

NHS Emergency Planning Guidance 2005

**Planning for the Management of Burn Injured Patients
in the Event of a Major Incident**

Best Practice Guidance

Consultation

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Consultation Version 03 October 2006

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This material should be read in conjunction with the NHS Emergency Planning Guidance 2005. All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the Guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency planning in the NHS in England.

The web version of the guidance is available at:-

www.dh.gov.uk/emergencyplanning

Introduction

1. This section gives guidance to National Health Service (NHS) organisations in planning, preparing and responding to all types of emergencies arising from any accident, natural disaster, failure of utilities or systems or hostile act resulting in an abnormal casualty situation or posing any threat to the health of the community or in the provision of services that involve significant numbers of burn injured patients. The guidance covers adults and children.
2. This section must be used in conjunction with the NHS Emergency Planning Guidance 2005 and the relevant underpinning sections including:
 - Strategic Health Authorities (SHAs)
 - Immediate medical care at the scene
 - Primary care organisations
 - Ambulance services
 - Acute and Foundation Trusts
 - Children – to be published for consultation Autumn 2006
 - Critical Care –published for consultation 1 August 2006
3. It is essential that there is good communication between different health care services in order to ensure that responses are structured and cohesive; thus primary care practitioners must be aware of any restrictions / limitations of secondary care that arise as a result of a significant event to allow them to make appropriate decisions about the management and referral of patients.
4. The purpose of the NHS Emergency Planning Guidance 2005 is therefore to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the requirements of the Civil Contingencies Act 2004 (the CCA) to:
 - respond to a major incident or incidents or emergency
 - manage recovery whether the incident or incidents or emergency has effects locally, regionally, or nationally.
5. Throughout this underpinning document, the term emergency is used as in the CCA, i.e. to describe an event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. To constitute an emergency this event or situation must require the implementation of special arrangements by one or more Category 1 responders.
6. The responses outlined in this guidance should only be considered appropriate in the event of emergencies that comply with the definition

above. Under no circumstances should any NHS organisation seek to initiate or adapt these in order to respond to a problem arising from staff shortages, waiting list pressures, management failures or other local institutional deficiency. The accompanying ethical and medico legal endorsement that will support NHS organisations and staff in an appropriate escalation response will not be applicable in other circumstances.

7. This Guidance is built on best practice and shared knowledge, while also acknowledging that in certain circumstances restrictions or limitations of normal standards of care will be inevitable. It is intended to provide a platform for all NHS organisations to undertake major incident and emergency planning and to provide information on associated activities that may also be required. In the context of this Guidance, the term NHS organisation includes Foundation Trusts.
8. The NHS Emergency Planning Guidance 2005 gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a Major Incident Plan in place that will be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan will link into the organisation's arrangements for ensuring business continuity as required by the CCA. Planning for the needs of burn injured patients forms part of that responsibility for Chief Executives of Acute Trusts. SHAs and Primary Care Organisations will need to ensure that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances.
9. A wide range of potential incidents may result in a sudden increase in the number of patients who require admission to services for burn injured patients. Major chemical incidents such as an explosion within a production factory, or isolated terrorist bomb attacks are possible causes for burn injuries. Considerable uncertainty exists about the potential consequences of a CBRN or bio terrorism incident, which could have local, regional, or national implications. There is also the theoretical potential that climate change may result in a freak weather-related event (such as flooding or hurricane) that could cause serious damage to large areas of the population.
10. This document focuses on planning, preparing and responding in the NHS in England, recognising the need for a high level of networking with services provided in Scotland, Wales, Northern Ireland and the Republic of Ireland in order to support mutual aid arrangements.

Definitions of burn injuries

11. Burn injuries range from the most minor, dealt with in the community, to

the most severe and devastating. They are highly variable and individual injuries affecting all ages and social groups. In general terms the definition is based on the size and anatomical site of the injury, the depth of skin injury, and the presence of co-existing conditions.

12. The care for such patients may be provided on an in-patient or outpatient basis depending on progression and recovery. Individuals may require input from a range of services including surgical, nursing and physical therapy. In some cases the major need is for specialist psychological or social worker involvement. With a complex injury the whole burn care team are involved throughout the acute care period with continuing care and rehabilitation, plus reintegration of the individual into society. This post-acute period may continue with the same team for some years, especially for children, and involve multiple outpatient interventions and several admissions to hospital for reconstructive surgery.
13. The observations and recommendations in the National Burn Care Review (NBCR 2001) indicate that the subject of burn injury should be explicitly mentioned in future publications concerning national preparedness and disaster response. This is in recognition that the majority of chemical and cutaneous radiation injuries, as well as thermal injuries, would ultimately receive care from burn services around the British Isles. These are the only services that have significant experience in the management of large and complex cutaneous injuries.
14. In 2003, the National Burn Care Group (NBCG) was created with the task of taking forward the strategy for burn care as identified within the recommendations of the National Burn Care Review. This group is taking forward the plans for Managed Clinical Networks. As part of their work, a subgroup was created to consider a plan for the management of a major incident involving significant numbers of burn injured adults and children. The resulting plan is published in parallel with this Guidance. It is available at:

www.nationalburncaregroup.nhs.uk

15. Specialist burn care is provided at the centres described in Annex A.
16. The baseline for funded burn bed capacity in March 2006 was 393 across the British Isles. The totals of funded beds in each country are:

England, 279;
Wales, 32;
Scotland, 49;
Northern Ireland, 19;
Ireland, 14
17. The National Burn Bed Bureau (NBBB) was officially launched in April 2003. It is managed by the Capacity Management Team, part of the First

Response Agency, and is based at West Midlands Ambulance Service NHS Trust.

Across the British Isles, NBBB provides:

- 24 hour coverage of availability in response to requests for patient transfers to specialist burn services across the British Isles;
 - Twice-daily establishment of bed capacity and availability;
 - A coordinated approach to bed availability
 - Part of the nationwide response to a major incident involving burn injuries
18. Burn Assessment Teams (BATs) may be activated if there is a major incident to provide advice and support at the site of an incident or at the receiving hospital(s). It is the responsibility of the burn care network in the area and the burn service to ensure that the individuals likely to form this team are aware of who they are and their role. Reference should therefore be made to the appropriate burn unit for details of BATs. SHAs will wish to ensure that there is appropriate coverage within their area and that liaison with Medical Emergency Response Incident Teams (MERITs) is possible.

Planning for an emergency or emergencies where the numbers of burn injured substantially exceeds normal capacity

19. This section offers guidance relating specifically to the planning and preparation for/ response to, emergencies likely to cause a demand for adult and paediatric services for burn injured patients that would exceed normal capacity. Such emergencies include those arising from any accident, natural disaster, hostile act, or failure of utilities or systems.
20. The underlying principle is to provide the greatest good for the greatest number of people during the course of an emergency and the follow on period.
21. NHS Organisations are required to have a Major Incident Plan which are performance managed by Strategic Health Authorities ensuring that local plans are consistent with NHS major incident planning guidance and other relevant legislation and guidance. SHAs also assume strategic command and control of widespread major incidents – incidents that cannot be contained within the resources of a local health economy. Major Incident plans are reviewed and "quality assured" in England by the Healthcare Standards Commission (or their devolved equivalents) as part of the performance management framework.

NHS and DH Emergency Planning Guidance, Section 5 (2005)
www.dh.gov.uk/emergencyplan

22. Individual health major incident plans need to reflect the local command and communication structures specified within their system at all levels to avoid confusion.
23. Each NHS Acute Trust with critical care services should plan for how it will manage the care of burn injured patients in the event of an emergency working in partnership with formally designated services for burn injured patients. In these circumstances it is understood that ways of working and clinical practices may have to be adapted but should be sustainable for a period of up to three months.
24. To support this approach, NHS organisations will need to ensure that staff are well prepared and can be supported appropriately in the event of an emergency. This will require NHS organisations to:
- Facilitate access to appropriate training for staff and for other staff who may be called upon to expand burn care services, either directly or indirectly, in the event of an emergency. This must include both clinical and essential support staff;
 - Make plans to ensure the best use of existing resources including escalation of services as part of an organisational approach. This will need to take account of the extent to which burn care clinicians and others who provide related services such as plastic surgery can continue to be involved in the care of less severely burn injured patients depending on the scenario being responded to;
 - Ensure that essential equipment and supplies are available to support the provision of existing and expanded critical care services;
 - Ensure that processes for planning and responding to a major incident or incidents of emergency where the number of patients substantially exceeds normal burn care capacity are compatible with local, regional and national command, coordination and control and decision making arrangements.
 - Ensure that arrangements can be put in place to long-term follow up care for patients including psychological support. This must include enabling access for patients to trauma support services such as those offered, for example, by the charity Changing Faces whilst still patients in hospital.

Declaration of an emergency

25. The NHS Emergency Planning Guidance 2005 describes the specific responsibilities Ambulance Trusts have in terms of alerting NHS organisations in the event of a civil emergency and/or major incident. These are:

- immediately notify, or confirm with police and fire controls, the location and nature of the incident, including identification of specific hazards, for example, chemical, radiation or other known hazards
- alert the most appropriate receiving hospital(s) based on local circumstances at the time
- alert the wider health community as the incident dictates.

26. Whilst many major incidents are triggered by 'big bang' incidents such as traffic accidents, explosions etc, there are other potential circumstances where an NHS major incident is triggered by a 'rising tide' or non-acute traumatic event, for example, infectious disease outbreak, power cuts, covert radiation leakage. In such cases the ambulance services may be involved but may not be the natural 'alerting' NHS organisation. In the event of a rising tide event, and/or a widespread incident, the communication cascade mechanism used should ensure referral via the Strategic Health Authority (SHA). The SHA will take responsibility for implementing Command and Control mechanisms and also the appropriate deployment of NHS resources. NHS organisations should endeavour to use the standard alerting messages whenever possible and, for this reason, the alerting messages have been standardised.

27. A burn major incident may arise from a variety of causes in a variety of situations. At the outset of any incident the Ambulance Incident Commander (AIC) will estimate the number of casualties and the extent of injuries. The numbers of burn injured patients will determine whether it is a burns major incident and at what level. More detail on this area is set out in detail in the NBCG Plan.

28. Command, control and coordination arrangements for the NHS are described in the NHS Emergency Planning Guidance 2005. In addition, the underpinning guidance for Acute and Foundation Trusts describes arrangements for Hospital Coordination Teams. These arrangements must be followed in responding to any major incident, incidents or emergency involving burn services. This process will include the notification of the National Burn Bed Bureau as appropriate.

Capacity

29. Local SHAs, NHS Acute and Foundation Trusts (referred to as Acute Trusts for the rest of the document) should map existing burns capacity, including potential areas where burns patients might be cared for outside formally identified burns beds. This should include potential capacity in the independent sector. Other services, such as critical care and those for children, which operate on a network basis, will also have developed plans and response arrangements. It is important to work

closely with other groups to ensure that there are no overlaps or duplications. Annex A gives details of the location of specialist burn services in the UK. Well developed plans for mutual aid are seen as being key to planning for supporting burn care services in the event of an emergency.

30. An important element of this work will be to consider how to use Burn Assessment Teams (BATs) and Mobile Emergency Response Incident Teams (MERITs) to best effect in the event of an emergency.
31. Local and regional planning should also include making arrangements for the transport of burn injured patients and/or the staff and equipment necessary to provide support to burn injured patients.
32. In any Acute Trust, the absorption of significant numbers of patients with burn injuries will seriously disrupt the non-burn activity of the hospitals as burn injuries typically require longer stays. However, it is important that beds are allocated in the best interests of the largest number of patients.
33. It will be a matter of clinical judgement whether an individual patient should be cared for in an area not formally identified for burns care or transferred to another burns unit.

Equipment and supplies

34. Acute Trusts should have available an inventory of available equipment on site that may be of use in increasing the capacity of the organisations to treat burns case. Care should be taken to avoid double counting of equipment such as ventilators where a similar process may be in place for other care groups.
35. Burn Services do not carry large stocks of dressings, spare equipment or drugs. Typically they have sufficient to deal with fluctuations in their normal activity. In the event of a burns major incident, when assessing how many burns cases could be managed, consideration should be given to the levels of stocks carried and how quickly additional stocks could be resourced.

Workforce

36. It is anticipated that in the event of a burns major incident the resources of network(s) of care will be required. Accessible beds should be utilised according to the availability of staff. Consideration will be given to repatriate patients to their nearest service when clinically appropriate and when transport is available. The National Burns Bed Bureau will continue to monitor the availability of specialist

burn beds to ensure their use in a sustainable manner in the best interests of the maximum number of patients.

37. The small number of plastic surgeons, other surgical specialties and anaesthetists in the UK with a sub-specialty interest and training in burn care is such that they will need help from plastic surgery colleagues and other clinicians. In the event of mass casualties, these colleagues will be most active in areas where patients have been admitted to hospitals that do not normally have a burn service.
38. In planning for a burn major incident, Acute Trusts should identify minimum staffing levels. Support and training for non-specialist staff such as that provided by the British Burn Association in the emergency management of severe burns should be used to develop potential capacity with the trust as much as possible, thus providing choice to clinicians making decisions on the care of individual patients.

Access, admission and discharge

39. The nature and severity of the burn major incident will usually be assessed by the Ambulance Service who will also map the available care assets (e.g. Burn Assessment Teams, (BATs), MERITs (Medical Emergency Response Incident Teams, British Association for Immediate Care services (BASICs) or similar at the scene, at the Emergency Departments / or Burns Service.
40. The Ambulance Incident Commander (AIC), in collaboration with the Medical Incident Commander (MIC), will usually determine the evacuation pattern and rate of flow for patients leaving the scene. While patients may be sent to multiple different receiving Emergency Departments, every attempt should be made to try to cluster the patients with significant burns, who may need a specialist opinion, into the fewest number of Emergency Departments, and where possible, those co-located with burns services.
41. Once the number and severity of the patient referrals is known, a dispersal pattern should be determined and arrangements for transfer made. It is the responsibility of the local/nearest burns service on the initiation of a major incident to inform the National Burn Bed Bureau (NBBB). As part of the overall incident control, the role of the BAT will be to assess the burn injuries (accurate determination of size of burn, risk of inhalation injury etc) and to communicate with the host burn service clinical lead. They will also be responsible for liaising with the host hospital clinicians regarding the priorities for treatment where multiple injuries are present.
42. In most major burn incidents there may be a significant number of small burn injuries that can be associated with other injuries and do not require admission to a specialist burn unit for their optimal

management. Each burns service should have a plan within their network that will allow the input – either in person or remotely or via a website - of specialist burns and plastic surgical staff, if required, to assist with the ongoing outpatient management of these patients.

Communications

43. On receipt of information regarding a major incident as a declared or standby event, working within the context of the NHS command, control and coordination arrangements as described in the NHS Emergency Planning Guidance 2005, the NBBB will undertake a series of tasks:
 - Notify the Capacity Management Team (CMT) on-call manager of the incident;
 - The CMT will contact the lead for the incident i.e. the originator of the first call to establish further details;
 - Provide notification to all other burn services that a major incident or a standby event has been declared;
 - Establish current capacity;
44. Upon instruction from the lead contact of the incident, NBBB will inform all other burn services that the incident has been declared or stood down.
45. The Strategic Commander for the incident will make decisions as to the level of response required and the appropriate distribution of patients, staff and equipment as described in the NBCG guidance.

Information/resources

Further information on burns services and emergency planning can be found at:

Department of Health: Emergency Preparedness Division

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4121049&chk=C2CJv3

Department of Health: Specialised Services National Definition Set: 9 Specialised burn care services (all ages)

http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/SpecialisedServicesDefinitionArticle/fs/en?CONTENT_ID=4001838&chk=xTV7o6

National Burn Bed Bureau – information can be obtained from

mark.curran@wmas.nhs.uk

The Intensive Care Society

<http://www.ics.ac.uk/>

The Health Protection Agency

<http://www.hpa.org.uk/>

The Hospital Infection Society

<http://www.his.org.uk/>

The Burn Survivors Association

<http://homepages.tesco.net/~terryev/>

Annex A
Locations of specialist burn care centres in England and Wales

LOCATION	HOSPITAL	NHS TRUST	STRATEGIC HEALTH AUTHORITY
Birmingham - Adults	Selly Oak Hospital	University Hospital Birmingham NHS Trust	West Midlands
Birmingham - Children	Birmingham Children's Hospital	Birmingham Children's Hospital NHS Trust	West Midlands
Bristol	Frenchay Hospital	North Bristol NHS Trust	South West
Salisbury	Salisbury District Hospital	Salisbury NHS Foundation Trust	South West
Chelmsford	St Andrews Centre for Burns and Plastic Surgery Broomfield Hospital	Mid Essex Hospitals NHS Trust	East of England
East Grinstead	Queen Victoria Hospital	Queen Victoria Hospital NHS Foundation Trust	South East Coast
Newcastle - Adults	Freeman Hospital	The Newcastle Hospitals NHS Trust	North East
Newcastle - Children	The Royal Victoria Infirmary	The Newcastle Hospitals NHS Trust	North East
Liverpool	Alder Hey Hospital (children)	Royal Liverpool Children's Hospitals NHS Trust	North West
	Whiston Hospital (adults)	St Helen's & Knowsley NHS Trust	North West
Manchester - Adults	Wythenshaw Hospital (adults)	South Manchester University Hospitals NHS Trust	North West
Manchester - Children	Booth Hall Hospital (children)		North West
London	Chelsea and Westminster Hospital	Chelsea & Westminster Healthcare NHS Trust	London
London	St George's Hospital	St George's Healthcare NHS Trust	London
Wakefield	Pinderfields Hospital	Mid Yorkshire Hospitals NHS Trust	Yorkshire and The Humber
Wales - Swansea	Morrison Hospital	Swansea NHS Trust	Wales