or be geographically diverse but require a Mass Casualty response to be enacted due to the large number of simultaneous casualties.

For specialist services such as Burns the trigger for activation of their Mass Casualty arrangements will be lower due to the limited availability of resource for incident response.

Casualties are likely to be a mixture of categories with 25% requiring immediate life saving intervention, 25% requiring intervention that can be delayed and 50% being walking wounded or minor injuries.

1.3 Scope

This document is focused on the response of NHS England at a national level, and is supported by regional and local arrangements for managing mass casualties, and the arrangements of the wider NHS which are detailed elsewhere.

2 Roles, Accountabilities and Responsibilities

This section describes the roles, accountabilities and responsibilities of those functions required to deliver a response under the NHS England Incident Response Plan (National) (IRP(N)).

2.1 NHS England

2.1.1 NHS England National

During a mass casualty incident NHS England will ensure that its response arrangements are activated. NHS England (National) will be responsible for ensuring that:

- A NHS England Incident Director (National) (ID(N)) is appointed and fully briefed
- National strategic priorities are established, in addition to those in the IRP(N), and these are communicated throughout the organisation and the NHS
- Regional EPRR On Call teams are informed of the incident and any required reporting arrangements
- Mutual aid and the mobilisation of national assets is coordinated
- Any cross boarder mutual aid or military aid requests are coordinated with the Department of Health
- Briefing is provided to the Department of Health to support central Government arrangements as required
- Briefing arrangements for NHS England senior staff are established

2.1.2 NHS England Regions

The NHS England Regional Office where the incident occurs will be the lead region and other regions referred to as supporting regions.

NHS England regional offices, will be responsible for:

- Liaison with the Incident Management Team (National) and Director of Commissioning Operations Offices' (DCO) response teams
- Appointing an Incident Director (Regional)
- Establishing regional strategic priorities, in line with national priorities and communicate these throughout the region and the NHS in the region
- Identifying suitable representatives for local Strategic Coordinating Groups (SCG) in conjunction with DCO teams
- Supporting local communications
- Supporting local decision making in line with national and regional priorities
- Working with Clinical Commissioning Groups to ensure an adequate response
- Providing timely and accurate incident situation reports to NHS England (National)

2.1.3 NHS England EPRR Clinical Reference Group

The NHS England EPRR Clinical Reference Group (CRG) will be called upon during a Mass Casualty incident to provide clinical advice to the NHS England Incident Director (National). As per the Terms of Reference of the CRG, the NHS England Incident Director (National) may ask the chair to convene the group, as a meeting or

teleconference, along with additional specialist advisors in order to ensure appropriate clinical advice is available. The CRG is responsible for:

- Clinical advice to the NHS England Incident Director (National)
- Advice on the adoption of revised triage categories
- Liaison with ambulance Strategic Medical Advisor on the distribution of patients
- Establishment of the NHS England Incident Management Team Clinical Cell

2.1.4 National Ambulance Resilience Unit

Upon activation of the NHS England Concept of Operations for the Management of Mass Casualties the National Ambulance Resilience Unit will activate the National Ambulance Coordination Centre (NACC).

The NACC will be responsible for:

- Coordination of ambulance assets to arrange transfers including air support from Air Ambulances, Her Majesty's Coast Guard and the Military.
- Reporting to and liaison with NHS England Incident Management Team
- Supply a liaison officer to the NHS England Incident Coordination Centre (National)
- Act as a conduit for coordination of mutual aid between NHS Ambulance Service Emergency Operations Centres (EOC)

2.2 Department of Health

The Secretary of State will be ultimately accountable for health emergency response, supported by the Chief Medical Officer (CMO) and the Department of Health.

The Department of Health, as the Department of State, supports the Secretary of State in the discharge of their responsibilities for assuring a ‘whole system’ accountable response.

In fulfilling its responsibilities on behalf of the Secretary of State, the Department will:

(a) ensure the co-ordination of the whole system response to high-end risks impacting on public health, the NHS and the wider healthcare system;
(b) support the UK central government response to emergencies including ministerial support and briefing;
(c) provide a data and information conduit between NHS England, Public Health England (PHE) and the Cabinet Office for emergency preparedness, assurance and response
(d) take other action as required on behalf of Secretary of State to ensure a national health emergency is managed.
(e) Liaise with other Government departments on behalf of the NHS

2.2.1 Liaison with the other Government Departments

2.2.1.1 Department of Communities and Local Government

The Department of Health will work closely with the Department of Communities and Local Government during an incident to ensure that services to support the discharge of patients in social care settings are also surged as appropriate, and new services that may need to be commissioned by Local Authorities are identified at all levels.

2.2.1.2 Requesting Military Aid

Military Assistance to the Civil Authorities (MACA) is the collective term used by the Ministry of Defence (MOD) for the operational deployment of Armed Forces personnel in support of the civilian authorities, other Government departments or the community as a whole.

All health requests for military assistance must be referred to DH Emergency Preparedness Resilience and Response (EPRR) branch via the NHS England regions and national EPRR team.

A Health Minister must authorise all Health MACA requests, there must be no direct request made to MOD. DH EPRR will lead and coordinate the arrangements with MOD.

2.2.1.3 Military Support for Blast and High Velocity Injuries

An agreement is in place between MOD and the DH that in the event of a major national incident resulting in blast and high velocity injuries, the DH can request MOD to make available personnel with recent operational experience from within the Defence Medical Service (DMS). These individuals would be able provide expert advice and guidance on treatment of these types of wounds in the fields of anaesthetics, emergency medicine, plastic and reconstructive surgery, general surgery, trauma and orthopaedics surgery, and radiology.

This process is not designed to enhance NHS England's capacity but may support local and regional (in-hospital) response with an enhanced capability to deal with these types of injuries.

In order to activate the military assistance process, the relevant NHS trust will need to reach a decision in consultation with NHS England EPRR (via local and regional offices) to identify any likely, or actual, gaps in capability where specialist resource is needed, in addition or instead of mutual aid arrangements with other trusts. Once the requirement for military assistance has been made, the request for activation must be made by contacting DH EPRR via the NHS England Incident Coordination Centre (National). DCOs should send their requests to the NHS England Incident Coordination Centre (Regional) which will pass this to the NHS England Incident Coordination Centre (National).

2.2.2 Devolved Administrations

Support from the Devolved Administrations may be requested by NHS England via the Department of Health. Support required to respond to an incident in a Devolved Administration by the NHS in England will be made via the Department of Health to NHS England National Duty Officer.

Arrangements for cross border working not covered under mutual aid arrangements for NHS Ambulance Services will also be requested in this way. It should be recognised that cross border working occurs under routine business and this will continue as normal during an incident.

2.2.3 International Support

Where capacity is exceeded in the NHS in England and the Devolved Administrations, NHS England may request support internationally via the Department of Health. Consideration will need to be given to which countries are best placed to seek support from and offer appropriate standards of care including

infection prevention control. Reciprocal arrangements are in place for the receipt of patients from overseas.

2.3 NHS Supply Chain

NHS Supply Chain will provide delivery services and inventory information in support of requests from the NHS England Incident Management Team (National) Logistic Cell. They will also liaise with key suppliers to try and source additional product and accelerated product dispatch, as necessary to meet the demands of the response.

It is likely that multiple trusts may make simultaneous requests for urgent resupply and this will need to be managed to ensure all organisations can continue to effectively support patients.

NHS Supply Chain will immediately escalate any problems relating to stock availability, delivery access and timescales, and direct requests to the NHS England Incident Management Team (National) Logistic Cell, with significant problems being further escalated to the NHS England Incident Management Team (National).

2.4 NHS Blood and Transplant

NHS Blood and Transplant will manage supplies of blood products and tissues to responding hospitals, and ensure adequate supplies remain available during the incident making substitutions where necessary to maintain supplies. Where it is necessary to ask trusts to restrict activity to preserve stocks, this will be done via NHS England's Incident Management Team Clinical Cell.

NHS Blood and Transplant will be responsible for ensuring the recovery of blood stocks following the return to normal business.

2.5 Operational Delivery Networks (ODN)

Whilst ODNs do not provide an on call service, it is anticipated they will:

- Assist with the coordination of the network's response, including local supply management
- Provide supporting arrangements with respect to patient transfer.

2.6 Clinical Commissioning Groups

Clinical Commissioning Groups will discharge their statutory duties as a Category 2 responder under the Civil Contingencies Act 2004 and act in accordance with the locally agreed response arrangements.

2.7 NHS Improvement

NHS Improvement will support NHS England's response during an incident to ensure appropriate understanding of the impact on an organisation or organisations. The two organisations will identify where assistance may be needed in response and recovery and ensure this is put in place appropriately.

2.8 Care Quality Commission

NHS England may request that the Care Quality Commission suspend its inspection regime in organisations responding to a Mass Casualty incident, and will request that they take this into account when inspecting organisations which have recently responded.

3 Provision of Services

During a major incident (as defined in the NHS England EPRR Framework) which results in mass casualties, organisations will be expected to deliver emergency care to those affected. In addition, it may be necessary for services to consider enhanced care or the expansion of these functions beyond normal service provision to deal with the surge in patients.

All organisations are expected to ensure that they maintain appropriate safeguarding measures at all times, especially for incidents involving children or persons of interest. Where persons become persons of interest due to their connection to the incident governance arrangements similar to those used for VIPs should be considered.

During an incident that results in mass casualties the normal arrangements that the organisation has to ensure that those that are difficult to communicate with, or have specialist needs may increase due to the range of casualties. Plans developed should take this into account and allow for support services, e.g. for disabilities and language issues to be overcome. Organisations should adhere to their own arrangements for reducing inequalities in the access to treatment and healthcare in the immediate response and long term care needs.

3.1 Ambulance Services

The local NHS Ambulance Service will be responsible for the command and control of all health assets and responders at the scene through the Ambulance Incident Commander. Operations at the scene will focus on the triage, treatment and transportation of casualties to the most appropriate receiving care setting, which will be notified using the standard alerting messages. The Ambulance Incident Commander will direct conveying ambulances to these care settings as appropriate, under the advice of the Strategic Medical Adviser.

3.1.1 Role of NHS Ambulance Services

The NHS Ambulance Service response may be supported at the scene by specialist assets such as:

- Medical Teams provided by Helicopter Emergency Medical Services (HEMS) or British Association for Immediate Care (BASICS)
- Hazardous Area Response Team (HART) Paramedics
- Mass Casualty Vehicles deployed by the NHS Ambulance Trust as appropriate

3.1.1.1 Role of the Emergency Operations Centres

Emergency Operations Centres (EOC) should liaise with neighbouring EOCs to allow for mutual aid and capacity usage in other ambulance areas, the coordination of support to the incident and business as usual provision during the incident

Within an hour of a Mass Casualty incident being declared the EOC should contact all its possible receiving centres and request they update their immediate receiving capacity. NHS Ambulance Services are to work with NHS England and acute providers to pre-identify patient receiving capacity. The EOC should contact the neighbouring ambulance trusts to request they do the same.

Once the NACC has been established this information should be shared and coordinated through them.

Receiving Capacity	Immediately 0 – 2 hours	Delayed 2 hours plus
Priority 1 Patients		
Priority 2 Patients		
Priority 3 Patients		

3.1.1.2 Casualty Clearing Stations

It is expected that NHS ambulance services will perform secondary triage (sort) in the Casualty Clearing Station (CCS) prior to the transfer of a patient to a receiving care setting.

The aim of the NHS Ambulance Service should be to ensure the right patient, right place, right time, first time to avoid secondary transfers. This will need to be in accordance with the agreed patient distribution models held by the service.

3.1.2 Patient Transport Services

NHS Emergency Ambulance Services will make use of available patient transport services to support the response, as appropriate.

3.1.3 Private Ambulance Services

Private ambulance services, where appropriate, will come under the direction of the local NHS Ambulance Trust in order to ensure patients are transported in a timely manner from the scene to an appropriate care setting. Where possible, this should be done via pre agreed memorandums of understanding.

Where private ambulances are contracted directly by NHS providers, for example intra hospital transfer and retrieval services, these will operate as required but may be redeployed if deemed necessary by NHS England Incident Management Team.

3.1.4 Voluntary Ambulance Services

Voluntary ambulance services, where appropriate, will come under the direction of the local NHS Ambulance Trust in order to ensure patients are transported in a timely manner from the scene to an appropriate care setting. Where possible this should be done via pre agreed memorandums of understanding.

Where voluntary ambulances are contracted directly by NHS providers, for example intra hospital transfer and retrieval services, these will operate as required but may be redeployed if deemed necessary by NHS England Incident Management Team.

3.1.5 Public Transportation

Requests for support from public transport providers will be directed through the local strategic coordinating group for action. Public transport should be used with caution to transport lower priority patients with an appropriate medical escort.

3.1.6 Patient transfer vehicles

Secondary patient transfers may be unavoidable during the response to a mass casualty incident(s) and may need to be provided by NHS or Independent ambulance

providers across a wide geographical area. In addition to this considerations will need to be made for the transfer of patients to support accelerated discharge.

The responding Trust may need to support the deployment of these services to support the response. Vehicles should be able to support the transfer of levels 2 and 3 care transport requirements. Some transfers may need to be multimodal in order to reach available capacity, especially if international transfer is required.

Retrieval transfer teams will most likely need to be provided by the receiving hospital.

3.2 Acute Care

Receiving and supporting hospitals will be designated by the NHS Ambulance Service responding to the incident or NHS England as appropriate and receive the majority of the casualties.

3.2.1 Immediate response

Trauma Centres, Trauma Units and Emergency Departments should work with their NHS England DCO or Regional Office and NHS Ambulance Service to predetermine the number of patients in each priority they can take during the initial distribution of patients from the incident scene. An example of this is provided in Annex 3: Patient distribution model example.

On receipt of notification of a declared mass casualty incident, the hospital should confirm their casualty receiving capacity, and consider the likely impact on the organisation, and those receiving units nearby.

All receiving hospitals should ensure they enact plans to enable them to free up 20% of their total bed base, 10% of which should be in the first six hours, and a further 10% within 12 hours of the incident declaration, allowing patients from the incident scene to be rapidly placed and ensure patient flow.

In addition to this, hospitals with level 3 Intensive Care capability should prepare to surge to double their normal level 3 ventilated bed capacity, and maintain this for a minimum period of 96 hours.

Trauma Units should be prepared to manage patients who they would usually treat and transfer, for extended periods, along with preparing to receive additional repatriations from Trauma Centres.

During a mass casualty incident it may be necessary for receiving hospitals to expand their emergency capacity into space not usually occupied by the emergency pathway. This will require the activation of business continuity measures.

Organisations will need to consider activation of their lockdown arrangements to support site security and the need to protect access to health care facilities to those in need of treatment. In the event of being in a scene cordon the hospital may be asked to act as a temporary rest centre or reception centre.

Trusts will immediately provide to ambulance service the receiving capacity of their Trusts Trauma Centres and/or Units:

Receiving Capacity	Immediately 0-2 hours	Delayed 2 hours plus
Priority 1 patients		
Priority 2 patients		
Priority 3 patients		

3.2.2 Hospital reporting

Trusts should be prepared to provide the information required on the NHS England National Incident Situation Report Template, or specific incident template issued during the incident to the appropriate time scales.

Critical Care Centres, Burns Centres, Burns Units and ECMO Units are required to update their position, within an hour of the incident declaration, on NHS PathwaysDoS (Directory of Service) Capacity Management System.

3.2.3 Supporting Hospitals

Those hospitals not directly receiving patients from scene will be considered a supporting hospital for the incident.

Nominated supporting hospitals are also expected to maximise available capacity in their bed base to a maximum of 20% of their total bed base within 12 hours of the incident declaration.

When nominated a supporting hospital, those with level 3 Intensive Care capacity should be ready to surge to double their normal capacity for level 3 beds for general use and supporting the decant of patients from other receiving medical centres.

In addition, supporting hospitals may have to support patient transfers by providing suitably skilled transfer teams for each patient needing to be moved. All hospitals with critical care capacity should have in place plans to support the retrieval or transfer of patients.

Where hospitals routinely have retrieval teams, they will be asked to support these transfers if this will not cause a reduction in the response at the scene or responding hospitals.

3.2.4 Urgent Treatment Centres

These units should be prepared to receive casualties from the incident. This will be especially important for units close to the scene that may be overwhelmed, in all cases units and centres should have plans to treat lower priority patients and have holding areas for higher priority patients who need onward transportation to trauma centres and emergency departments.

3.3 Community Care (NHS funded)

NHS Community Care providers may be alerted to the incident by NHS England, or their local Health Partners.

3.3.1 Immediate

Identify patients suitable for discharge to make available beds for acute discharge support. Identify resources to support accelerated discharge assistance, assessment and discharging of rehabilitation patients and physiotherapy patients.

Identify staff who may be able to support treatment in any walk in centres operated by the organisation which has patient presentations and surge for low priority patients transferred to these units.

Community Care organisations may be asked to support medical coverage at Survivor Reception Centres or establish treatment centres for low priority patients in spaces close to the incident scene. These services may be augmented by the Voluntary Services via Local Authority arrangements, or other commissioned clinical providers.

3.3.2 Medium

Invocation of medium term business continuity measures to support the management of patients requiring ongoing care in an alternative setting and ensure continued creation of capacity to support the local acute hospital.

Ensure appropriate links from urgent treatment centres to the nearest acute hospital established, to enable deteriorating patients to be managed. Liaison with mental health provider and other referral systems to ensure appropriate patient management.

3.3.3 Long Term

Recovery of services to normal business as soon as possible with identification of specific patient groups and support services which may continue to have surges of patients.

3.4 Mental Health

3.4.1 Immediate

Ensure adequate mental health liaison resources are made available to responding care settings if requested. Ensure the discharge areas are supported with suitable staff able to give advice on where to seek treatment and support and the issuing of the post incident leaflet (Annex 4: Access to post incident mental health services leaflet).

Receiving providers should ensure they are supported by suitable staff who are able to:

- Give advice to everyone who visits the care setting on where to seek support and psychosocial care for distress;
- Make referrals to specialist mental health services for people who require immediate assessment and treatment immediately after events.

Responding providers should liaise with the NHS England DCO teams to ensure that arrangements for psychosocial care and mental healthcare are made, coordinated and signposted across the agencies.

They should ensure adequate mental health liaison resources are made available to those care providers which have responded to the incident.

3.4.2 Medium

Everyone involved is likely to benefit from social support after a mass casualty event and most people are likely to receive it from their families and a range of agencies. Assumptions about which agencies are to provide social support should not be made.

Mental health services providers should work with local agencies to design and deliver an appropriate mechanism that is able to identify people who continue to

need supporting and welfare arrangements beyond those that their families can provide. It should signpost them to agencies and facilities that are able to offer the enhanced psychosocial support they require.

They should escalate the need to commission specialist mental health services from specific organisations for the projected numbers of persons who are likely to need specialist assessment and treatment. They should work with commissioners to identify processes to recover normal business after the incident.

3.4.3 Long Term

People who develop new episodes of psychiatric disorders or exacerbations of previous disorders may require specialist care in the medium and long-term. A minority of people may require them for several years.

Mental health service providers should work with commissioners to build referral, assessment and treatment processes for people who need further or extended care. They should identify methods to continue to deliver assessment and treatment for patients in the long-term before these facilities are absorbed into their ordinary business.

They should work across sectors of care to identify patients who require monitoring or may present later in need of specialist care. They should consider likely triggers for patients who might need intervention during similar or subsequent events or at specific times of the year. Some of these services may be provided by other mental health organisations.

3.5 Primary Care

3.5.1 Immediate

Primary Care services - in the form of General Practice and Community Pharmacy services - may be asked to support the treatment of patients who are of a lower priority in care settings and assist in managing patients triaged away from Emergency Departments. GPs may have a role in Emergency Departments to see and triage existing patients out of the department to make way for incident victims.

Support may also be requested to support NHS 111/Integrated Urgent Care services and allow for virtual web based consultations and the supply of medication to the scene or to treatment centres.

General Practitioners can support messages being issued to the public to give reassurance following the incident. Consideration needs to be given to using clinical services of Out of Hours providers and other similar resources and providers that can support a response for primary care services.

Available nursing care / medical care capacity may be utilised to augment other services where patient presentation is greatest.

3.5.2 Medium and Long Term

Primary Care services will be an important part of the mechanisms to ensure those involved in the incident receive appropriate mental health support and are able to triage those who are emotionally traumatized in the appropriate support and response services.

Commissioning organisations will need to ensure the appropriate pathways for these services are made available and known to Primary Care services.

3.6 NHS Supply Chain

NHS Supply Chain will provide:

- Delivery services – emergency deliveries can be made within 5 hours of order receipt
- Inventory information
- Product sourcing support, where product is exhausted or held in insufficient quantities to meet the exceptional demands created by the incident
- Call handling services to manage enquiries from the NHS on stock and deliveries.

3.7 NHS Blood and Transplant

NHS Blood and Transplant will ensure there is appropriate management of blood products and tissues based upon the incidents use. In order to do so they will work closely with the NHS England Incident Management Team Logistics Cell to monitor hospital response and ensure any directions to the NHS are reflected in the management of blood products and tissue. Where possible NHS Blood and Transplant will have a representative within the Logistics Cell or Clinical Cell to inform on product utilisation and maximise usage.

3.8 Mortuary Services

National arrangements for the identification of victims are likely to be invoked. These may include the activation of National Emergency Mortuary Arrangements (NEMA) or the designation of a Designated Disaster Mortuary (DDM) which may be on NHS premises but operated by the local authority.

It may be the case that the mortuary space in NHS hospitals has to be managed carefully, and coordinated with the appropriate HM Coroner's Office, HM Police and Local Authority to maintain capacity. This will be important where deceased are to be held for a period of time, and there will be delays in taking hospital mortuary bodies to the designated disaster mortuaries.

3.9 Voluntary Agencies

The Voluntary Agencies will be requested to support the response to any Mass Casualty incident by various organisations and agencies. It may become necessary to coordinate the response requests through agencies arrangements centrally, to get the best use of these resources and ensure deployment is effective.

4 Activation

These arrangements will be activated when a Mass Casualty Incident has been declared and informed to the National EPRR Duty Officer.

4.1 Initial Alerting

4.1.1 Declaration

National declaration will be as per the arrangements of the NHS England Incident Response Plan (National), the incident will be declared to all the Regional Offices to ensure appropriate command and control is established. A mass casualty incident may be declared before exact numbers of casualties or their type are known.

4.1.2 Notification

Notification of the initial declaration will be via the on call system for the regional office and should be cascaded as appropriate.

4.2 NHS England Internal Staff Alerting

At the declaration of a Level 4 incident, the EPRR Duty Officer will alert Communications colleagues and request Communications to prepare a staff briefing for release once approved by the Incident Director (National). This will be disseminated via the usual internal communications channels including email and the intranet and the use of Everbridge will also be considered as appropriate to alert staff.

4.3 Alerting External Agencies

NHS England Duty Officer will alert relevant external agencies to the incident, including the Department of Health and Public Health England, via the Duty Officer system alongside NHS Supply Chain and NHS Blood and Transplant upon declaration of the incident. Further notification of agencies will be conducted through established routes. NHS England regions, and DCOs will be responsible for local alerting of organisations to the incident. Where organisations have a duty to inform regulators of the incident, they are expected to do so through normal routes.

4.4 NHS England Incident Levels

A Mass Casualty incident will likely be declared a Level 4 Incident, as per the NHS England Incident Response Plan (National), a Level 4 incident is described as:

“An incident that requires NHS England National Command and Control to support the NHS response.

NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.”

4.4.1 National Command and Control

As a result of declaring a Level 4 incident, NHS England may enact its powers under section 252A of the NHS Act 2006 as amended by the Health and Social Care Act 2012 to take national command and control of the NHS and providers of NHS funded care. NHS England will direct these services to respond to the incident with national

direction communicated through Regional and Director of Commissioning Operations (DCO) Offices, and direct to providers where necessary.

4.5 Escalation and de-escalation

Escalation or de-escalation through the incident levels need not occur sequentially but will be driven by the nature, scale and complexity of incidents combined with the expectations of the NHS England response. Any incident response can be changed following a review, including a risk assessment, of the strategic direction and operational management of the incident.

The level of response may need to be escalated or de-escalated for a number of reasons. These may include:

Criteria for Escalation	Criteria for De-escalation
• Increase in geographic area or population affected • The need for additional NHS external or internal resources • Increased severity of the incident • Increased demands from DH, partner organisations or other responders on the NHS • Heightened public or media interest • Establishment of COBR • Increased UK threat level	• Reduction in incident resource requirements • Reduced severity of the incident • Reduced demands on the NHS from DH, partner organisations or other responders • Reduced public or media interest • Decrease in geographic area or communities affected • Decreased UK threat level

Changes in incident level can only be authorised by the Incident Director (National).

All response level changes need to be communicated both internally and externally, as appropriate. A brief description of the resource implications of the new level should be included.

5 Incident Management Structure

5.1 NHS England Incident Management Team (National)

The incident management team for NHS England (National) will be formed as per the Incident Response Plan (National). In support of these arrangements, specific support cells will be formed to ensure appropriate clinical advice is available and there is coordination of logistic arrangements for NHS England and the NHS in England.

NHS England will appoint an Incident Director (National) to oversee the response and ensure appropriate response structures are in place.

5.1.1 Specialist Staffing

As the incident progresses specialist advice may be required to support the response and the Incident Management Team (National) will request individual organisations or persons join the response and indicate the specific cell they will join.

5.1.2 International Support Requests

Any requests for support from international agencies should be made through the Department of Health; this may include the use of resources overseas or the placement of medical staff and resources within England.

5.1.3 Reporting

During a mass casualty incident, there will be a requirement to report on a variety of issues to allow the response to be coordinated.

5.1.3.1 Situation reports

Situation Reports will be completed for all responding organisations, on the appropriate template, and those asked to support this. The national situation reporting template should be used by organisations and the regional offices to ensure shared situational awareness and common understanding.

5.1.3.2 Central Government Emergency Response Arrangements

The Cabinet Office Briefing Rooms (COBR) are likely to be activated and cross government coordination established to ensure the response is appropriately managed at a strategic level.

5.1.3.3 Regional and Local Response Arrangements

Response Coordinating Groups (ResCG) may be established to coordinate multiple Strategic Coordinating Groups (SCGs).

SCGs will be established to respond to a large or wide area mass casualty event. These groups may have competing priorities, so work will need to be undertaken to ensure these approaches are coordinated at a regional and national level.

Reporting to Strategic Coordinating Groups should always reflect the position given to the Regional Office or NHS England Incident Management Team (National) to ensure reporting across departments is coordinated if COBR is established.

The Department of Communities and Local Government is responsible for reporting on SCGs through ResCGs to COBR.

5.1.3.4 Casualty reporting

It is the responsibility of health organisations to ensure reporting of casualty numbers is undertaken, including the triage and treatment of patients at scene and medical facilities. In some cases this may not be in NHS facilities depending on the location of the incident.

The NHS has no responsibility for the reporting of fatalities from an incident as this is undertaken by the police.

5.2 Logistics Coordination Cell

Mass Casualty events will be resource intensive and may require some clinical and non-clinical products to be managed centrally by a coordination cell to ensure continued supply. This cell will be responsible for:

- Coordination for the movement of stock by NHS Supply Chain
- Coordination with NHS Blood and Transplant
- Coordination of information regarding available capacity and ensure this is passed to the Clinical Cell and NHS Ambulance Trusts

These arrangements may need to be duplicated at a local and regional level to ensure continued best use of limited resources. The focus of the Logistic Coordination Cell will be national logistics rather than local supply management between individual organisations. The logistics coordination cell will be established by NHS England and have representatives from NHS Supply Chain, Department of Health, and NHS Blood and Transplant as a minimum.

5.2.1 NHS Supply Chain

Coordination with NHS Supply Chain will be necessary to ensure adequate stock is made available to support the initial response and ongoing supply requirements at receiving hospitals.

It is likely that multiple trusts may make simultaneous requests for urgent resupply and this will need to be managed to ensure all organisations can continue to effectively support patients.

In addition to this, the Logistics Cell will be responsible for supporting supply of stocks to newly established areas and arranging support to the NHS Ambulance Service should specialist equipment be needed at the scene to allow for treatment outside of normal care settings where patients are held for transport.

5.2.2 NHS Blood and Transplant

The logistics cell will be responsible for coordination with NHS Blood and Transplant so that NHS Blood and Transplant can effectively manage blood products and tissues, throughout the incident.

5.2.2.1 Demand management

Early in an incident it may be necessary to request a suspension of the normal blood stock management processes and ensure supplies are controlled.

Hospitals should be prepared to receive Amber and Red Blood stock alerts, which may be issued to hospitals across the country to ensure adequate stocks remain available through the incident response and casualty management process.

NHS Blood and Transplant (NHSBT) will remain responsible for donor management during the incident and any calls for blood donations. There will be no call for donors to self-present to any of the blood collection centres, unless otherwise indicated by NHSBT.

5.2.2.2 Stock relocation

NHSBT will be responsible for the movement of blood stock and tissues; however NHS England may need to direct the supply to those facilities responding to the incident. Where it becomes necessary to move patients away from the scene, the relocation of blood stock may not be appropriate from blood processing centres close to those hospitals supporting the incident to ensure adequate supplies locally. NHS England and NHSBT will work together to ensure these factors are taken into account when releasing products.

5.2.3 Specialist Staffing

It may be necessary to relocate specialist staff to support the response or arrange for specialist staff to give specific advice for the treatment of patients.

5.2.4 Bed information

Information on the availability of beds will be provided by the regions through the situation reports. An overall summary will be shared by the IMT(N) with all regions and appropriate partner organisations.

Regional Offices will report bed information to the national team to create single representation back to Lead Regional Office ICC.

5.3 National Ambulance Resilience Unit

The National Ambulance Resilience Unit (NARU) will establish the NACC on declaration of a mass casualty incident in England, or at the request of NHS England.

5.3.1 National Ambulance Coordination Centre (NACC)

The NACC is to provide the focal point for the collection, collation and assessment of data regarding all NHS ambulance service providers in the UK and specifically their ability to provide mutual aid if called upon to do so. It will ensure that the NARU strategic liaison officer within the NHS England ICC(N) is fully aware of the developing situation. It will also have a role in the collection of information for NHS England as appropriate and the subsequent dissemination of that information to providers around the country (including the devolved administrations) in order that they have the best possible situational awareness on major incidents and emerging issues elsewhere in the UK.

The NACC will have 3 principal functions:

- Information analysis and Intelligence Dissemination,
- Feedback on and Dissemination of National Policy Decisions,
- Managing Requests for Mutual Aid (see paragraph 5.3.2).

5.3.2 Mutual Aid

Whilst the NACC will principally provide a focus on operations in England, there is an agreed ability that the Ambulance Service nationwide is able to provide mutual aid across boundaries to the devolved administrations.

Requests for mutual aid will be made through the NACC and will then be organised in accordance with the national memorandum of understanding (MoU) concerning the Provision of Mutual Aid. Requests outside of the MoU to NHS England and Department of Health are to be agreed separately.

5.3.3 Air Ambulances

Air Ambulances utilised by the NHS Ambulance Service in England are charitably funded by their communities and their use must therefore be carefully considered before being requested. However, the charities that support these assets allow the NHS Ambulance Service Control Rooms to coordinate their tasking. These assets may be available to support the national response to a major incident.

The NACC will coordinate requests for Air Assets and liaise with the appropriate Air Ambulance Provider's Control Room as to their availability. The final decision on Air Asset mobilisation will always rest with the pilot and crew, subject to the operating limitations and procedures of the aircraft.

5.4 Communications Cell

5.4.1 Ministerial Briefing

The production of ministerial briefings is the responsibility of DH. This will be done by DH in conjunction with NHS England, to ensure briefings contain the most accurate and up to date information and that it is shared with Ministers at the appropriate time.

5.4.1.1 Casualty figure disclaimer/explainer

During the early stages of an incident, it is often not possible to provide accurate casualty figures. However, where indications of numbers involved are available, these should be shared but heavily caveated as a best guesstimate based on the circumstances emergency services are responding to at that time.

5.4.2 Communicating with the NHS

The Communications Cell will ensure that the NHS is communicated with on a regular basis and establish appropriate communications management with in the responding services. The following methods may be used to communicate with the NHS.

5.4.2.1 CAS Alert

A template CAS alert has been developed (see Annex 2: CAS Alert Template) and will be populated based on the methane report. This will be issued across NHS organisations in the affected geographical area if a Level 4 incident is declared. Distribution levels to the wider NHS will be agreed by the Department of Health in conjunction with the NHS England Incident Director (National) depending on relevance to the issue.

5.4.2.2 NHS Communications Network

The NHS has a tried and tested method of disseminating information to organisations across the network of NHS communications staff. During an incident, information can be quickly shared for wider circulation to NHS staff via email, intranets and if appropriate, social media and other public facing communication tools. These can

also be shared with communications colleagues in other local organisations for wider dissemination if necessary.

5.4.3 Messages for Key Stakeholders

In addition to using the NHS communications network to disseminate information quickly to NHS staff, consideration should be given to using key stakeholders such as Royal Colleges to share information with members, dependent on the nature of the incident and the audience reach required.

5.4.4 Public messaging

Public messaging will be delivered through a dedicated incident page on NHS Choices (www.nhs.uk/incident). This page will only go live if a Level 4 incident is declared and this page is not visible at other times. A sample of the content of this page is attached at Annex 1: NHS Choices Web Page. It will contain commonly recognised information about the incident and will signpost the public to places where they can obtain further information (such as the relevant police website, or missing persons bureau). It will also inform people of which hospitals are receiving mass casualties and where and how to obtain alternative healthcare services.

Appropriate public messaging will also be delivered through use of traditional and social media. Messages will be developed by the EPRR Communications Lead in conjunction with the Incident Director and will be issued via the NHS England national media team. All messaging should be agreed with the local Strategic Coordination Group prior to issue and should be open and transparent, reflecting an accurate picture of the situation as it is known at that time.

NHS Blood and Transplant will be responsible for any public messages regarding the donation of blood. NHS England will reflect this messaging in communications with the public.

5.5 Clinical Cell (CRG)

NHS England will form a Clinical Cell with the Duty Clinical Director along with representatives of the NHS England EPRR Clinical Reference Group, with additional specialist representation as required.

This cell will act to ensure that the NHS England Incident Management Team (National) has the appropriate access to clinical advice to inform the response.

NHS England may make use of Medical Directors from Regional Offices and DCO teams to support the clinical cell in a protracted incident or where they have specialist subject advice required of the response. In addition to this, NHS England may contact individual experts to offer advice based on available known staff in organisations.

5.5.1 Clinical Impact Assessment Call

Within the first twenty four hours of an incident, the Lead National Medical Director will establish a clinical call with responding centres to ascertain the likely impact to services and patient management across all services. An agenda for this is provided in Annex 6: Clinical Impact Assessment Call Agenda

Where possible this call will be held on the secure teleconferencing facilities accessible through the NHS England EPRR Duty Officer (NHS05).

5.5.2 Medical support to NHS ambulance services

There should be two tiers of medical advice to the pre-hospital staff. Strategic medical advice to the NHS ambulance service should be available in the emergency operations centre to liaise with the ambulance strategic commander, the acute hospital sites and the ambulance incident commander on scene.

Also available should be senior clinical advice to the casualty clearing station to ensure accurate triage of patients to the correct receiving unit. There will need to be close liaison between this individual and the strategic medical advisor to avoid overload of the local major trauma centre and to identify patients who may benefit from transfer to more distant major trauma centres.

5.5.3 Ethical decisions

It may become necessary to enact decisions relating to the ceilings of care during a mass casualty incident to ensure the greatest number of survivors possible.

This may include the decision by the Clinical Cell to invoke the expectant triage category at the scene. This decision will be time limited, continually under review and only used at a time when NHS resources are overwhelmed

5.5.4 Patient Placement

The Clinical Cell will advise on the placement of patients who need to be transferred out of the incident response areas to ensure they receive the most appropriate definitive care.

5.5.5 Clinical Debrief

The Clinical Cell will establish a clinical debrief for the incident, the hot debrief will be held within two weeks of the incident, with a structured clinical debrief within one month.

5.6 Recovery Cell

Nationally a Recovery Cell will be established to coordinate with the response and ensure work is undertaken to manage the recovery of NHS England and the NHS in England. This group will look at the recovery support required and ensure liaison between recovery groups at all levels of the organisation and out to those groups established as part of SCG response.

The Chair of the Recovery Cell will be the Recovery Director (National).The Recovery Cell may include representation from appropriate NHS bodies such as NHS Improvement and regulatory bodies such as CQC.

5.6.1 Liaison with Regional and SCG Recovery Groups

The Recovery Director (National) will be responsible for ensuring Regional Recovery Groups established within NHS England are made aware of national recovery priorities and any nationally mandated decisions in relation to the recovery of NHS services.

This liaison may be direct through the Recovery Leads (Regional) or through the appropriate incident response structures.

5.7 Finance

5.7.1 NHS England

During and following a Mass Casualty Incident(s) costs associated with responding to the incident(s) will need to be identified, monitored and documented, so that discussions may subsequently take place between relevant parties in relation to recovery monies.

5.7.2 The NHS in England

All responding organisations should ensure they have arrangements in place to account for the costs related to the incident response. All NHS Trusts and commissioned services which respond or manage patients as a result of a Mass Casualty Incident(s) should have arrangements in place which enable them to track incident expenditure.

6 Stand Down and Recovery

Once it has been decided that the NHS England national response structure is no longer appropriate, the stand down process will be initiated by the Incident Director (National) as per the arrangements in the Incident Response Plan (National).

Recovery will be led at a Regional Level and coordinated with support from the Recovery Director (National). The Region will nominate a NHS England Recovery Lead (Regional), and NHS Recovery Representatives (see 5.6).

The NHS will be represented at Recovery Coordination Groups by a designated NHS Recovery Representative who will link to the NHS England Recovery Lead (Regional) and through them to the NHS England Recovery Director (National). Where Regional Coordinating Groups are established the NHS England Recovery Lead (Regional) will represent the NHS and coordinate with their representatives at a local level.

6.1 Recovery considerations

- Decision making for return to normal working ultimately rests with Incident Director (National). This may be delegated as the incident response evolves and recovery commences to regional leads; however the option to refer to the designated national lead should remain in the case of local/regional dispute or unacceptable variation in recovery actions occurs.
- Financial implications must be transparent and principles applied consistently across the system by providers and commissioners (see above section 5.7)

- Recovery should be led by a senior Regional Recovery Lead and coordinated nationally across the health economy to ensure continued application of mutual aid principles, effective use of resources and to facilitate repatriations
- National, regional and local recovery leads should liaise at an early stage and throughout the process with ODNs. The ODNs will provide local intelligence and advise on actions to be taken at system level (local/regional/national)
- Return to organisational business as usual may take considerably longer than normal.
- Trauma cases may require multiple and prolonged returns to surgery and/or stays in critical care.
- Specialist services may need to be commissioned or expanded to deal with additional demand on a medium to long term basis
- Patients may need to be repatriated into their own health economy a long way from the incident location and may require medium to long term care and rehabilitation. Commissioners will need to agree the provision of additional resources.
- National support will be required to recover costs from overseas patients and national arrangements should be set out in advance. Costs may be for short, medium or long term care and treatment and could include; emergency and/or specialist treatment and care, rehabilitation services and repatriation.
- Discussions around the reduction, alteration, suspension or cancellation of services by organisations supporting the incident that impact on their national standards should be conducted between regulators at a national level.
- Proactive capture of points to inform learning from response and facilitate recovery should be achieved.

6.2 Debriefing

All NHS organisations involved in the response will be expected to undertake a debrief as per the requirements of the NHS England EPRR Framework and Core Standards. Trusts may be invited to multiple debriefs by many agencies and should attend these where possible.

6.3 Psychosocial Support

Psychosocial support should be offered to patients and staff as needed they should also be made aware of those symptoms that are normal during the initial period following a traumatic event, The NHS England post incident leaflet is available in Annex 4: Access to post incident mental health services leaflet.

7 Background information

7.1 Risk factors and likely injury types

National planning assumptions state the likely split across triage categories will be 25% Priority 1 (casualties needing immediate intervention), 25% Priority 2 (casualties needing early treatment but delay acceptable), 50% Priority 3 (casualties needing treatment but a longer delay is acceptable).

The cause of the incident is likely to dictate the type of injury from a Mass Casualty event however there is likely to be:

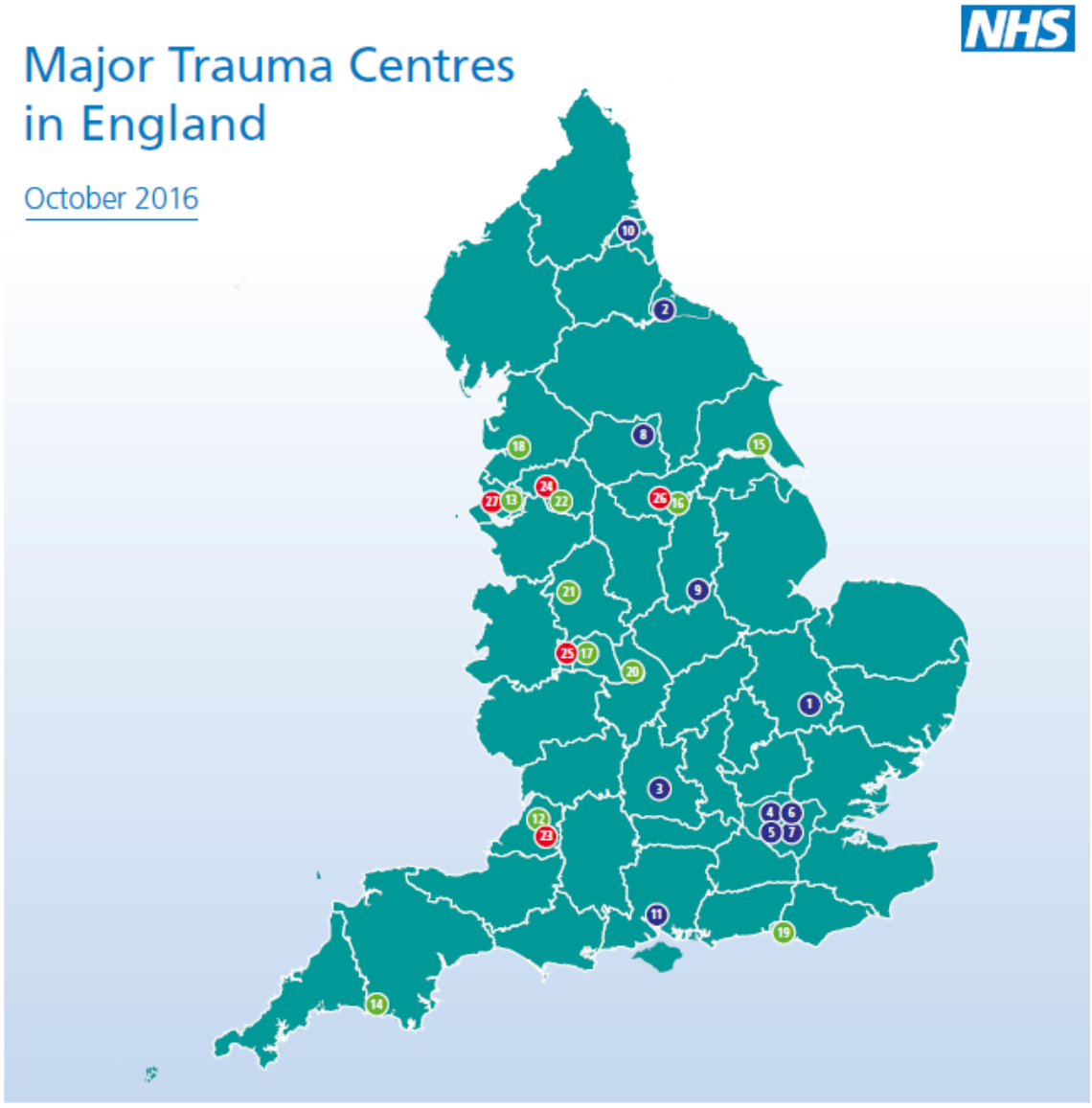
- Severe Blunt Force or Ballistic Trauma (especially in fire arms and bomb related incidents) across specialties.
- Burns
- Acoustic Injuries (where blasts have occurred)

7.2 Specialist services

The NHS in England provides specialist services at a smaller number of locations to ensure high quality of care and improve patient outcomes these include, but are not limited to:

7.2.1 Major Trauma Centres

England is split into Trauma Networks with a Major Trauma Centre, and supporting Trauma Units, allowing the centralisation of specialist skills and resources.



Adult & Children's MTCs

1: Addenbrooke's Hospital Cambridge
2: James Cook University Hospital Middlesborough
3: John Radcliffe Hospital Oxford
4: St Mary's Hospital London
5: St George's Hospital London
6: Royal London Hospital
7: King's College Hospital London
8: Leeds General Infirmary
9: Queen's Medical Centre Nottingham
10: Royal Victoria Infirmary Newcastle
11: Southampton General Hospital

Adult MTCs

12: Southmead Hospital Bristol
13: Aintree University Hospital Liverpool
14: Derriford Hospital Plymouth
15: Hull Royal Infirmary
16: Northern General Hospital Sheffield
17: Queen Elizabeth Hospital Birmingham
18: Royal Preston Hospital Lancashire
19: Royal Sussex County Hospital Brighton
20: University Hospital Coventry
21: University Hospital of North Staffordshire Stoke on Trent
22: Salford Royal Hospital and Manchester Royal Infirmary (Collaborative)

Children's MTCs

23: Bristol Royal Hospital for Children
24: Royal Manchester Children's Hospital
25: Birmingham Children's Hospital
26: Sheffield Children's Hospital
27: Alder Hey Children's Hospital Liverpool

7.2.2 Extra Corporeal Membrane Oxygenation

There are five adult and five children's Extra Corporeal Membrane Oxygenation (ECMO) Centres in England providing highly specialised care within Critical Care capacity – it may be necessary to utilise this capacity in the event of a mass casualty incident(s).

ECMO Centres are commissioned to provide retrieval of patients via transfer teams, It may be necessary to use these teams to support the transfer of patients to other facilities where the patient can be supported and create capacity in hospitals close to the incident location.

Centre Locations

Centre	Region	Adult/ Children
Guys and St Thomas Hospital	London	**Adult**
Royal Brompton & Harefield	London	**Adult**
Papworth Hospital	Midlands and East	**Adult**
University Hospitals of Leicester	Midlands and East	**Adult and Children**
University Hospital of South Manchester	North	**Adult**
Great Ormond Street Hospital	London	**Children**
Birmingham Children's Hospital	Midlands and East	**Children**
Alder Hey Children's Hospital, Liverpool	North	**Children**
Freeman Hospital, Newcastle	North	**Children**

Beds are available in Scottish centres, at Aberdeen (Adults) and Glasgow (Children)

7.2.3 Burn Centres

There are four burns networks covering England and parts of Wales, which manage the treatment of burns patients, in many cases these patients will travel through a Trauma Centre or Trauma Unit and await onward referral.

It may be necessary to establish an assessment team able to travel to the receiving hospitals to assess patients for distribution across the networks where there are large numbers of patients.

- Burns Centres may need to offer advice to Trauma Centres and Units to ensure appropriate care is received
- Parts of the Network unlikely to receive patients may be asked to support the assessment and distribution of patients into the local network to maintain capacity

7.2.4 Rehabilitation Services

The NHS has well established and diverse rehabilitation services, however these may come under intensive pressure following a Mass Casualty incident where patients have severe and complex trauma. Rehabilitation related supplies such as wheel chairs may also come under severe strain and require coordination.

In addition to this, the military have extensive rehabilitation experience which may be of use to the NHS in this situation to improve patient outcomes. Utilisation of these services would be via a MACA request, potential requests could be:

- Use of current model for Trauma and ballistic advice to the NHS but for rehabilitation
- Military Rehabilitation Subject Matter Experts assistance and advice for individual cases
- Mobilisation of Military Rehabilitation Teams in NHS settings
- Use of the Defence Medical Rehabilitation Centre to support patients where the NHS cannot offer appropriate rehabilitation.

7.2.5 Renal Services

Specialist Renal Services may need to be surged depending on the nature of the incident and where there is a requirement for Renal Services, a specialist in these services will be asked to join the Clinical Cell.

Renal Services include both Specialist Centres and Units offering Renal Care supported by a specialist centre,

7.2.6 Hospitals with Defence Medical Units

- Frimley Park Hospital, Surrey
- James Cook Hospital, Middlesborough
- Plymouth Hospital, Devon
- Portsmouth Hospital, Hampshire
- Queen Elizabeth Hospital, Birmingham

7.2.7 Reception Arrangements for Ministry of Defence Patients (RAMP)

Reception Arrangements for Ministry of Defence (MOD) Patients (RAMP) are arrangements agreed between the MOD, DH and NHS England for the movement, secondary healthcare and welfare of MOD patients who have been aero medically evacuated from overseas locations to the UK (normally to the Queen Elizabeth Hospital, Birmingham).

Under normal circumstances the MOD patient transportation, admission, transfer and clinical management will be managed according to arrangements made between the MOD Royal Centre for Defence Medicine (RCDM) and NHS providers in the Birmingham area.

In the case of a major incident involving numbers and/or types of MOD casualties that cannot be managed by normal resources, the NHS England National Duty Officer will be notified and instigate arrangements under this framework and in line with normal Incident Response Plans to manage the situation.

Tracking and support of MOD patients will remain the responsibility of the MOD.

MOD patients may include military personnel, dependents of military personnel, Government personnel posted oversees and other entitled persons.

7.3 Anticipated impacts for non-health sectors

Any mass casualty incident could have an impact on any non-healthcare services; the impact of these should be considered when activating these arrangements.

7.3.1 Transport Infrastructure

Extreme disruption to transport services in the localised area, especially if the transport infrastructure has been targeted for use in the incident, this includes transportation hubs.

The Security Services may also advise the temporary closure of transport to prevent suspects escaping or further potential attacks from being staged. This should be considered in planning a response or choosing Coordination Centre locations.

7.3.2 Power & Gas Supplies

There may be temporary loss of power and gas supplies to an area where an incident has occurred depending on the cause of the incident. Additional loading in any location where temporary clinics are established should also be considered to prevent overload of health care facility power supplies.

7.3.3 Telecommunications

Locally to the incident there may be considerable disruption to telecommunications including mobile phones and land lines. In addition to this, there will be high demand for these services following an incident and where large numbers of people continue to use telecommunication channels. This may be accompanied by disruption to infrastructure supporting telecommunications networks, and organisations should ensure coordination arrangements take this into account.

7.3.4 Environmental

Local conditions can impact on the ease to get to medical facilities and the ease of access to patients requiring a greater response from the hospital. Weather conditions can impact on the number of casualties in an incident and the type of treatment and staff required to respond, extremes of temperature can increase the risk of shock, and bring about exposure related illness.

7.3.5 Water Supplies

Water supplies could be the cause of a mass casualty incident or impacted upon by an incident. The Trust has in place utility disruption plans to allow services to continue in the event of a disruption or contamination to supplies. Advice should be sought from Public Health England during any incident of this nature.

Lack of water supplies may require a change in the way patients are cared for and effect immediate treatment.

7.3.6 Children's Sector

Any incident that has an impact on schools, nurseries and other child care settings are likely to require an expanded response from the Mental Health Services due to the emotive nature of these events. Care should be taken in responding to events involving the children's sector to ensure staff have adequate training and are aware of child protection legislation.

7.4 Previous mass casualty events

Examples of complex incidents which could produce numbers on a scale that could be described as mass casualty events include the following:

Incident	Date	Location	Fatalities	Injured
Terrorist attack on the World Trade Centre	2001	New York, USA	2,993	8,700
Bomb in a nightclub	2002	Bali, Indonesia	202	300
Multiple bombing attacks to a transport system	2004	Madrid, Spain	191	1,900
Tsunami	2004	S.E Asia	200,000+	Unknown
Multiple bombing attacks to a transport system	2005	London, UK	52	650
Marauding terrorists with fire arms	2008	Mumbai, India	166	293
Marauding terrorists with fire arms and bombing	2011	Oslo, Norway	85	176
Earthquake and Tsunami	2011	Japan	15,853	6,023
Marauding terrorists with fire arms	2013	Nairobi, Kenya	67	175
Marauding terrorists with fire arms and bombings	2015	Paris, France	130	368
Terrorist with fire arms	2016	Orlando, USA	49	53
Vehicle borne terrorist with fire arm	2016	Nice, France	84	308
Bombing and fire	2016	Bagdad, Iraq	326+	246

7.5 VIP Visits

It is likely during and/or following a mass casualty incident there will be significant interest from VIPs to visit hospitals and those affected. This may need to be coordinated nationally to ensure that appropriate arrangements are in place.

Visits from VIPs can require extensive resourcing and organisations need to carefully consider these against the need to deliver ongoing patient care.

Annex 1: NHS Choices Web Page

Proposed web address: www.nhs.uk/incident

Advice for patients

We are aware of an emerging incident in [insert geographical area].

The NHS is forming part of the emergency response for this incident, which is being led by [police force name]. For further information, please visit [insert police web address and possible central Government and/or PHE web links depending on incident].

If you are concerned about a family member you believe may have been in the area and you are unable to make contact with them, please call [xxxxx] or visit [www.xxxxx] to register their details.

The NHS is working hard to ensure that as few patients as possible are affected. The following hospitals are currently receiving patients from this incident:

- [insert list of receiving hospitals]
-
-

If you were in the [xxxxx] area and have been affected by this incident, please visit your GP for further advice and support. [Possible link to PHE public health messages – depending on nature of incident].

Helping the NHS at this time

You can help the NHS cope by choosing the right service for your needs, and attending A&E only if it is essential. If it is possible, you should try to avoid attending the A&E Departments listed above at the present time, as demand for services is extremely high and this will impact on the amount of time you have to wait to be seen and treated if your problem is not immediately life threatening.

NHS Blood and Transplant

We have sufficient blood stock at this current time, but if you wish to donate in the future please register here https://www.blood.co.uk/

Other services

Apart from your hospital, there's a range of other primary care services that can offer help, such as your GP, pharmacist, dentist or optician. There are also specific services provided by midwives, health visitors and specialist nurses.

Planned treatment and outpatient appointments

If you have a planned operation, procedure or outpatient appointment at a hospital affected by this incident, please visit the hospital website for further advice and information about routine services at this time. If you are still unsure what to do, contact the hospital direct.

Patients already in hospital at this time will continue to receive normal care. Inpatients will be told if any changes to their planned treatment are needed because of this incident.

GPs

Your GP practice will be open and working as normal but may be experiencing higher than usual demand for services. Please be patient when contacting them

A&E

If you need emergency care, Accident and Emergency departments will be open to deal with serious and life-threatening conditions. As is always the case, only those adults and children with genuine emergency needs should go to A&E. Emergencies include:

- major injuries, such as broken limbs or severe head injury
- loss of consciousness
- an acute confused state
- fits
- severe chest pain
- breathing difficulties
- severe bleeding that can't be stopped
- severe allergic reactions
- severe burns or scalds

Alternatives to A&E

If you become ill with a non-urgent condition and need advice, please visit Health A-Z for information or go to your local pharmacist. For more urgent conditions that you believe you can’t take care of yourself, you should contact your GP as usual, or call 111.

For minor injuries or illness (cuts, sprains, rashes and so forth) you could visit a walk-in centre, minor injuries unit or urgent care centre if the problem can't wait for a GP appointment. Bear in mind that these services may be busy because of the incident which has just occurred.

Annex 2: CAS Alert Template

Department of Health

CAS Alert

Title box

Date

Alert reference number:	Request no. prior to issue

Key messages

We are aware of an emerging incident in [insert geographical area] which has been declared as a major incident. Early indications are this appears to be [nature of incident] attack affecting [xxx] people.

Emergency response for this incident is being led by [police force name]. For further information, please visit [insert police web address]. Missing persons should be reported on [xxxxx] or via [www.xxxxx] to register details.

The following hospitals are currently receiving patients from this incident:
[insert list of receiving hospitals]

Further information based on the METHANE report should be included below:

- Major incident declared.
- Exact location.
- Type of incident - eg, explosion and fire in a tall building, release of gas in the underground system.
- Hazards - present and potential.
- Access - routes that are safe to use.
- Number, type, severity of casualties.
- Emergency services now present and those required.

Mutual aid requirements—state mutual aid requirements rom surrounding Trusts, other ambulance services and where relevant Major Trauma Network and/or Burns Network.

Staffing— detail staff call back/shift arrangements

Bed requirements—All Trusts are required to update their current bed status on the pathways DoS.

Professor Dame Sally C Davies
Chief Medical Officer

Actions

Who: Identify professional groups

When: Give timescale

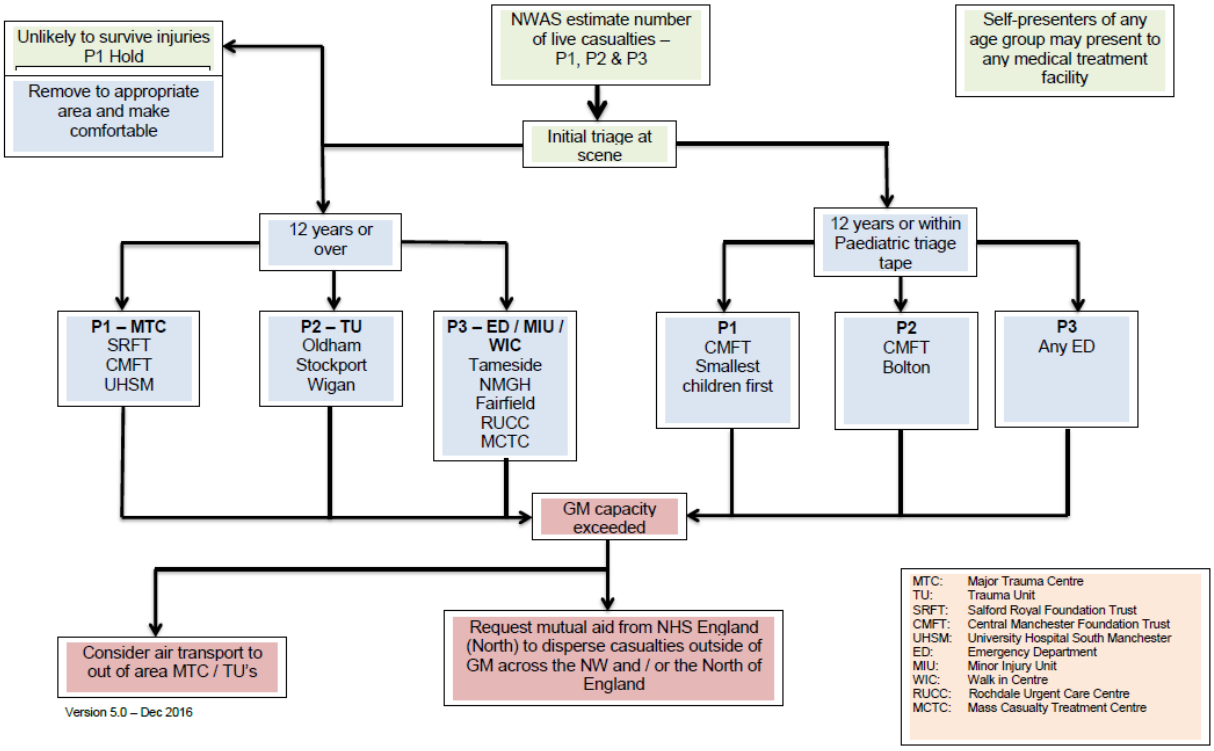
Explain what needs to happen

Annex 3: Patient distribution model example

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GM Framework for Patient Dispersal in a Mass Casualty Event



Version 5.0 – Dec 2016

GM Casualty Capability Chart in a Mass Casualty Event

	Over 12 years			Under 12 years
Pre-determined GM P1 capability for the first 2 hours	**Salford Royal 20**	**CMFT 20**	**UHSM 20**	**CMFT 20**
Pre-determined GM P2 capability for the first 2 hours	**Oldham 15**	**Stockport 15**	**Wigan 15**	**Bolton 10**

Pre-determined GM P3 capability for the first 2 hours	Tameside 40	NMGH 30	RUCC 10	Fairfield 20	Bolton 20	WIC/ MIU + Mass Casualty Treatment Centres*
	P3 adults/ paeds					

Total capacity for GM: c 300: General concept is P1 to MTC's, P2 to TU's, P3s to other sites (P2 could travel to MTCs if P1 aren't present in sufficient quantity)

Note: The figures above relate to the first 2 hours and should be viewed in the context of incidents producing mass numbers of casualties (300+): within smaller incidents the figures for each unit will be lower.

Within practicalities the intention is that stroke will flow to Fairfield and angio to UHSM sites.

* Mass Casualty Treatment Centres (MCTC): specific none acute hospital sites designated and developed for treatment of P3 and "worried-well" in the event of a mass casualty incident exceeding capacity available (Plan in the process of being developed, however, currently on a goodwill and best intentions basis).

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Annex 4: Access to post incident mental health services leaflet

How can I help myself or others to overcome these difficulties?

Do:

- Take time out to get sufficient sleep (your normal amount), rest and relax, and eat regularly and healthily.
- Tell people what you need. Talk to people you trust. You don't have to tell everyone everything but telling nobody anything is often unhelpful.
- Take care at home or when driving or riding - accidents are more common after a traumatic or stressful event.
- Try to reduce outside demands on you and don't take on extra responsibilities for the time being.
- Make time to go to a place where you feel safe and calmly go over what happened in your mind. Don't force yourself to do this if the feelings are too strong at the moment.

Don't:

- Bottle up these feelings. Think whether it would be helpful to talk about them with somebody you trust. The memories may not disappear straight away.
- Get embarrassed by your feelings and thoughts, or those of others. They are normal reactions to a very stressful event.
- Avoid people you trust.

More information on post trauma reactions

www.rcpsych.ac.uk/healthadvice/problemsdisorders/posttraumaticstressdisorder.aspx

www.nhs.uk/Conditions/Post-traumatic-stress-disorder/Pages/Treatment.aspx

www.gov.uk/guidance/westminster-attack-march-2017-support-for-people-affected

Where to find more help?

Contact your **GP** or **NHS111** about possible symptoms of anxiety, depression, or post traumatic disorder, visit **NHS Choices - www.NHS.uk** or call the **Samaritans on 08457 90 90 90**

Coping with stress following a major incident

You may find this leaflet helpful if you have been involved in, or affected by, a traumatic incident, in particular the recent events in Westminster.

It provides information on how you may expect to feel in the days and months ahead, and to help you understand and have more control over your experience.

You might need help if you have been experiencing any of the following reactions for several weeks and there is no sign of them getting better:

- You want to talk about what happened and feel you don't have anyone to share your feelings with.
- You find that you are easily startled and agitated.
- You experience vivid images of what you saw and have intense emotional reactions to them.
- You have disturbed sleep, disturbing thoughts preventing you sleeping or dreams and nightmares.
- You are experiencing overwhelming emotions that you feel unable to cope with or experience changes in mood for no obvious reason.
- You experience tiredness, loss of memory, palpitations (rapid heartbeat), dizziness, shaking, aching muscles, nausea (feeling sick) and diarrhoea, loss of concentration, breathing difficulties or a choking feeling in your throat and chest.
- You feel emotionally numb.
- Your relationships seem to be suffering since the incident.
- You are worried about your alcohol or drug use since the incident.
- Your performance at work has suffered since the incident.
- Someone who you are close to tells you they are concerned about you.

In addition, if a child has witnessed or experienced a traumatic event it is quite natural for them to be stressed. They may be very upset and/or frightened. This should not usually last beyond four weeks.

If symptoms of being very upset continue beyond four weeks, this may indicate Post Traumatic Stress Disorder (PTSD) and it is important to seek help for your child.

These are typical reactions after a traumatic event:

- Nightmares.
- Memories or pictures of the event unexpectedly popping into their mind.
- Feeling as if it is actually happening again.
- Playing or drawing about the event time and time again.
- Not wanting to think or talk about the event.
- Avoiding anything that might remind them of the event.
- Getting angry or upset more easily.
- Not being able to concentrate.
- Not being able to sleep.
- Being more jumpy and being on the lookout for danger.
- Becoming more clingy with parents or carers.
- Physical complaints such as stomach aches or headaches.
- Temporarily losing abilities (e.g. feeding and toileting).
- Problems at school.

How to help your child:

- Try to keep things as normal as possible: keeping to your usual routine and doing normal activities as much as you can, will help your child feel safer more quickly.
- Be available to talk to your child as and when they are ready. If it is difficult for you to do this, ask a trusted adult such as a family member or teacher to help.
- Try to help your child understand what has happened by giving a truthful explanation that is appropriate for their age. This may help reduce feelings of confusion, anger, sadness and fear. It can also help correct misunderstandings that might, for example, lead the child to feel that they are to blame. They can also help reassure the child that although bad things can happen, they don't need to be scared all the time.
- In the event of a death, particularly a traumatic one, it can be difficult to accept the reality of what has happened. It is important to be patient, simple and honest in response to questions about a death. Some children, for example, will seem to accept a death but then repeatedly ask when that person is coming back. It is important to be patient and clear when dealing with these questions: for example, it is better to say "John has died" than "John has gone on a journey".

What to look for:

Children experiencing PTSD might show that they think differently either about themselves or other people. They might:

- Blame themselves or show lowered self-esteem.
- Describe thinking that they are a bad person or talk about thoughts of deserving bad things to happen to them.
- Show less trust in other people and be less able to experience a sense of safety.
- Experience overwhelming feelings in the form of shame, sadness and fear.
- Avoid situations that they fear could increase their emotional response – i.e. might make them feel more frightened, threatened, ashamed or reminded of the event.

What to do:

If you have any concerns about your child, it is important to seek help via your GP. There are some very effective treatments including Cognitive Behavioural Therapy (CBT) for children and young people experiencing the effects of trauma.

Annex 5: Use of Section 252A

Section 252A of the NHS Act 2006, as amended by the Health and Social Care Act 2012 allows NHS England to direct the NHS in response to an emergency situation. This would be invoked by the Chief Executive and notified to the Secretary of State for Health. For clarity the instruction will also be issued to NHS Organisations to ensure compliance with any incident instructions.

Annex 5a: Invocation

Upon invocation of 252A of the NHS Act 2006 as amended by the Health and Social Care Act 2012 the following notification will be issued by the NHS England Chief Executive to all NHS Organisations, copied to the Secretary of State, NHS Improvement, CQC and NHS Blood and Transplant. The following wording will be used:

"Following the incident at [insert name], we are required to establish national command and control to direct and coordinate the response of the NHS in England.

To facilitate this requirement, NHS England (the NHS Commissioning Board), is invoking section 252A of the NHS Act 2006, as amended by the Health and Social Care Act 2012 and has appointed an Incident Director (National), to lead the response. Our Incident Response Team (National) will coordinate the strategic response, in collaboration with local health commissioners at the tactical level.

All providers of NHS funded care are required to cooperate with the response as directed by NHS England during this time.

I would like to thank you for your ongoing support during this challenging time and would be grateful if you would share this with your own incident management team."

Annex 5b: Stand down

Following the decision to stand down the response to the incident the NHS England Chief Executive will write all NHS Organisations, copied to the Secretary of State, NHS Improvement, CQC and NHS Blood and Transplant to confirm the return to normal business and suspension of the powers of NHS England under 252A of the NHS Act 2006, as amended by the Health and Social Care Act 2012. The following wording will be used:

"Further to my letter of [date & gateway reference] confirming the NHS response to the [incident name] incident, I can confirm this has now been stood down to a level which no longer requires NHS England to direct and coordinate the response of the NHS in England.

Following this decision, NHS England (the NHS Commissioning Board), has now agreed to suspend its use of section 252A of the NHS Act 2006, as amended by the Health and Social Care Act 2012.

Local coordination and response arrangements may continue to be in effect and we request providers of NHS funded care continue to cooperate with these.

I would like to take this opportunity to thank you and your staff for the cooperation during this time and the dedication and commitment shown while responding to this incident."

Annex 6: Clinical Impact Assessment Call Agenda

1. **Update from each MTC / TU see following table**
   - Overall Numbers remaining in hospital:
     - ITU
     - HDU
     - Trauma Ward
   - Number admitted with:
     - Blunt Trauma
     - Penetrating Trauma
   - Are transfers to other hospitals anticipated in next few days?
   - Number of patients requiring further surgery?
   - Any impact on other services / elective surgery?
   - Is psychological support available for
     - Patients
     - Relatives and carers
     - Staff

2. **Infection control:**
   - if terrorist attack: Blood Bourne Viruses
   - if incident abroad and repatriation: multi resistant organisms

3. **Rehabilitation issues**
   - Inter-Regional support

4. **Repatriation issues**
   - UK nationals
   - Foreign nationals

5. **Supply chain**
   - Equipment and instruments
   - Pharmaceutical supplies

6. **Recovery**
   - Managing routine business
   - Early clinical debrief for networks

7. **AOB**

Clinical Impact Assessment Call Patient Summary Sheet – Mark Official Sensitive upon completion.

Injury	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10
Scene Triage										
ED Triage										
Age										
Mechanism										
Arrival										
Destination										
Outcome										
Traumatic Brain Injury										
Spinal injury – cord or fracture										
Chest trauma										
Abdominal trauma										
Vascular trauma										
Pelvic trauma										
Single open fracture										
Multiple open fracture										
Single closed fracture										
Multiple closed fractures										
Soft tissue injuries										
Burns										
Maxillofacial trauma										
Ocular trauma										
Others										

Annex 7: Reception Arrangements for Ministry of Defence Patients