NHS England-South
Mass Casualty Framework
Version 2.0
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References:

The references listed below have been used throughout this framework so therefore are not documented in any particular order.

Thames Valley LRF: Mass Casualties Framework, 2015;
South Western Ambulance Service NHS FT: Responding to a Mass Casualty Incident, 2012/16;
National Ambulance Resilience Unit (NARU) Clinical Guidance: Medical Support Minimum Requirements for a Mass Casualty Incident, 2014;
Management of Conventional Mass Casualty Incidents: Ten Commandments for Hospital Planning, 2006;
Critical Care, Trauma Care, Paediatric and Burns Networks Standard Operating Procedures;
MTC 27 Event-EPRR: Beyond Day One, 2015

Joint Doctrine: The Interoperability Framework, Joint Emergency Services Interoperability Programme (JESIP) 2013;
Developing Dynamic Lockdown Procedures, National Counter Terrorism Security Office; November 2015;
NHS England EPRR Framework 2015;
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1 Executive Summary

This NHS England-South Mass Casualty Framework brings together the work done by the Local Health Resilience Partnerships across the South and key individuals who have led this imperative work stream.

It will act as an overarching document for the NHS in the South and will support all mass casualty plans across our various health economies. It highlights the key aspects that are required to be prepared, resilient and will give us the ability to respond in a cohesive, effective and collaborative manner to a mass casualty incident.

The preparation for the production of this framework has brought together a huge amount of NHS personnel which have identified the enormity of the resources that will be required to respond in synchronisation to an incident of this nature. It must therefore not be underestimated the continuous and coordinated management required to achieve this goal.

In light of a number of recent tragic incidents across the World every effort needs to be made to ensure the United Kingdom is as prepared as possible to cope with the impact of such events on the health care system.

This framework aims to look at those incidents and others to endeavour to ensure that our emergency preparedness, resilience and response to a mass casualty incident is as accurate and seamless as possible and that we action from the harsh lessons we have learned.

Jennifer Howells
Interim Regional Director (South)

22 November 2016
2 Background

Global terrorist events and the ever changing tactics of terrorist groups across the World require the United Kingdom to continually review and improve arrangements for response to mass casualties’ events. The NHS will play a significant role in the response to events that fall within this remit and as such need to maintain operations which support that response, putting in place arrangements which provide the best care possible and focus on the interests of all patients and casualties.

Recent tactics of terrorist groups has changed and provide the potential for the generation of much larger numbers of casualties with diverse injuries than has hitherto been planned for in traditional major incident response arrangements.

The NHS will play a significant role in the response to a mass casualty incident and will need to maintain operations which best support that response by putting in place arrangements that will provide the best care possible.

Mass casualty incidents will involve a step change in demands that are made on response capabilities. Doing more of the same is unlikely to be adequate, organisations and their staff will need to adopt a different approach to their preparedness and response for such incidents in order to achieve the required outcome.

This framework is primarily designed to supplement existing local and multi-agency emergency preparedness arrangements in the South of England, to ensure that we can meet the Cabinet Office (2015) national planning assumptions in relation to mass casualties. It is focused on facilitating the response to conventional and non-conventional incidents. Conventional incidents are normally a sudden impact event or an emergency, which may result in up to large numbers of casualties occurring in one or more locations simultaneously. Conventional incidents are defined as those that cause traumatic injuries (involving internal/external catastrophic haemorrhage, burns and fractures, etc.) and/or fatalities and do not contain any chemical, biological, radiological or nuclear elements. They also cover for example incidents such as an influenza pandemic and major flooding. These types of incidents are not covered in the framework and should be part of specific local plans. Non-conventional incidents include those caused by marauding firearms attacks (MTFA) including active shooters or explosions in crowded areas.
2.1.1 Security Classification

This framework is marked ‘Official Sensitive’ in line with Government Security Classifications published in 2014. The framework includes extracts from the National Resilience Planning Assumptions which have the same security marking. This framework should not be published on any unrestricted networks or shared with any individual who does not need it. Holders of this framework should refer to Section 14 of Government Security Classifications for a list of recommended controls.

3 Aim

The aim of this framework is to ensure that all commissioners and providers of NHS funded care have a common understanding of their role in preparing for and responding to mass casualty incidents and have a framework from which to formulate, influence and build local plans.

This framework supports and is separate from locally held plans. The PHE report of Exercise Fortuna published in September 2016 provided useful clarification of the distinctions between different types of documents:

“There are myriad definitions of the various terminologies but using the Civil Protection lexicon and JESIP glossary as guides, the following definitions and hierarchal order could be considered.

- CONOPS - A high level description of how a defined system will operate to achieve defined strategic objectives
- Guidance – Provides guiding principles, practical considerations and operational doctrine
- Framework - A broad overview of interlinked items which supports a particular approach to a specific objective
- Plan - A document or collection of documents that sets out the initiation, management, coordination and control of personnel and assets to reduce, control or mitigate the effects of an emergency (this document will contain detail on the steps including timing and resources, used to achieve an objective)”

All NHS organisations in the NHS England –South are expected to have plans that underpin this framework and address the requirements of these and other mass casualties’ scenarios. The requirements are explained in this document.
4 Objectives

This framework is intended to support commissioners and providers of NHS funded care in preparing for the types of incidents described above. It takes the indirect format of a patient pathway. It provides guidance on the:

- planning assumptions;
- declaration and activation procedures;
- key responses required of all organisations;
- command, control, coordination and communication structure;
- defined models of care;
- information on relevant capacity and clinical resources;
- information about supporting resources;
- training and exercising work programmes as part of the 2016/17 schedules;
- psychological impact;
- ethical impact;
- legal issues;
- forensic evidence

It is finalised by focussing on the aftermath of an incident of this nature including legal issues, management of forensic evidence, management of the deceased and the recovery process.

5 The Requirements

This framework provides guidance to all NHS responders in the NHS England-South for preparing and responding to different types of events that may result in mass casualties. This framework will focus mainly on the following two but can be applied to all:

- a marauding terrorist firearms attack (MTFA) in a crowded area
- a conventional explosive attack in an urban area
6 Definitions

Multi-agency Major Incident
An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.\(^5\)

NHS Major Incident
A major incident is 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. For the NHS this will include any event defined as an emergency as in section 6.4 (of the NHS EPRR Framework).\(^6\)

Mass Casualties Incident
An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency services\(^7\)

Malicious Attacks Involving Firearms
Emergency services, including ambulance trusts, have plans to respond to malicious attacks involving firearms. Plans include responses to two particular types of firearms incidents, Marauding Terrorist Firearms Attack (MTFA) and active shooter incidents. Definitions of those two types of incident are not fixed, but local plans in the South include the following explanations of both:

- **Marauding Terrorist Firearms Attack (MTFA)**
  "Marauding, simultaneous or near simultaneous firearms attack in a crowded urban area but fragmenting into separate locations"\(^8\)

- **Active Shooter**
  "An armed person who has used deadly force on persons and continues to do so whilst having unrestricted access to additional victims" (College of Policing formerly known as the National Police Improvement Agency).

From those two definitions it can be seen that an MTFA will incident will meet the definition of an ‘active shooter’. In contrast, an active shooter may be a local incident with relatively few casualties, or may be a MTFA incident.

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\(^5\) Published by Cabinet Office 11 July 2016 and to be included in next revisions of the Civil Contingencies Lexicon and JESIP Joint Doctrine

\(^6\) Section 6.5.3 of NSH England EPRR Framework
https://www.england.nhs.uk/ourwork/eprr/gf/#preparedness

\(^7\) https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

\(^8\) https://www.resilience.gov.uk/RDService/home/54903/CCS-Risk-Documents-Group
6.1 Major v Mass

As described above, the Civil Contingencies Lexicon describes a mass casualty incident as

An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency services.

Potential differences in the responses to major incidents and mass casualty incidents are shown in the table at Appendix 1 alongside the national alert levels. However it is the consequence management of these types of incidents that will result in health services working in a different way. Any response would be to the actual incident and the numbers and types of casualties that may not always fit the more defined criteria associated with mass casualties.

Recognising that the threshold of the mass casualty definition has been met is crucial if the appropriate command, control, co-ordination and communications structures are to be put in place to manage an incident such as this which will be protracted and demanding.

Any mass casualty incident will also have a significant impact on clinical treatment protocols and patient pathways.

Command, control, co-ordination and communications arrangements for this type of incident are addressed from page 17.

7 NHS Planning Assumptions

This framework is produced with the following assumptions about existing plans held and practised by NHS organisations:

- All NHS organisations and organisations providing NHS funded care have an up to date mass casualty plan in place or be part of a joint plan if appropriate;
- All NHS organisations and organisations providing NHS funded care have accelerated discharge and admissions criteria within their surge plans;
- All Acute Trusts will aim to empty 20% of their total bed base in order to receive large numbers of casualties;
- All acute trusts must have an emergency treatment centre (ETC) identified and an ETC protocol in place to enable the management of all self-presenting walking wounded casualties (P3s) in clinical areas away from the emergency department;
- All ambulance services will manage ETCs at the scene; these will be combined with Survivor Reception Centres when appropriate;
- NHS England will liaise with the trauma, critical care, paediatrics and burns networks to consolidate patient pathways at local levels;
• Providers of NHS funded community services have plans to rapidly enable community services to respond to assist with accelerated discharge and to help avoid admissions into acute settings;

• All NHS organisations and organisations providing NHS funded care have business continuity management plans for their critical functions. Those arrangements include mechanisms for redeploying staff and resources to services under the most severe pressure;

• All NHS organisations have policies and practiced plans for the lockdown of buildings and sites and for partial and complete evacuation;

• Mutual aid arrangements between NHS organisations will be managed at local, regional and strategic levels depending on the need;

• All NHS organisations have training and exercising programmes in place for existing plans which dovetail into the LHRP and LRF multi-agency work programmes;

• The regional communications team will liaise to form common internal and external messages, which will be cascaded to local regional teams;

• NHS Blood and Transplant, NHS Supply Chain and the UK Reserve National Stock for Major Incidents are integral to local plans;

### 7.1 Scenario Specific Planning Assumptions

The scenarios considered in this framework are sudden impact or ‘big bang’ events, for example a serious transport accident, explosion or series of incidents that have an immediate effect on health services. However events elsewhere involving marauding terrorist firearms attacks (MTFA) have demonstrated that the numbers of casualties may be difficult to determine. Although these may be small or large in number, both will have the same dynamic effect on all responders.

Casualty movement into acute settings may take many hours and acute trusts may experience peaks of activity over a drawn-out period that are not typical of other sudden impact events that may involve mass casualties. Receiving hospitals and other responders should plan to sustain their initial response phase for up to 48 hours. Likewise the management of Emergency Treatment Centres (ETC) at the scene will be vital for treatment of Priority 3 patients (definition detailed in Table 1). For ETC management please see Section 15.

Casualty numbers these two scenarios being considered will be difficult to determine exactly so consequence management must prevail at all times, however:

• A marauding terrorist firearms attack using and explosives in a crowded area can result in an undetermined number casualties with ballistic injuries. These injuries may be caused by high velocity firearms munitions and/or fragments of explosive devices and debris;
A conventional explosive attack or attacks at one or more locations in an urban area can result in over a hundred casualties with bomb and blast injuries.

Table 1: The National Planning Assumptions for Mass Casualty Triage Applied Scenarios

<table>
<thead>
<tr>
<th>Priority numbers</th>
<th>Percentage</th>
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<tr>
<td>Priority P1 Immediate</td>
<td>25% of total casualty figures</td>
</tr>
<tr>
<td>Priority P2 Urgent</td>
<td>25% of total casualty figures</td>
</tr>
<tr>
<td>Priority P3 Walking wounded</td>
<td>50% of total casualty figures</td>
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The characteristics associated with these scenarios can be summarised as:
- Large number of casualties;
- High velocity ballistic injuries;
- Delays in moving casualties to appropriate acute settings;

It is emphasised that no measure of likelihood of either event occurring should be inferred from this framework or its associated work streams. The National Risk Assessment lists these risks and planning as being devolved to a more local level in line with a range of wider policies not affected by likelihood. Furthermore, the planning assumption on triage proportions shown in the table above (25%-25%-50%) has been issued nationally for a range of risks with clear guidance that it is only a planning assumption and that incidents vary greatly.

The table of Hazards from the Local Risk Management Guidance showing Casualty Number Planning Assumptions can be found as Appendix 2.

8 Reasons for Declaring a Mass Casualty Incident

Declaring a mass casualty incident will be a judgement based on a combination of factors, including the number and types of casualties, but also the ability of local services to become overwhelmed. This declaration will then initiate the NHS England –South command, control, co-ordination and communications arrangements and ensure contact is made to the National EPRR Team and the Department of Health.

The early involvement of strategic and national partners will support local services in getting access to expertise and resources for example military support from outside the area if required and will be the conduit into the overarching response. Whilst reasonable worst case planning assumptions provide the estimated casualty numbers, incidents within the scenarios described may also occur with minimal
casualties. The ability of local services to cope with demand may itself be affected if an incident has a direct impact on NHS sites or staff.

An NHS organisation may declare a mass casualty incident if the number of casualties requiring non-specialist treatment is not manageable by the NHS in a local regional office catchment area.

### 8.1 Scenario Specific Considerations for Declaring a Mass Casualty Incident

Once a mass casualty incident has been declared, there may be other considerations to be made alongside actual casualty numbers and pressures on clinical services (outlined above) that will support a decision to declare a mass casualty incident. These considerations are:

- Media interest and scrutiny – is likely to be intense and reactive;
- Government interest – a situation reporting cycle will be influenced or decided by central government information requirements;
- Police response – not allowing access to casualties in the hot zone of an incident as this would put responders at risk, the responsibility to investigate crime and apprehend offenders which may affect the provision of care by NHS services;

In summary, a mass casualty incident must be declared when the number of casualties caused by an incident or incidents overwhelms the combined resources of the NHS. A marauding firearms attack or a conventional attack with explosives crowded area may cause this number of casualties and/or other pressures and should be declared a mass casualty incident at the earliest opportunity.

### 8.2 Responsibility for Declaring a Mass Casualty Incident

Any NHS organisation can declare a ‘mass casualty’ incident. However, as blue light responders, all ambulance services across NHS England South will usually be the NHS organisations that make this declaration. Without an ambulance service declaration, any other NHS organisation will ensure that their executive director on-call (or equivalent) and/or medical director is consulted before declaring a mass casualty incident. The organisation must then inform the relevant:

- Local regional office (as the NHS leads);
- Clinical Commissioning Group/s (CCG);
- Ambulance service for cascading as normal;
If the Police are required at the scene of an incident then the normal 999 route must be taken. As with a major incident there will be procedures in place for the organisation to record the declaration, the reasoning behind it and for subsequent actions.

### 8.3 Declaration of a Mass Casualty Incident

Ambulance service staff will often be among the first to attend an incident scene and therefore will, in most cases, be the organisations that notifies NHS organisations of a mass casualty and/or active shooter incident. This declaration will be cascaded in the same way as in a major incident (see flow chart below). The supporting EPRR national operating model response can be found in Table 2 page 20.

The initial mass casualty incident message will be issued as a ‘METHANE’ report in accordance with JESIP principles and the NHS England Emergency Preparedness Resilience and Response Framework (page 28).

### 8.4 Outcomes from Declaring a Mass Casualty Incident

Declaring a mass casualty incident will initiate NHS England regional command, control arrangements and establish coordination with other regions through the NHS England national office. Regional command and control arrangements will support the local regional offices and their relevant commissioners and providers of NHS funded care to:

- Contribute to and receive situation reports;
- Receive consistent information from regional and national partners;
• Have a route to escalate issues that cannot be resolved locally;
• Implement a route for mutual aid;
• Work together to produce and issue communications messages;

9 Activation

Mass casualty plans will be activated the same as with any major incident, with a declaration cascaded by the ambulance service to all receiving hospitals and the appropriate local regional office.

Receiving hospitals notified of a mass casualty incident, or declaring a mass casualty incident themselves, must inform the appropriate local regional office and local CCG. Depending on the nature of the incident, the ambulance services or police may also advise ‘lockdown’ takes place. Lockdown is the process of controlling the movement and access – both entry and exit – of people (NHS staff, patients and visitors) around a trust site or other specific trust building/area in response to an identified risk, threat or hazard that might impact upon the security of patients, staff and assets or, indeed, the capacity of that facility to continue to operate. A lockdown is achieved through a combination of physical security measures and the deployment of security personnel.

All trusts must therefore ensure that arrangements are in place to cascade that message from their initial point of contact to all relevant services.

Similarly, in the event of an on-going shooting incident the ambulance service notification will include notice of an ‘active shooter’. On notification of an active shooter all trusts will lockdown key areas or as much as possible until further information is available and a stand-down message is cascaded. The scale of this will be dependent on the type and nature of the incident and based on advice from the local police service.

10 Command, Control, Coordination and Communication (C4)

Command, Control, Coordination and Communication (C4) of the NHS response will be through the normal major incident response model with all organisations adopting the principles for joint working as documented in the Joint Emergency Services Interoperability Principles (JESIP). Please refer to Appendix 1A and 1B for definition of incident levels and management of those incident levels.

The multi-agency strategic command will normally be established at the local Police Headquarters and will be the Strategic Coordination Centre (SCC) for the Strategic Coordinating Group (SCG). In the early stages of any mass casualty incident all
organisations are expected to manage their individual response using local incident response plans. Multi-agency SCGs will be set up in due course. However due to the nature of these incidents the requirement of multiple SCGs may be necessary. It may also be decided that a Regional SCG (ReSCG) should be convened to combine the response and minimise the resources required. This process will normally be implemented by the Police Service leading the response. This will always be incident dependent and based on a number of different variables.

CCGs may be asked to support NHS England by providing the health representation at local Tactical Coordinating Groups.

It also needs to be considered that the Southern region whether directly or indirectly, may also be impacted by an event within neighbouring regions and the capital. Events of this nature will extend for a significant period of time and so it is imperative the level of C4 arrangements that are required over such a protracted period are sustainable. More broadly, releasing staff to undertake these duties and to maintain an effective rota will undoubtedly impact other services. Business continuity arrangements will therefore have to be invoked.

### 10.1 Incident Coordination Centres

All affected health organisations will need to establish their Incident Coordination Centres in order to manage an incident of this nature.

The ICCs will serve as a focal point for all liaisons between the NHS and partner organisations regarding the incident. The main role of the relevant local regional office ICC will be to:

- draw together information regarding the operational/tactical response across the NHS in the relevant geographical area;
- gather information from wider sources relating to the incident;  
- make sure information flows efficiently between the chain of command and partner organisations;
- Provide sitreps as and when required once a cycle of command has been agreed;

### 10.2 Situation Reporting

Situation reports in a mass casualty incident will be as used for major incidents. The cycle of command will be determined by COBR.

The national sitreps as issued in the NHS England EPRR Framework will be used.
10.3 Performance Standards

The cessation of performance standards during an incident of this nature is unknown. This will be determined by the Department of Health and will be defined at the time of the incident. This information will be fed down from the national EPRR team to regional and local regional offices for dissemination to commissioners and providers.

10.4 Operating Model Response

The operating model response of all partners to a mass casualty incident will follow the national framework detailed in Table 2 page 20.
Table 2 Health System EPRR Operating Model- Response

1. DH
2. NHS England national
3. NHS England region
4. Health Economy Tactical Coordination Groups
5. NHS funded organisations and commissioners
6. NHS Strategic Commander (NHS England)
7. NHS Tactical Commander (CCG or NHS England as appropriate)
8. Strategic Coordination Group (SCG)
9. DCLG - RED
10. Tactical Coordination Group (TCG)
11 Capacity and Capability Planning

When considering the numbers of casualties following declaration of a mass casualty incident, will bring an immediate operational challenge to all healthcare systems, many of which are already functioning at or above capacity, placing a huge burden on the NHS in the South of England. Therefore, in preparation, priorities should first be directed toward the development of infrastructures to respond to sudden mass casualty events. Every effort will be made to maximise the outcome for the casualties including consideration for different ways of working. This will include the triage, treatment and transfer of some casualties to areas outside the local NHS facilities for example Emergency Treatment Centres at scene set up in conjunction with Survivor Reception Centres where 100+ casualties maybe treated (see section 15). Equally a large number of casualties will have significant traumatic injuries and as such will be triaged in the Priority One category and transferred to the nearest major trauma centres (MTCs) and possibly trauma units as appropriate as these will be quickly overcome. More widespread MTCs across England will be invoked alongside use of the other trauma units for initial stabilisation before transfer.

11.1 Mutual Aid

All requests for mutual aid will come through the normal channels. This request and coordination will go through the local NHS England ICCs to the regional NHS England ICC for regional and possibly national management. It must not be overlooked that business as usual will have to be maintained during and after a mass casualty incident which will put a huge strain on all NHS services. A robust communications programme will be required to support this and to inform the public not only about the ongoing situation but how to seek alternative immediate/urgent services.

Given the numbers of casualties involved it is anticipated that the ambulance service providers in the South will implement a request for mutual aid at the initiation of the incident affecting the National Memorandum of Understanding for Ambulance Services, this is likely to be coordinated by the National Ambulance Coordination Centre (NACC) who are responsible for the ambulance services national assets.

Additional support will be sought through the existing agreements which may be in place with Community First Responders, the British Red Cross, St. John Ambulance and spontaneous volunteers.
Additional transport support from Category One and Two agencies to the health response will require collaborative working through the Strategic Coordinating Group (SCG) or Regional SCG (ReSCG) of the affected Local Resilience Forum/Fora and the Voluntary Aid Societies (VAS).

11.2 Critical, Trauma and Burns Care

Throughout a period of surge demand such as this, it would be expected that clinicians would have due regard to the management of a large number of casualties especially in relation to critical, trauma and burns care through implementation of the national standard operating procedures. It is acknowledged however, that clinical judgement for the relevant and appropriate care of individual casualties in light of these specific circumstances will be required.

The National Clinical Advisory Group via the normal chain of command to the national EPRR team will provide a systematic region wide support for the management of large numbers of casualties requiring critical care during such an event.

The detailed roles and responsibilities of the networks can be found on page 37-40.

11.3 Paediatric Critical Care (PCC)

The day to day operational management of PCC capacity is the responsibility of the Paediatric Intensive Care Units. The National Standard Operating Procedures (SOP) published by NHS England clarifies that all NHS acute hospital providers with Paediatric Intensive Care facilities on site should follow these SOPs. In addition, the National SOP guidance should be incorporated within local acute trust escalation plans and viewed as part of the overall response to surge events.

NHS England London maintain the national lead for PCC Surge and Escalation, with NHS England South Regional leads, commissioners and networks (where these exist) operating with Paediatric Intensive Care Units (PICU) and EPRR leads across the South region.

In order to support patient pathways in response to severe periods of surge, the South region PICUs will work in liaison with acute hospital providers, Regional Leads and NHS England London ensuring engagement with any telephone conference calls. All ensuing relevant information will be managed through the normal C4 arrangements.

SOPs published cover:

https://www.england.nhs.uk/commissioning/ccs/
• Adult critical care services;
• Paediatric intensive care services;
• Burns services (adults and children);
• Adult respiratory extra corporeal membrane oxygenation (ECMO) services;
• Paediatric respiratory extra corporeal membrane oxygenation (ECMO) services;

**Accelerated Discharge and Admissions**

**11.4 Calculation of the Total Number of Casualties and the Maximal Number of Severely Injured to Be Absorbed**

Providers of health and social care services work together in local A&E Delivery Boards. These produce plans that guide the management of those systems at times of both routine and high demand. The following are included to support Boards and their member organisations as they review their accelerated discharge plans or protocols and update them as necessary.

Surge management plans or other arrangements for restricting NHS services put in place because of a mass casualty incident, will be implemented after a formal declaration of the incident has been recorded. The proposed starting point of surge capacity planning as is based a model described in the Management of Conventional Mass Casualty Incidents: Ten Commandments for Hospital Planning 2006. To therefore calculate the total number of casualties and the maximal number of severely injured to be absorbed, this document recommends that the number of victims that any hospital is reasonably capable of receiving during a mass casualty incident is 20% of the total number of registered beds. As an example, the maximal number of mass casualty incident victims that can be managed in a 1500-bed hospital would be 300 patients.

After a conventional mass casualty incident, the distribution of victims by severity that may be expected is described in Table 1, page14.

In order to achieve desired targets a Mass Casualty Accelerated Discharge protocol for the South of England has been developed working on the planning assumption for 20% of each receiving hospital bed base to empty in 4 hrs (The ambulance trusts aiming to triage and treat patients on the scene for up to 8hrs).

The protocol consists of a series of checklists detailed below for each stakeholder, acute hospitals, community hospitals, local authority and transportation agencies. This protocol has been developed broadly and will require each stakeholder to

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ensure that within their own organisation local policies and procedures are developed to ensure that this protocol can be ‘operationalised’.

11.4.1 Acute

- Notification of incident and expected number of casualties by ambulance services;
- Advise NHS England relevant local regional offices and CCGs of present capacity status and forward planning;
- Activate major/mass casualty incident plans;
- Call extra ordinary internal tactical escalation meeting / teleconference (meetings occur daily as standard);
- Internal tactical SITREP or equivalent (completed daily) will identify all medically fit and Delayed Transfers of Care (DToC) (this number is usually 50 -100 patients), this may be done via software already in place or manually;
- Internal tactical SITREP also identifies existing capacity i.e. beds across all health community and social care settings;
- Ward level consultant review of all amber (as part of reverse triage protocols within local surge/escalation plans) patients that would be suitable for accelerated discharge;
- Patients to be moved in line with normal discharge planning into existing capacity within 4 hrs;
- Partners to report gaps in capacity and escalate to commissioners;
- Partners to request additional funding for spot commissioned beds;
- Establish Emergency Treatment Centre for receiving P3 casualties away from ED (capacity 100 +);
- Establish major incident discharge lounge as single collection point for accelerated discharges;

11.4.2 Local Authority (Social Care)

- Notification of number of patients requiring accelerated discharge from acute SITREP/teleconference;
- Set up strategic command structure within the Council, open incident room;
- Implement local accelerated discharge policy and procedures;
- Identify gap in existing bed capacity and number of medical fit / DToC;
- Agree additional funding for spot purchasing beds ;
- Identify additional personnel from all sites to construct a dedicated ‘Resource Team’ and task them to spot purchase beds;
- Identify additional personal from offsite social work teams (across entire local area) and to construct a “rapid assessment team”;
- Rapid assessment team to attend Acute and Community Hospitals to implement accelerated discharges
Including arranging of family / other forms of community transport;

- Rapidly assess all green and amber patients deemed suitable for accelerated discharge and implement discharge to newly identified bed based resource;
- When discharge is identified advice will be given to the ward to move patients to major incident discharge lounge for collection;

11.4.3 Community Hospitals

- Arrange urgent attendance of consultant/GP to review all amber patients to agree those suitable for accelerated discharge;
- Advise rapid assessment team of all medically fit and DToC;
- Establish major incident discharge lounge as single collection point for accelerated discharges;

11.4.4 Patient Transport

- Decision required between PTS providers, commissioners and ambulance trusts about ensuring patient transport resource is assigned to all the acute trusts for accelerated discharge;
- To free up PTS services the focus must be on non-ambulatory transfers as other transport options will be sought for ambulatory patient’s i.e.
  - family members;
  - community based voluntary service;
  - other specialised transport resources from within the local authority, e.g. education/day centre vehicles;
  - Local taxis, utilisation of Local Authority Passenger Transport Units (PTU) if applicable;

12 Pre-hospital Care

As already outlined in the scenario specific planning assumptions, some incidents will result in large numbers of casualties with a range of traumatic injuries. In these incidents the demand on healthcare services will be extreme and have an immediate impact on the pre-hospital phase of the response. This is also the case for incidents, such as some involving firearms, in which the nature of the incident site restricts the extraction and safe transport of casualties. In these cases pre-hospital care may be required at or close to an incident site for longer than is usual in major incidents.

A national ambulance service concept of operations addresses these scenarios with procedures summarised here for the information of other responders. These procedures have been developed in accordance with ethical guidelines and in consideration of the most extreme circumstances.
Enhanced arrangements allow casualty clearing stations to be sustained for up to eight hours. Ambulance services operational plans should describe available specialist resources.

A casualty collection point may be established at or close to the incident site as a place of safety where basic life saving measures can be applied when the incident is still is on-going, or other circumstances make casualty movement dangerous.

**Table 4 - Diagram showing pre-hospital care close to an on-going incident.**

![Diagram](image)

**12.1 Pre-hospital Care Staff**

It is advocated that clinical care is aimed at minimal intervention to get casualties to hospital combined with the ability to see, assess and refer to the most appropriate facility such as Emergency Treatment Centres or Minor Injury Units. This is to protect the major trauma centres/trauma units from being overwhelmed and preventing them from seeing the most seriously injured casualties. Providers of critical care interventions must be integral to a response of this nature. These personnel provide an enhanced level of care to the skills provided by the
ambulance paramedic service. Enhanced Care Teams are currently deployed in
different capacities within normal ambulance operations under a variety of names
and have the role in the care of complex pre-hospital events including having the
knowledge and ability to:

- triage;
- treat;
- provide appropriate specialist interventions;
- advise on transfer times and options for emergency and definitive care;

The scope of incidents that would warrant a pre-hospital care response is difficult to
define specifically, but would include any multiple casualty incidents where
ambulance personnel at the scene identify a potential benefit, following assessment
and triage. Having specialist or advanced clinical care at the scene for decision
making and critical interventions for the care of adults and children may be
considered.

Clinicians involved in the delivery of pre-hospital care response will be required to
interface with a number of other agencies and personnel on scene. This will include
the conventional ambulance response, and where applicable, the ambulance
Hazardous Area Response Team, BASICs (British Association of Immediate Care
Scheme) doctors and/or Urban Search and Rescue Teams. Specialised training and
exercising will be required to understand these specialist roles and how all pre-
hospital staff will operate accordingly.

Provision of these services will be determined locally by the three ambulance trusts.
The key roles and responsibilities of these teams are listed on page 34-35.

12.2 Hazardous Area Response Teams (HART)

Hazardous Area Response Teams are especially recruited and trained ambulance
personnel who provide the ambulance service response to major incidents involving
hazardous materials, or which present hazardous environments, that have occurred
as a result of an accident or have been caused deliberately. Hazardous Area
Response Teams bring paramedics into the 'hot zone' of an incident, where
traditionally ambulance service personnel wouldn't be allowed in order to provide
triage, treatment and care to patients. Previously colleagues from other Emergency
Services would retrieve patients from the 'hot zone' and bring them to ambulance
personnel in the safe area. In a mass casualties incident the Hazardous Area
Response Teams will provide extra resources to the responding ambulance services
should they be required.
13 Casualty Triage

Triage of multiple casualties at the scene of the incident presents unique problems for those undertaking the initial assessment. This is largely due to the difficulty in assessing the large numbers of injured and dying. This initial triage is vital to reduce the need for secondary transfer of patients. New information following recent international events also suggested that the use of stabilisation teams from the acute trusts that are not major trauma centres to enable safe clearing of the scene and the correct systematic dispersal of the casualties may be put in place.

Effective triage of patients is a key component in ensuring that the right patients are sent to the right service and that the most is done for the most.
It is recognised that this can be problematic in the pre-hospital environment, particularly when managing large numbers of casualties with catastrophic injuries at the scene. It is in these mass casualties situations where the Priority 4 category may be invoked. This is not only a clinical dilemma but one that also has huge moral implications. However this triage category will need to be used in order to care for those that can survive with the most appropriate treatment and resources. Triage priorities are listed below:

Table 5 Triage Priorities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>25%</td>
<td>Priority 1 – Most severely injured casualty requiring immediate lifesaving and invasive medical intervention</td>
</tr>
<tr>
<td>P2</td>
<td>25%</td>
<td>Priority 2 – Seriously injured requiring invasive medical intervention within a short period.</td>
</tr>
<tr>
<td>P3</td>
<td>50%</td>
<td>Priority 3 – Least seriously injured casualty requiring medical attention in the next few hours, commonly referred to as ‘walking wounded’</td>
</tr>
<tr>
<td>P4/Expectant</td>
<td></td>
<td>Priority 4 – Casualty not expected to survive - fatal injuries – dependent upon timescale:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remain at scene until life extinct</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remain in Casualty Clearing Station or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed to allocated P4 quiet area of an Emergency Department or to a palliative care bed</td>
</tr>
<tr>
<td>Dead</td>
<td></td>
<td>Dead victims must be left until last and must remain in situ at the scene until movement is possible</td>
</tr>
</tbody>
</table>
14 Casualty Care Pathway

Casualties from a mass casualty incident will follow the most applicable pathway possible in order for them to receive the appropriate triage, treatment and transfer options for their injuries.

Casualty Clearing Points may be established to ensure casualties are removed to a safe shelter from the incident where they undergo an initial triage sieve and receive any basic life-saving treatment.

When it is safe to move them they will be transferred to a Casualty Clearing Station where a more formal triage sort is performed and where casualties with life-threatening injuries receive the appropriate clinical interventions. This treatment may continue for up to eight hours with casualty care being given by doctors, paramedics and/or enhanced care teams of some form dependant on location.

The following pathway depicts the flow of casualties from the 4 triage categories until definitive care and discharge. It also demonstrates the use of emergency treatment centre working alongside survivor reception centres for the management of Priority 3, walking wounded casualties and management of the dead and dying.
Table 6 Casualty Pathway

Casualty Pathway

Casualty

Injured?

Yes

Triage Sieve at Casualty Collection Point(s)

P1

Treatment at Scene by Ambulance Service, HART or BASICs where available

Triage Sort at the Casualty Clearing Station

P1

P2

Transport to Receiving Hospital

P1 to Major Trauma Centre

Definitive Care

Discharge

P2 to Trauma Unit

Emergency Treatment Centre

CO-LOCATE

Survivor Reception Centre

P4

Palliative Care

Move to body holding area when possible

Emergency Mortuary

Dead

No

Survivor
14.1 Liaison with Police Services

In addition to casualty bureau arrangements established under standing disaster victim identification processes by police forces, there may be occasions when those believed to be directly involved in causing harm may be treated by NHS services. All providers of NHS services should be cognisant of the potential for incident casualties to include those directly involved, or suspected of being directly involved, in the cause of the incident(s). Where that potential exists, police support must be requested by the relevant NHS provider directly and as soon as possible.

It must also be considered that these casualties may also be concealing weapons and/or infected/carrying a blood borne infectious disease giving them the potential to become a biological weapon.

Although a duty of care will always prevail this delicate scenario may have to be undertaken. Although not for this framework, due consideration must be given to this is any supporting mass casualty plan.

14.2 Management of High Velocity Ballistic Injuries

In addition to the number of casualties, the number of high velocity ballistic injuries will require specific clinical expertise. Blast, burn, crush and fragmentation are wounds are seen infrequently within the UK and are challenging to manage due to the various complications and the complex treatment required. Medical expertise can be supplemented by military personnel through a process facilitated by the Department of Health and Ministry of Defence as described in Gateway reference number 15835 at Appendix 7.

It should not be underestimated that this contingency arrangement is a limited resource and local expertise maybe available within ambulance services and hospitals that have serving military personnel or from staff that have previous military backgrounds in this field.
14.3 Supplies

As the consequence of an incident of this specific nature it is difficult to determine with accuracy the amount and type of extra supplies and equipment required by an ambulance service or acute trust.

As minimum acute trusts should monitor and review current supplies in preparation for an incident of this nature as part of the planning and preparation process.

Also available is the NHS Supply Chain 24/7, 365 days a year, if, or when, urgent supplies are required. See Appendix 5 for the NHS Supply Chain Emergency Procedure.

Ambulance services will mobilise their mass casualty vehicles.

15 Emergency Treatment Centres

As mass casualty arrangements are focused on facilitating a response to an incident, which may result in up to hundreds of casualties from a single or multiple locations a step change in demands is required as the normal processes implemented by the trauma centres/trauma units is unlikely to be adequate. The NHS is therefore required to provide a whole system response to ensure that the required level of care can be provided and maintained to all casualties.

Emergency Treatment Centres (ETCs) can be identified as an area within an acute trust normally located close to the Emergency Department and/or at the scene to assist in the treatment of Priority 3 walking wounded casualties (see page16-17 for definition) transported or self-evacuated from the incident scene. The location of the ETC close to the scene will be identified by the Local Authority at the time in conjunction with the ambulance and police services and will be co-located with the survivor reception centres.

The purpose of the ETC is to assess and treat casualties who have sustained minor injuries during a mass casualties’ incident. It will also provide short-term shelter and care for ambulant patients evacuated from the scene.

The ETC clinical activity has been designed to relieve pressure on the Emergency Departments to enable them to focus on treating the more critically injured Priority 1 and Priority 2 casualties.

The set-up, management and identification of appropriate ETCs across NHS England-South will be determined locally by the ambulance services at scene and by the acute trusts for self-presenting P3 casualties.
16 NHS Blood & Transplant Services (NHSBT)

NHSBT will be alerted to major incidents at a local level by either a hospital or ambulance trust contacting their local blood centre through the local blood ordering lines. This alert may be either to advise the organisation that an incident has occurred and products are required or that the trust is on major incident stand by.

NHSBT has service level agreements in place with all hospitals in England and North Wales for the provision of blood product deliveries under emergency conditions using NHSBT’s own fleet of blue light vehicles. In a situation where there are simultaneous requests from multiple hospitals NHSBT can supplement their response with approved couriers and the police.

NHS Blood and Transplant Services maintain contingency planning arrangements as outlined in their arrangements for major and mass casualty incidents.

17 Roles and Responsibilities

17.1 NHS England

The aim of NHS England-South in a mass casualty incident is to lead and coordinate the response of all health organisations in the South.

In the event of a mass casualty incident NHS England teams across the South will:

- establish, maintain and disseminate the best possible understanding of the incident and its impact on the health sector;
- ensure that all necessary and available support is provided to local health responders;
- establish command, control, co-ordination and communications arrangements in accordance with its Incident Response Plan (IRP) and those IRPs of its local regional offices;
- establish and maintain a reporting mechanism and daily cycle of command across all health organisations in the South;
- liaise with the local regional offices initially leading the incident and agree whether and how to conduct a handover to NHS England-South for a regional response;
- analyse reports received to identify strategic priorities and support required;
- implement mutual aid arrangements to identify resources and capacity inside and outside the South of England;
- link NHS organisations in NHS England-South area with the appropriate resources and capacity outside the area;
- liaise with the NHSE National Team on identification of, and access to, national resources;
• liaise with NHSE National Team if a national response is required;
• set up and maintain an ICC and an Incident Management Team (IMT);
• Local regional offices will attend SCG meetings in coordination with assistance from local clinical commissioning groups attending and TCGs that may be set up;
• provide a regional media/comms response;

17.2 Ambulance Services

Ambulance services will work with other NHS organisations to ensure that casualties receive the most suitable pre-hospital care and are conveyed to the most appropriate location for treatment.

In the event of a mass casualty incident ambulance services will:

• invoke their mass casualty plans which includes mobilisation of specialist assets.
• identify and source additional ambulance resources;
• identify and source all available pre-hospital care clinical resources;
• provide the most appropriate pre-hospital care with the resources available;

In response to the declaration of a mass casualty incident and to meet the objectives above, the ambulance services will:

• provide NHS England and local Clinical Commissioning Groups with situation reports as requested;
• cascade notification of a mass casualty incident in accordance with standing major incident cascade procedures;
• monitor multi-site incidents for potential escalation to mass casualty incidents and cascade as appropriate;
• introduce revised treatment protocols when necessary;
• invoke and coordinate ambulance service mutual aid when necessary;
• mobilise the mass casualty vehicles and other incident support vehicles;
• mobilise the ambulance reserve and all available Patient Transport Services resources;
• mobilise the mass casualty pods should they be needed to requesting acute trusts;
• mobilise voluntary sector ambulance resources;
• deploy British Association of Immediate Care Scheme (BASICS) doctors if applicable;
• deploy community first responders where possible and available;
• provide Hospital Ambulance Officers and Hospital Ambulance Liaison Control Officers at receiving hospitals;
• provide appropriate representation at SCG or equivalent meetings.
• management of casualties and casualty flow to the receiving hospitals;
• retain appropriate forensic evidence;

17.3 Urban Search and Rescue (USAR)

Certain incidents may make urban search and rescue operations necessary with the initial response being led locally. Fire & Rescue Services (FRS) will coordinate these arrangements working in conjunction with the Hazardous Area Response Teams (HART) to provide additional Urban Search and Rescue (USAR) teams and equipment into any damage-affected areas. The USAR capability is primarily provided to respond to major incidents involving collapsed structures and or serious transport issues. However, FRS’s who host a USAR team have incorporated the assets into their routine operational response, determined by local arrangements. This has resulted in USAR personnel and equipment being deployed as part of the pre-determined attendance at incidents including road traffic collisions (RTC) and rope rescue in several FRS’s around the country.

In the event of a mass casualty incident across the South this response will be coordinated by the SCGs and the Fire and Rescue National Coordination Centre (FRSNCC).

17.4 Acute Health Care Providers

Aim

The aim of every acute trust in a mass casualty incident is to provide optimum care to the maximum number of casualties possible (do the ‘most for the most’).

In the event of a mass casualty incident the acute healthcare providers will:

• consider the care of existing patients whilst meeting the clinical needs of those affected by the mass casualties incident;
• ensure additional stock is readily available to meet these clinical needs and that supply chain processes are in place to obtain additional stocks as required in a timely fashion;
• work with ambulance services and other healthcare providers to ensure casualties are treated at the most appropriate location;
• work with NHS England and the relevant Clinical Commissioning Group (CCG) to gather and convey information necessary to manage the wider response to the incident;
• provide a safe environment for staff, visitors and patients
• notify the CCG and NHS England of any difficulties in fielding adequate staff or resources;
• provide support to other healthcare providers in accordance with mutual aid agreements;

**Actions**

In response to the declaration of mass casualty incident and to meet the objectives above, acute trusts will:

• implement major incident/mass casualty and surge capacity plans;
• maintain site security, ensuring that sites can be locked down to ensure the security of the site. This may be due to various reasons not only due to an active shooter;
• establish local command, control and co-ordination arrangements;
• provide the relevant NHS England local regional office with situation reports;
• monitor capacity and manage local resources appropriately;
• provide a clinical response to all casualties;
• inform NHS England local regional office of specialist clinical resources and advice required at the earliest opportunity;
• inform the relevant Ambulance Service and NHS England local regional office of limits to capacity at the earliest opportunity;
• use major incident clinical guidelines;
• ensure recovery is addressed in organisational strategic incident management meetings;
• ensure that local clinical priorities are identified and conveyed to the relevant NHS England local regional office;
• retain appropriate forensic evidence;

In the event of an incident resulting in multiple high velocity blast and ballistic injuries in another area:

• advise the Trust Medical Director, Director of Nursing or On call Director of any regular military consultants/nurses within the trust who may be required to support the response under Military Aid to Civil Authority (MACA);
• should the Trust provide military advisors to the response in another area, ensure that significant local clinical responses are covered by other staff.
17.41 Critical Care Networks

In the event of a mass casualty incident the Critical Care Networks will invoke their standard operating procedures and the use of response levels ranging from 1-4.

- **Response Level 1** – Single or isolated admissions to Critical Care;
- **Response Level 2** – Single Intensive Care Unit Capacity Exceeded and Compromised Emergency and Elective Surgical Activity;
- **Response Level 3** - Multiple Intensive Care Units Capacity Exceeded;
- **Response Level 4** – Resources overwhelmed or survival once ventilated is unlikely

They will also:

- ensure that systems are in place to ensure timely data collection (on a daily basis) and rapid reporting of information;
- liaise with surrounding critical care networks;
- ensure supply of key equipment and consumables used in critical care;
- determine collaborative agreements between critical care units on the use of limited sedation drugs and combined storage/stockpiling of agreed resources;
- identify best use of limited resources in an escalation setting;
- liaise with emergency care networks to identify points of access in later responses.
- apply normal intensive care therapy and triage;
- identify the number of designated adult Intensive Care and High Dependency beds;
- Identify areas that could be utilised for level 2 or 3 care during a surge event. Suitable arrangements might include planning to utilise level 2 areas for level 3 patients, in areas such as theatre recovery or ward areas with appropriate staffing and monitoring equipment;
- prepare an inventory and record the location of all equipment that might prove suitable for use in the provision of limited critical care. In addition, consideration should be given to training of staff and plans for the storage of equipment, how it will be accessed and the maintenance of supply and delivery chains;
17.42     Trauma Networks

Trauma networks have been established nationally from 2013 and within NHS South of England, there are 7 Trauma Networks, consisting of a Major Trauma Centre (MTC) hospital (in brackets below) and Trauma Unit Hospitals (see Table 7).

- Peninsula Trauma Network (Derriford Hospital Plymouth)
- Severn Trauma Network (Southmead Hospital Bristol)
- Wessex Trauma Network (Southampton General Hospital)
- Thames Valley Trauma Network (John Radcliffe Hospital Oxford)
- South West London & Surrey Trauma Network (St George’s Hospital London)
- Sussex Trauma Network (Royal Sussex County Hospital Brighton)
- South East London, Kent & Medway Trauma Network (Kings College Hospital London)

In a mass casualty incident, the trauma network MTC and Trauma Unit hospitals may quickly reach capacity and patient transfers to networks outside the area will be required. The information below in Table 7 is provided to support planners across the health sector that should recognise patient movements within the networks in their planning. Planners should also engage with the networks to identify services (including tertiary) that could be transferred into an area to support the local response as appropriate. Movements of patients for transfer, repatriation or for mutual aid should follow the normal pathways for a major incident. Any further information can be found documented in the trauma network operating procedures held within Networks and at all of the MTC hospitals for each of Trauma Networks.

Each MTC and Trauma Unit will have localised supporting action cards and alerting protocols.

17.43     Burns Networks

Some mass casualty incidents, including those described in the scenarios above will cause burn injuries. As with all types of injury, access to specialist care will be through the triage mechanisms established.

The inability of a burn service to maintain effective routine burn care to their local population because of a sudden demand on the service could also result in a burn service declaring a burn major incident. A burn major incident is an event which results in a significant increase in the demands placed on a specialised burn service and as a consequence the service cannot deliver optimal level of burn care using the routine resources available to the local burn service.
During a large scale major incident or mass casualty incident patients will be taken to the nearest trauma service that best meets their life saving needs. If a patient has other acute life threatening injuries they will be transferred on to the appropriate service which is required by their clinical needs see Figure 4. Specific details of the management of burns patient can be found in the burns networks plans for the South West and London and the South East.

**Table 8 – Specific Injury Management**

<table>
<thead>
<tr>
<th>Injury type</th>
<th>Transported to, Transferred to or Outreach obtained from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple injuries with burns as secondary injuries</td>
<td><strong>Trauma Centre</strong></td>
</tr>
<tr>
<td>Life threatening burns</td>
<td><strong>Burn Centre</strong></td>
</tr>
<tr>
<td>Non-life threatening Burns</td>
<td><strong>Burns (Centre/Unit/facility)</strong></td>
</tr>
<tr>
<td>Life threatening inhalation injury</td>
<td><strong>Critical Care</strong></td>
</tr>
</tbody>
</table>

**17.43.1 National Burn Bed Bureau**

The National Burn Bed Bureau (NBBB) has been developed in conjunction with the National Network for Burn Care in association with the NHS Specialised Commissioning Groups. The objectives of the NBBB are to:

- enable clinicians to source an appropriate burn bed for either primary or secondary transfers;
- provide a resilient service to quantify national burn bed availability in the event of a major incident;

**17.44 Paediatric Critical Care**

Paediatric Critical Care Networks will deliver:

- Paediatric Critical Care;
- Paediatric Burn Care Services;
- Paediatric Respiratory Extra Corporeal Membrane Oxygenation (ECMO);
The National SOP\textsuperscript{11} states that only when referrals increase above \textit{NORMAL levels and capability within the service is exhausted, will escalation be required}. The 2015/16 National SOP uses Critical Care Condition (Critcon) definitions adapted from those applied to adult critical care (within London). These are summarized below:

<table>
<thead>
<tr>
<th>Definition</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL – Business as usual</td>
<td>PCC CRITCON 0</td>
</tr>
<tr>
<td>LOW SURGE – Bad Winter</td>
<td>PCC CRITCON 1</td>
</tr>
<tr>
<td>MEDIUM SURGE – Full stretch</td>
<td>PCC CRITCON 2</td>
</tr>
<tr>
<td>HIGH SURGE - Unprecedented</td>
<td>PCC CRITCON 3</td>
</tr>
<tr>
<td>TRIAGE – Last Resort</td>
<td>PCC CRITCON 4</td>
</tr>
</tbody>
</table>

The Emergency Bed Service (EBS) manages the data held within the CMS2. Trusts and NHS South hub teams across the Region will be responsible for collecting additional data to inform more regular Sitreps as and when required. These are referred to in the National SOP ‘Surge Action Cards’ in response to change in PCC Critcon statuses.

### 17.5 Clinical Commissioning Groups

In the event of a mass casualty incident the CCGs will:

Support NHS England in discharging its EPRR functions and duties locally including supporting health economy tactical coordination groups during incidents. The CCGs may also assist the NHS England-South local regional offices undertake the following tasks:

- mobilising resources from locally commissioned services;
- providing local NHS leadership if required;
- liaise with relevant partner organisations;
- cascading information to relevant service level providers;
- inform and maintain dialogue with neighbouring CCGs when appropriate;
- support CCG commissioned organisations with any local demand, capacity and systems resilience issues;

### 17.6 Community and mental health provider trusts

In the event of a mass casualty incident the community and mental health trusts will:

\textsuperscript{11} [https://www.england.nhs.uk/commissioning/ccs/](https://www.england.nhs.uk/commissioning/ccs/)
- increase capacity in order to receive patients from acute trusts;
- provide care to affected casualties in community settings (e.g. minor injuries units), if and where appropriate;
- ensure that a continuing health service is provided to those unaffected by the incident;
- ensure central lines/messages are being communicated to staff and patients;
- provide situation reports as required by NHS England and CCG’s;
- provide mutual aid where appropriate and capacity permits
- will contribute to the health community response in line with local established plans and procedures;
- escalation/surge plans will be implemented as appropriate;
- the suspension of non-essential services to support re-deployment of staff and the ability to respond to workload pressures;
- provide psychosocial support to victims and staff members affected by the incident increase ED Psychological Liaison resource where necessary;
- retain appropriate forensic evidence;

17.7 NHS 111

NHS 111 hubs will follow their normal pathways when responding to any calls related to a mass casualty incident. All calls will be dealt with using existing algorithms and clinical advice.

If the system begins to get over loaded with calls then normal escalation routes will be followed in order to support the demand and gain additional resources. If network resilience becomes an issue then a decision will be made to invoke national contingency.

17.8 Military Aid to the Civil Authorities

Experienced military clinicians are available to give telephone advice or visit MTCs in the event of a mass casualties’ incident. This may be as an individual or as a team. National NHS indemnity arrangements are in place. This may also apply to the trauma units if applicable.

The Ministry of Defence holds a list of military specialist with experience in ballistic injuries. These specialties available include: Anaesthetics, Emergency Medicine, General Surgery, Plastics, Radiology and Trauma and Orthopaedics.

The role of these specialists will be to give advice on management strategy and it is not anticipated that they will need to undertake procedures. It is also foreseen that attendance at Day-2 Multidisciplinary Team meetings would be very helpful. Please
refer to Appendix 7 Gateway Reference No 15835: Expert Military Support to the NHS.

For sharing knowledge the Combat Trauma app (formally Role 4 Trauma Guidelines) is available. This is a resource to share lessons learned, help future outcomes and increase knowledge, particularly clinical pathways shared collectively. This needs to be activated by MTCs or trauma units as soon as possible and is accessible on: www.role4trauma.co.uk
Table 7 NHS South of England major trauma systems

NHS South of England major trauma system

Emergency departments are not shown on the map, however they do form an integral part of the NHS South of England major trauma networks.
17.9 Communications Team

In the event of a mass casualty incident, NHS England would be expected to act and speak on behalf of the service as a whole and to coordinate communications activity across the NHS. In line with this, NHS England national communications would take the lead in cascading information up and down the system and to and from its stakeholder partners, as well as submitting briefings and information to the Department of Health and other national partners.

It would also be responsible for engaging with both press and key external stakeholders to explain what steps the NHS is taking to respond to an incident and address any concerns about the health system’s ability to manage the situation. Furthermore, it would have a key role to play in ensuring that the public receives the information it needs about the specific situation and about the health services that are available to them, and supporting Public Health England (PHE) and other partners with the dissemination of key public health messages and information.

The regional and local communications teams of NHS England would support the national team as required, with a particular focus on the following:

- regularly engaging with the NHS and other partners in their area to ensure that messaging and information is disseminated and is consistent and aligned with national communications;
- ensuring information about the number and condition of casualties is only issued with the approval of NHS England and the SCG, with the police leading on any announcements;
- developing localised communication strategies in liaison with multi-agency partners for the media, public and staff. Regular and accessible information should be provided to all audiences and include:

  - information on operational NHS issues, such as where to go for treatment or advice (this must be closely tied to public health information provided by PHE);
  - authoritative information on all health aspects of the incident, for example health risks arising from the original incident, self-care, how to get treatment, and any further potential hazards to health;
  - raising awareness of arrangements for any treatment centres and publication of the incident helpline;
- the use of NHS 111 to ensure that consistent health messages are available and to help reduce the pressure on other health services;
- information for staff so that they are kept informed of the incident and know how to safeguard their environment and respond to patient enquiries;

17.10 Casualty Bureau

A Casualty Bureau is activated following a major/mass casualty incident and manages information relating to people involved in the incident. This may however take up to four hours so all NHS funded care organisations should have holding lines via their switchboards prior to CB activation which should refer callers to the Casualty Bureau number for all enquiries relating to persons involved in the incident.

When a mass casualty incident occurs involving large number of casualties, or is likely to result in a large number of telephone calls from concerned relatives and friends, the police will normally activate the Casualty Bureau.

If it is thought that a local Casualty Bureau becomes overwhelmed then a system called CasWEB will be invoked where other police services across the UK will provide a mutual aid capacity.

A Casualty Bureau serves three main purposes:

- to gather as much information as possible about the people involved, or potentially involved;
- to process the information;
- to provide accurate information to relatives and friends as well as the police officer in charge of the enquiry;

In addition:

- a Casualty Bureau is designed to receive details from friends and relatives about people who have not returned from the scene of an incident;
- details of anyone who has either been evacuated or has survived will also be received from the scene of the incident;
- although a Casualty Bureau is receiving information from the scene, it may not be in a position to immediately answer any specific concerns about a particular person;
- details of any casualties will be forwarded to the Casualty Bureau by the hospital so that any next of kin are informed quickly;
- witnesses to the incident may also be requested to contact the Casualty Bureau to pass on any information they may have;
17.11 Primary Care

Primary Care Services (PCS) have no formal or specifically defined role during the response to a mass casualty incident. Despite this primary care providers must seriously consider the requirement of any hospital referrals during the response and recovery phase of this type of event.

Any self-presenters to a primary care facility will be dealt with in the normal way with first aid being carried out followed by an immediate call to the ambulance service if required.

18 Training and Exercising

Training and exercising forms an integral part in ensuring any organisation is fit to respond to any incident or emergency. All NHS-funded organisations must meet the requirements of the Civil Contingencies Act (2004), the Health and Social Care Act (2012), the NHS standard contracts, the NHS England Core Standards for EPRR and the NHS England Emergency Preparedness Framework 2015.

All NHS funded organisations should also ensure that staff involved in the planning for or response to an emergency receives appropriate training. Training plans should also consider other people who have a role in the emergency plans such as all multi-agency partners.

Organisational and personal development forms a key part of responding effectively to an incident. The infrequency of significant/major incidents means that, unless participation in the various exercises takes place, the skills acquired during the initial training will fade.

NHS funded organisations should liaise with their Local Resilience Forum (LRF) partners to align their training and exercising with the community risk registers to ensure they are ready to respond to any incident.

19 Psychological Support

Health and social services in the UK have specific responsibility for making coordinated arrangements for appropriate social and psychological support of staff, survivors, relatives and other affected individuals following an emergency. As the nature of an emergency varies so does the potential for adverse reactions that may lead to significant psychological trauma and harm.

Disasters, terrorism and traumatic events whatever their source or scale bring with them potential to cause distress. Sometimes that distress can be severe and can
affect every person who is directly or indirectly involved in such an event requiring them to need psychological support. A sizeable minority of people may also develop other psychosocial problems and/or mental health disorders for which they may require more substantial and sometime sustained interventions and treatments.

As the overall world incidence of military conflicts and terrorism remains high the national and international dimensions of disaster, terrorism and traumatic events needs to be recognised.

Any psychological response to a mass casualty incident needs to reflect the enormity of the incident itself ensuring that it is well measured and tailored to such a specific event. Localised plans will need to be developed to support this process.

### 19.1 Trauma risk management (TRiM)

TRiM is a method of secondary Post Traumatic Stress Disorder (PTSD) and other traumatic stress related mental health disorders) prevention. The TRiM process enables health and non-healthcare staff to monitor and manage colleagues. TRiM training provides TRiM Practitioners with a background understanding of psychological trauma and its effects.

TRiM is a trauma-focused peer support system and the way it works is wholly compliant with the PTSD management guidelines produced by the National Institute for Health and Care and Excellence.

Each organisation is required to have a plan to manage psychological issues in conjunction with their LRF/LHRP frameworks.

### 20 Ethics

In lieu of any national guidance the following generic principles may be followed as ethical issues.

In preparing for, and responding to, a mass casualty incident, governments, policy makers, public and private sector organisations, professional leaders, clinicians, health workers and others involved in caring professions or leadership roles will face difficult decisions and choices that may impact on the freedom, health and, in some cases, the prospects of survival of individuals for example invocation of the P4 category. Many people are also likely to face individual dilemmas and tensions between their personal, professional and work obligations. Given the anticipated levels of additional demand, capacity limitations, staffing constraints and potential shortages of essential medical material, hard choices and compromises are likely to be particularly necessary in the fields of health and social care. This also entails key clinical management of the severely injured and dying.
The ethical principles that need to be considered in weighing different sorts of harm, and in trying both to minimise harm and to be fair, are summarised below.

The principle of:

- Respect;
- Fairness;
- Working together;
- Reciprocity;
- Keeping things in proportion;
- Flexibility;
- Good decision making which involves:
  - Openness and transparency
  - Inclusiveness;
  - Accountability;
  - Reasonableness;

### 21 Legal Issues

Following any major incident a number of legal investigations and challenges can and will be made. These may include Coroners Inquests, Public Inquires, Corporate Manslaughter and Civil Action.

When planning for and responding to a mass casualty incident NHS England-South have procedures in place to ensure that any decisions made and actions taken are recorded and stored in a way that can be called upon at a later date to provide evidence.

Accurate record keeping by the decision maker and the loggist is described in the NHS England EPRR Framework 2015. All NHS organisations across the South of England must have teams of trained loggists who will be mobilised to support the management of any incident or event. Logs are produced at best practice standards and all records are essential for a robust audit trail.

To support the response process NHS England-South will use the Joint Emergency Services Interoperability Programme (JESIP) Decision Making Model (see table 9). The DMM is suitable for all decisions and can be applied to spontaneous incidents or planned operations. Decision makers are advised to use it to structure a rationale of what they did during an incident and why.
Forensic evidence is obtained by scientific methods such as ballistics, blood tests and DNA test and is used in legal proceedings. Evidence and forensic evidence often helps establish the guilt or innocence of possible suspects but can also provide the science behind any weapons that may have been used.

Analysis of evidence and forensic evidence can also be used to link crimes that are thought to be related to each other and to those perpetrators that may be involved if a criminal act has been committed. The linking of crimes helps the police services narrow down the range of suspects and to establish the patterns of crimes to identify and prosecute suspects.

The gathering of forensic evidence is vital in a mass casualty incident and must be understood, respected and not forgotten by multi-agency partners.
Ambulance services and acute trusts must have local procedures in place to protect effects or samples from casualties that may assist this process despite this being a difficult task to consider at the time.

23 The Deceased

The death of any individual must be managed with sensitivity having regard to the religious and cultural traditions of the deceased and the needs of the bereaved family, whilst ensuring all legal and judicial procedures are followed. All mass casualty plans should have references in place on how to deal with the deceased and their families if applicable. This process may be documented in more detail in supporting plans such as mass fatalities.

The death management process is complex and in this type of incident will involve multiple agencies and many interdependencies. Partner agencies across the public and private sectors have well established processes for ensuring and efficient and sensitive service which is able to meet requirements during time of normal business but following a mass casualties’ incident will come under extreme pressure with the capacity at mortuaries becoming stretched which needs to be considered.

If a temporary mortuary is set up at the scene then any casualty dying in hospital following a major or mass casualty incident has to be transported back to that facility if still in place. Arrangements must therefore be in place locally to understand and fulfil that requirement effectively.

24 Stand Down and Recovery

Stand down following a mass casualty incident will follow normal command and control processes but will be initiated by the ambulances services for health.

It must be recognised that although ambulance services have declared a stand down from the scene acute trusts may not be in that position and therefore stand down will then be decided at a local level. Formal stand down from the whole incident will be led by the SCG in conjunction with its multi-agency partners.

Recovery and the return to normal in the aftermath of a mass casualty incident will become an imperative and vital role for all multi-agency partners and will take a considerable amount of time. Taking stock of the overall impact and facilitating the restoration of the incident of normal services should commence whenever feasibly possible, It should start with the identification of key priorities, the maintenance of business as usual (BAU), the provision of care and support to staff that may have been personally affected and consideration of legal and financial risks that might
ensue. SCGs will initiate hand over of the incident for the recovery phase, to the local authorities who will invoke local LRF Recovery Plans.

Considerations may also include the implementation of a NHSE Regional Recovery Cell that may focus on:

- Repatriation/onward care procedures;
- Ongoing management of a protracted incident;
- Management of BAU versus recovery;
- Legal/financial impacts;
- Public scrutiny;
- Political impacts;
- The return to normality;

**24.1 Beyond One Day - Potential impact on capacity for acute trusts:**

Planning beyond day one is essential. Recent events across the World have indicated that management of this type of event will continue for a significant protracted period of time. Acute Trusts are advised to not only implement their business continuity plans but consider the following which were lessons learned from the Paris 2015 attacks:

- Not re-opening EDs too early (this does not include life threatening emergencies);
- All emergency work may need to be strictly triaged for 48 hours;
- Management of medical emergencies may resume after 48 hours
- Surgical emergencies are likely to be restricted for up to one week;
- Trauma and plastics emergencies are likely to be restricted for up to two weeks;
- Orthopaedic and plastics surgery electives may be restricted for up to one month.
### Appendix 1A Incident Levels

<table>
<thead>
<tr>
<th>NHS Level</th>
<th>Description</th>
<th>No of casualties</th>
<th>Local Regional Office NHS Response</th>
<th>Regional NHS Response</th>
<th>National NHS Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major (Incident Alert Level 2)</td>
<td>An incident that Individual trusts can manage implementing their Incident Response/Major Incident Plans in conjunction with the relevant CCG, local regional office and the comms teams</td>
<td>10’s</td>
<td>Activate command, control coordination and communication arrangements; Participate in local multi-agency response arrangements</td>
<td>Advised for information only</td>
<td>Advised for information only</td>
</tr>
<tr>
<td>Mass (Incident Alert Level 3/4)</td>
<td>A large scale incident involving many acute trust facilities</td>
<td>100’s</td>
<td>Mass Casualty Framework to be invoked; Local Regional Office to initially</td>
<td>Mass Casualty Framework to be invoked; Regional Office to take over</td>
<td>Advised of incident and its potential to require a national</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibilities</td>
<td></td>
<td></td>
<td></td>
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<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>lead the response in conjunction with the regional office if escalated; ICC’s to be set up and managed; Local regional office to be part of multi-agency response and attend SCG/SCGs; To provide sitreps to the region as required; To liaise with the comms team</td>
<td>leading the response if indicated; To lead on mutual aid requests; To report to the national team when requested; To lead on the comms response</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>response and national support; To determine a battle rhythm/cycle of command if required; Brief ministers; Assists in mutual aid requests; To work and participate in the cross government response; Lead on national comms messages</td>
<td>lead the response in conjunction with the regional office if escalated; ICC’s to be set up and managed; Local regional office to be part of multi-agency response and attend SCG/SCGs; To provide sitreps to the region as required; To liaise with the comms team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To liaise with the comms team</td>
<td>leading the response if indicated; To lead on mutual aid requests; To report to the national team when requested; To lead on the comms response</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>including the local trauma centres and other NHS providers; Incident that spreads over local area boundaries; Mutual aid required for robust response; Incident protracted and attracting high levels of media interest</td>
<td>lead the response in conjunction with the regional office if escalated; ICC’s to be set up and managed; Local regional office to be part of multi-agency response and attend SCG/SCGs; To provide sitreps to the region as required; To liaise with the comms team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophic (Incident Alert Level 4)</td>
<td>An incident that is of such proportions that it severely disrupts health and social care and other supporting functions. The response required needs national leadership and COBR to determine the response and actions required</td>
<td>1000’s</td>
<td>All plans invoked across health and its multi-agency partners; Command, control, coordination and communications being lead nationally; Regional SCGs in place; Battle rhythm/cycle of command lead by COBR</td>
<td>To be part of national response liaising directly with affected local regional offices; Support the brokering of mutual aid requirements; Report directly into national team; Be part of national comms response</td>
<td>Lead on national response; Brief ministers/COBR; Relay battle rhythm/cycle of command to regional offices; Coordinated distribution of national assets if required; Invoke military aid processes; Coordinate the national comms response</td>
</tr>
<tr>
<td>MTFA Incident Should be considered in all three categories listed above</td>
<td>Unknown</td>
<td>Mass Casualty Framework to be invoked (noting MTFA section)</td>
<td>Mass Casualty Framework to be invoked (noting MTFA section)</td>
<td>Lead on national response; Brief ministers/COBR; Relay battle rhythm/cycle of command to regional offices; Coordinated distribution of national assets if required; Invoke military aid processes; Coordinate the national comms response;</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>A marauding, terrorist firearms attack producing varying numbers of casualties with ballistic and high velocity type injuries. An incident that threatened national security</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 1B Management of Incident Levels

As an event evolves it may be described in terms of its level as shown. For clarity these levels must be used by all organisations across the NHS when referring to incidents.

<table>
<thead>
<tr>
<th>Incident level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>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.</td>
</tr>
<tr>
<td>Level 2</td>
<td>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 local office.</td>
</tr>
<tr>
<td>Level 3</td>
<td>An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.</td>
</tr>
<tr>
<td>Level 4</td>
<td>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.</td>
</tr>
</tbody>
</table>
# Appendix 2 Table of Hazards from the Local Risk Management Guidance showing Casualty Number Planning Assumptions

<table>
<thead>
<tr>
<th>Risk</th>
<th>Hazard and Sub-hazard category</th>
<th>Description of casualties</th>
</tr>
</thead>
<tbody>
<tr>
<td>H01</td>
<td>Major Industrial Accident - Fire or explosion at a gas LPG or LNG terminal (or associated onshore feedstock pipeline) or flammable gas storage</td>
<td>Casualties in the range of 150 to 1,500 up to 3km around site</td>
</tr>
<tr>
<td>H04</td>
<td>Major Industrial Accident - Fire or explosion at a range of industrial sites including fuel distribution sites or site storing flammable and/or toxic liquids in atmospheric pressure storage tanks</td>
<td>Casualties in the range of 100 to 2000 up to 3km around site</td>
</tr>
<tr>
<td>HL27</td>
<td>Industrial Accident - Localised fire or explosion at an oil refinery</td>
<td>Up to 1km around site, causing up to 150 fatalities and 500 casualties</td>
</tr>
<tr>
<td>HL05</td>
<td>Structural - Incidents involving piers and similar maritime structures</td>
<td>500 casualties and up to 100 fatalities</td>
</tr>
<tr>
<td>HL08</td>
<td>Transport Accidents - Fire, flooding, stranding or collision involving a passenger vessel in or close to UK waters or on inland waterways, leading to the ship's evacuation</td>
<td>Up to 50 fatalities and up to 100 casualties</td>
</tr>
<tr>
<td>HL09</td>
<td>Transport Accidents - Aviation accident</td>
<td>Causing up to 50 fatalities and up to 250 casualties</td>
</tr>
<tr>
<td>HL11</td>
<td>Transport Accidents - Railway accident</td>
<td>Up to 30 fatalities and up to 100 casualties (fractures, internal injuries – burns less likely)</td>
</tr>
<tr>
<td>HL14</td>
<td>Transport Accidents - Local (road) accident involving transport of fuel/explosives</td>
<td>Multiple serious casualties</td>
</tr>
</tbody>
</table>

[https://www.resilience.gov.uk/RDService/home/54903/CCS-Risk-Documents-Group](https://www.resilience.gov.uk/RDService/home/54903/CCS-Risk-Documents-Group)
TABLE OF PLANNING ASSUMPTIONS FOR NO-NOTICE NON-CONTAMINATED MASS CASUALTIES FROM THE NATIONAL RESILIENCE PLANNING ASSUMPTIONS

<table>
<thead>
<tr>
<th>Type of threat</th>
<th>Planning Assumption for Number of Casualties</th>
<th>Description from the NRPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marauding firearms attack</td>
<td>Up to 300 casualties</td>
<td>Injuries include burns, blast injuries, fractures and gunshot wounds caused by high velocity ballistics.</td>
</tr>
<tr>
<td>Conventional explosive attacks</td>
<td>Up to 2,000 casualties</td>
<td>Up to 2,000 casualties simultaneously from up to 2 busy public locations (although up to 3 locations cannot (sic) be ruled out.</td>
</tr>
<tr>
<td>Incidents at industrial sites</td>
<td>Up to 1,500 casualties</td>
<td>Up to 1,500 casualties occurring simultaneously at one industrial location including oil refineries or storage depots; an (sic) Liquefied Petroleum Gas or Liquefied Natural Gas terminal or flammable gas storage site; fuel distribution site or a site storing flammable and/or toxic liquids in atmospheric pressure storage tanks.</td>
</tr>
</tbody>
</table>
Appendix 3

A Model of Ambulances and Time required to Distribute Patients across a Network

The distribution of casualties is the responsibility of the responding ambulance services. To support ambulance service and system planning, the following tool was developed to help understand the resources and time required to move patients from an incident site to receiving hospitals.

To use this spreadsheet tool the following information will be needed:

- Location of model incident
- Typical travel time to each receiving hospital
- Local planning assumptions on casualty numbers to be received—typically 20% of acute hospital bed stock

This spreadsheet tool:

1. Links casualty numbers to length of ambulance call cycle from initial pick-up at casualty clearing station to the return of the ambulance to casualty clearing station.

2. Shows total time to convey patients across a known geographical spread of receiving hospitals against a known number of casualties and number of ambulances. The input of different ambulance numbers changes the total time.

3. Makes several assumptions but provides ambulance and hospital planners with indicators of the length of time it takes to convey large numbers of patients into receiving hospitals, even with significant numbers of ambulances dedicated to the response.

The scale of the NHS response for these events is unprecedented and will have enduring ramifications for all areas of care. Planning within receiving hospitals in particular is supported by this spreadsheet tool. Planning in some hospitals has highlighted the draw on key staff e.g. critical care, and it is likely that those staff areas will be overwhelmed in a similar way in all receiving sites.
Planners should populate their own spreadsheet based on the example from page XX. Columns and rows in the table contain the information listed below:

- **Column A** - Insert names of sites that will receive patients;

- **Column B** – Distance in miles from receiving hospital to incident site (e.g. a model response site);

- **Column C** – Planning assumption on time to collect patient at scene;

- **Column D** – Average travel time from scene to receiving hospital, e.g. as shown by ‘Google Maps’;

- **Column E** - Turnaround time at receiving hospital;

- **Column F** - as per ‘D’ for return journey - assumption is ambulances will make multiple journeys;

- **Column G**- totals time for a single journey complete journey as shown in diagram below;

- **Columns H, I, & J** – mass casualty planning assumption figures per acute trust – in this example P1 and P2 casualty numbers are each 25% of a number that is 20% of the site’s total bed base;

- **Column K** – Total travel time required to convey the patient numbers listed (J x G);

- **Rows 15-19** – Total travel time with different numbers of ambulances available. ('K' divided by a number of ambulances).
### Assumptions:
- 1 x P1 or P2 per DMA
- Moderate road conditions
- All movement by road (no air amb)
- No consideration to crews remaining at scene

### Table

<table>
<thead>
<tr>
<th>Receiving Hospital</th>
<th>Distances (from model response site)</th>
<th>Collect Time</th>
<th>Travel Time</th>
<th>Turnaround Time / Reset</th>
<th>Return Time</th>
<th>Total Time</th>
<th>P1 Capacity</th>
<th>P2 Capacity</th>
<th>P1+P2</th>
<th>Total Travel Time</th>
<th>Strict Triage: P1 Time</th>
<th>Strict Triage: P2 Time</th>
</tr>
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<tbody>
<tr>
<td>DCH</td>
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<td>01:15</td>
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<td>HHFT - Basing</td>
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<td>IoW</td>
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<td>04:45</td>
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<td>12</td>
<td>24</td>
<td>04:18:00</td>
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<tr>
<td>Poole</td>
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<td>00:50</td>
<td>00:30</td>
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<td>02:25</td>
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<td>25</td>
<td>50</td>
<td>05:00:50</td>
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<td>UHS</td>
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<td><strong>Total</strong></td>
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<td><strong>Mean time</strong></td>
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</table>

### 2hr working per DMA

<table>
<thead>
<tr>
<th>Amb</th>
<th>Time</th>
<th>Time</th>
<th>Time</th>
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<td>25 Amb</td>
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<td>100 Amb</td>
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<td>150 Amb</td>
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</tr>
<tr>
<td>200 Amb</td>
<td>00:03:10</td>
<td>00:03:10</td>
<td>00:03:10</td>
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</tbody>
</table>
Appendix 4 Voluntary Aid Societies

The Civil Contingencies Act guidance 2004 identifies that the voluntary sector can provide support in a number of key areas. Any Voluntary Aid Society (VAS) will be mobilised via the ambulance services in order to coordinate the response and manage the demand across the South. However as local authorities are also able to mobilise these resources for a range of key functions it is essential that this is a combined and coordinated managed process. This process will therefore be overseen and controlled by NHS England-South and the coordinating SCGs.

Roles

Voluntary sector organisations offer an extensive array of services and activities; many are applicable to mass casualty response. These can be split into two broad functions:

- Support Responding Organisations to Continue Critical Services (Business Continuity);
- Support implementation of Emergency Plans;

The will also:

Plan, consult and exercise with relevant voluntary organisations on a LRF/LHRP footprint and ensure responsibilities are aligned with guidance issued by national voluntary sector steering groups.

Management of the voluntary organisations during an incident resulting in mass casualties will be complex and multi-faceted as far as the demand and the nature of the demand is concerned.

This role will fall to the SCGs in conjunction with the local regional office incident coordination centres only rather than local organisations themselves. This may also need further coordination by the regional office and the RESCG if the incident requires it. This will be incident dependant.
<table>
<thead>
<tr>
<th>Functions</th>
<th>Examples</th>
</tr>
</thead>
</table>
| 1. Supporting Responding Organisations to Continue Critical Services (Business Continuity) | - Provision of additional vehicles (including air ambulances) and staff to support ambulance/other trust sector types  
- Provision of telecoms equipment to enable robust and extensive communications  
- ‘Home from hospital’ re-settlement schemes to support patient discharge or admission avoidance  
- Transport and escort of homeless, outpatients, next-of-kin, etc., to and from airports, railway stations, hospitals, mortuaries, rest centres, hostels, etc (also function 2)  
- Supply of properties (also function 2)  
- Essential supplies (also function 2)  
- Signposting-support lines/drop-in centres (also function 2) |
| 2. Supporting implementation of Emergency Plans | - First-aid and advanced clinical support within Casualty Clearing Stations, Reception and Rest Centres  
- Search and rescue, including coordination of smaller agencies  
- Documentation/administration  
- Psychosocial/welfare intervention and support; spiritual care & religious services  
- Coordination of convergent (spontaneous) volunteers  
- Provision of point of contact for multi-agency command and control groups e.g. Strategic Coordinating Group/Tactical Coordinating Group  
- Contact with ‘out of area’ voluntary agencies to determine whether they are able to support arrangements  
- Link between communities and NHS organisations/other statutory services |

The above is not exhaustive; regular engagement with the sector/organisation is needed to build up the necessary relationships to determine if other activities could be offered.
## Responsibilities-Planning, Response and Recovery

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>Voluntary Organisations</th>
<th>Statutory Bodies</th>
</tr>
</thead>
</table>
|                  | • Maintain any commissioned activities during course of incident, unless diversion of resources agreed with commissioner  
|                  | • Initial call-out and briefing of volunteers  
|                  | • Provision of points of contact to statutory bodies/command groups  
|                  | • Demonstrate their capabilities and that their support is reliable, consistent and sustainable to the required standard  | • Category 1 responders bear accountability for the overall emergency response  
|                  |                        | • Plan, consult and exercise with relevant voluntary organisations on a LRF/LHRP footprint and ensure responsibilities are aligned with guidance issued by national voluntary sector steering groups.  
|                  |                        | • Consideration to health and safety of volunteers under their command  
|                  |                        | • Call-out and briefing of voluntary organisations  
|                  |                        | • Clear tasking of voluntary organisations  
|                  |                        | • Work with voluntary agencies to formalise a process and procedure for the use of convergent volunteers  |

A record of available local voluntary resources should be maintained, where appropriate, as part of an LRF-level multi-agency plan.
Table 10 – Voluntary Sector Incident Reporting Response
Appendix 5 NHS Supply Chain Emergency Procedure

Our emergency service - there when you need it

The NHS is a 24/7 organisation that is in constant demand, so when things go wrong it needs 24/7 emergency backup.

NHS Supply Chain’s emergency service means that we will always be there when you need us - 365 days a year, 24 hours a day, 7 days a week.

It is available to all NHS funded organisations for use in an emergency.

Under our emergency service arrangements, we guarantee that we will respond to any major incident or unforeseen circumstance efficiently and rapidly, getting a new or replacement product to you as soon as we possibly can.

One phone call to our teams and we will do everything we can to support your organisation, protecting continuity of your service to your patients.

In response to an emergency call, we commit to getting any stocked product to you within five hours and aim to get non-stocked products to you by the next working day if not before. (Non-stocked products in our catalogue are marked with a blue diamond or e-Direct symbol). All you need to do is give us a call as soon as you become aware of the problem.

Our emergency service operates in support of your own trust’s emergency response.

Office hours
If your emergency occurs within normal office hours (i.e. 9am to 5pm), your first point of contact should be your own trust supplies manager/team who will respond to your emergency in the most appropriate way in line with your authorisation procedure. Any need to engage NHS Supply Chain can be done through the normal customer service contact.

Out of hours
If your emergency happens outside of normal office hours, or at the weekend or on a bank holiday, you must obtain the appropriate permission from an authorising officer within your trust and follow your trust’s authorisation/on-call procedure.

Once authorisation has been obtained, you (or your supplies team depending on your trust’s procedure) should contact NHS Supply Chain using the emergency contact telephone numbers.
Our duty security officer will answer and you must clearly state that it is an emergency situation and that you require an urgent delivery.

Before you call, make sure you have the following information:

- Authorising officer’s name
- Location name and telephone number
- Requisition point details
- NPC code for each commodity required
- Description of product with issue pack size
- Quantity required
- Delivery point if different from normal delivery location
- Precisely when the item(s) are needed.

Our distribution centre staff will let you know the details of the transport to be used and estimated time of arrival.

**Out of hour's emergency telephone numbers:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Midlands</td>
<td>01623 587173</td>
</tr>
<tr>
<td>South Midlands</td>
<td>01623 587183</td>
</tr>
<tr>
<td>North East England</td>
<td>01924 328751</td>
</tr>
<tr>
<td>South West England</td>
<td>01623 587187</td>
</tr>
<tr>
<td>Southern England</td>
<td>01622 402669</td>
</tr>
</tbody>
</table>
27 April 2011

Gateway reference number: 15835

To: NHS Acute Trust Chief Executives
    NHS Foundation Trust Chief Executives, Acute sector
    SHA Chief Executives
    SHA Medical Directors
    SHA Emergency Preparedness leads
    The Surgeon General
    ACDS (Health)
    Commander Joint Medical Command
    ACDS (Ops)

C.C: Monitor

Dear Colleagues:

Subject: Expert Military Support to the NHS

I am writing to inform you of the further development of contingency arrangements to enhance the NHS response in the event of a major incident involving significant blast and ballistic injuries, which go beyond normal NHS experience. This letter should be cascaded to the key personnel who will be involved in managing organisational responses to such an incident, including those who might need to authorise access to hospital facilities and staff on the day for those offering support to their NHS colleagues in dealing with casualties.

In the event of the Department of Health declaring such an incident, a very small number of specifically identified experts may be contacted to provide support, usually in person, to those hospitals that are the main recipients of casualties. This may mean that one or two consultants may be called away from a 'parent' trust to lend such support during the emergency phase of the incident response. See attached summary.

Given the national importance of this task, the limited number of individuals affected and the rarity of such a response being needed, I ask you to fully support this contingency whether you are the releasing principal employer or become the receiving unit for suitability experienced consultants, in such a major incident. I also ask you to confirm this support to relevant staff if you receive notification that one or more of your employees (or embedded regulars under honorary contract) might be involved.

If you require further information please contact Keith Willett, National Clinical Director for Trauma Care: keith.willett@dh.gsi.gov.uk; or Surgeon Commodore Alasdair Walker, Joint Medical Command: Alasdair.walker280@mod.uk

Yours sincerely

[Signature]

Professor Sir Bruce Keogh
NHS Medical Director
Summary

You will be aware of the ongoing review of the capability of the NHS to respond to major incidents. In recent years, coincidental with an increase in high velocity blast and ballistic injury threat, we have witnessed the development of substantial medical, surgical and imaging expertise in treating such injuries acquired in overseas military operations. Within NHS Trusts, there are senior staff who have gained this experience through serving as regular or reservist Defence Medical Services consultants, and there is a compelling logic to make their advice available to NHS colleagues in the event of a major incident involving such injuries.

The support of embedded regulars or reservists will be provided by the MoD at “best effort” in that there will not be a formal allocation of personnel to the task, instead they will seek someone suitable if and when required. It is being arranged under the Military Aid to Civil Authorities provision. The NHS will retain liability for professional indemnity and it is our clear intention, discussed with the NHS LA, that the clinical negligence scheme for trust will provide an indemnity to those trusts enjoying the assistance of these clinicians in responding to the incident. Please note that private sector healthcare employers are not being asked to enable their staff to participate in this scheme.

You should already be aware of the regular military Consultants in your Trust. If they are potentially part of this response they will inform your Medical Director and if they are ever required for such duties they will be managed through their normal chain of command. The situation is slightly different for military reservist personnel, who may provide the only potential responders in parts of the country away from Regular Armed Forces main bases. Under current legislation, a decision to as to whether to agree temporarily release of a Reservists for such an unplanned event remains with their primary civilian employer. You will be notified separately if a Reservist working in your Trust is provisionally selected and asked to record your formal agreement to them being part of this scheme. Periodically the MoD’s Medical Director will review and adjust the list of potential responders, in light of the currency of individuals’ military trauma skills.

The selected individuals will only respond in the following circumstances:

1. When there has been an event confirmed at national level in government involving significant blast and/or ballistic casualties and the MoD has decided that their particular skill set and geographic location makes them the most appropriate person to call.

2. Following direct contact from the MoD and having received information from the Department of Health.

3. When immediate significant clinical responsibilities can be covered locally.