

NHS Emergency Planning Guidance 2005

Mass Casualties Incidents: A Framework for Planning

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Contact Details	DR PENNY BEVAN EMERGENCY PREPAREDNESS DIVISION RICHMOND HOUSE 79 WHITEHALL LONDON SW1A 2NS 020 7210 5740
For Recipient's Use	

NHS Emergency Planning Guidance 2005

Mass Casualties Incidents; A Framework for Planning

Best Practice Guidance

Consultation Version 14 November 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 and policy to assist the NHS to plan for a major incident of extremely serious proportions involving potentially large numbers of casualties – i.e. casualty numbers that are beyond the capacity created by the local implementation of major incident plans - or other major disruptive challenges to the delivery of health care, regardless of their cause.
2. Conventional accidents, public health emergencies - such as outbreaks of infectious diseases - or the accidental or deliberate release of radiological, chemical or biological material might all cause incidents with mass casualties. Although the probability of some of these events may be considered low, their impact would be significant and even potentially catastrophic to some functions of the NHS. Each will require some specific contingency and remedial measures, but this framework focuses on those generic aspects that all NHS organisations need to consider, in developing their plans, the ability to respond to such events, whatever the cause.
3. 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
 - Burns – published for consultation 3 October 2006
4. 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.
5. 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.

6. 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.
7. The responses outlined in this guidance should only be considered appropriate in the event of emergencies that comply with the definition above. 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.
8. 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.
9. 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 mass casualties incidents 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.
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.
11. In the context of this Guidance the terms Acute Trust and Non Acute Trust are used to cover both NHS Acute and Non Acute Trusts and Foundation Trusts.

The term Primary Care Organisation is used to refer to Primary Care Trusts, Care Trusts and any other organisation with responsibility for the provision of NHS primary care services.

BACKGROUND AND CONTEXT

12. NHS organisations have previously demonstrated their ability to deal with major incidents, but now need to demonstrate their ability to prepare for, and respond to, events that may result in patient numbers well in excess of those used in past planning assumptions. This requirement sits in the context of cross-government work to ensure that local communities are more resilient to a range of major disruptive challenges, whatever the cause.
13. Even considering the most serious major incidents the NHS have experienced to date, patient numbers have not been on the scale that could be described as mass casualty incidents. The table below shows how this contrasts with other parts of the world that have experienced natural disasters such as floods, hurricanes or earthquakes. Incidents resulting in very large numbers of casualties have fortunately not occurred in UK during the past few decades, but following the terrorist attacks in the United States on 11 September 2001 and subsequent attacks in Bali, Spain and London, this has set the level and pace at which planning for such incidents must now be considered. Furthermore emerging infectious diseases, including a global influenza pandemic, would result in significantly high numbers of the population becoming ill. Therefore, the potential for incidents that produce larger patient numbers has increased, and there is now a need to be prepared to respond to incidents of a different scale and nature than might previously have been thought.

Figure 1 Examples of complex incidents

Incident	Location	Fatalities	Injured
Terrorist attack on the World Trade Centre	United States	2993	8700
Bomb in a nightclub	Bali	202	300
Multiple bomb attacks to a transport system	Madrid	191	1900
Multiple bombings across the city	London	52	650
Nightclub bombings	Israel	15	40
Truck bombs	Istanbul	27	450
Spanish flu 1918/1919 pandemic	World wide	250,000 (UK)	unknown
SARS outbreak	30 countries	900 (worldwide)	8000 (worldwide)

14. Detailed and revised NHS guidance on major incident planning was published by the Department of Health in October 2005, and this consolidates various guidance issued immediately after September 2001. As part of wider cross government work on resilience planning, a comprehensive cross-

departmental civil protection programme was established to strengthen planning and ensure greater resilience to a wider range and larger scale of disruptive challenges. This framework forms an important part of that programme and integrates into the processes being developed as part of the Capabilities Programme. This framework has therefore been developed as an annex to the NHS Emergency Planning Guidance (2005) for dealing with major incidents and supports the overall objective stated in that document:-

'To ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries'

15. The NHS Emergency Planning Guidance 2005 sets out the preparedness and response principles that should be applied to local planning for major incidents. This framework should be read in conjunction with that guidance and covers incidents which fall into the 'Mass' and 'Catastrophic' level¹ i.e. that which threaten severe disruption to health and social care and exceed the collective local capability available in the NHS.

¹ NHS Emergency Planning Guidance Sept 2005, Department of Health Emergency Preparedness Division, p.14, section 2.3

Response Framework

NHS Level	Description	No of Casualties	Local NHS Response	Regional Response	National Response
Major	Individual trusts handle incident within current and long established major incident plans	10's	Local NHS organisations activate local command & control arrangements. Participate in local multi-agency command arrangements	SHA advised for information only	None required
Mass	Larger scale incident with possibility of involving the closure or evacuation of major health facility or persistent disruption over many days. Collective mutual aid response required from neighbouring trusts.	100's	Local NHS organisations activate local command & control arrangements. Participate in local multi-agency command arrangements, SHA advised. All trusts link in to SHA Strategic Command arrangements. SHA co-ordinates mutual aid across the region.	SHA command & control activated to co-ordinate the health care system across the region. DH Emergency Preparedness Division notified. Consider the implementation of revised clinical treatment protocols	DH EPD available to support SHA as required. Facilitate requests for national mutual aid support. Participate in the cross-government response. Brief ministers
Catastrophic	An incident that is of such proportions that it severely disrupts health & social care and other support functions (for example, water supply, electricity supply, transport etc). The required response exceeds collective local capacity	1000's	Local trust plans activated. SHA advised. All trusts link in to SHA strategic Command arrangements. SHA co-ordinates mutual aid across the region	Potential for more than one SHA region to be directly affected by the incident. Each SHA activates their Strategic Command Arrangements. SHA contributes to Regional Civil Contingencies Committee DH EPD notified	DH EPD national co-ordination centre activated. National co-ordination of NHS strategic response and mobilisation of national mutual aid efforts Participate in cross-government response including Devolved Administrations.

STRUCTURE OF THE FRAMEWORK

16. Planning for incidents with mass casualties will need to reflect local circumstances, available capacity and build on what is already in place. This framework aims to provide practical guidance to inform and assist NHS organisations and healthcare providers - in partnership with other agencies - to plan their response effectively. It sets out to:
 - Define a mass casualty incident for NHS purposes
 - Look at some of the specific challenges they present to health services
 - Suggest some possible operational contingency measures.
 - Consider the co-ordination and communication aspects.
17. Due to the varying and complex nature of mass casualty events, this guidance should be seen as a framework for incident managers and emergency planners to use when planning for and responding to such incidents. The strength in applying this framework is for the response, and management to the emergency to remain pragmatic and flexible during what will be a most challenging experience for all concerned.

DEFINITION OF A MASS CASUALTY INCIDENT

18. For the purposes of this framework a mass casualty incident is defined as:

“a disastrous single or simultaneous event(s) or other circumstances where the normal major incident response of several NHS organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response”

By definition, such events have the potential to rapidly overwhelm - or threaten to exceed - the local capacity available to respond, even with the implementation of major incident plans.

19. The basic operational principles for dealing with an incident which results in mass casualties are the same as for a major incident and all NHS organisations must have contingency plans that:
 - demonstrate that they fully understand the potential scale and nature of the disruptive threat(s) to their organisation and any actions that may be needed, through involvement in multi-agency risk assessments in their area.
 - include appropriate measures to prevent an incident, if possible, or to mitigate its effect on the health of the community.

- place particular emphasis on inter-operability and mutual aid - both within and between Strategic Health Authority regions, and with the Devolved Administrations where appropriate.
- consider measures to utilise all existing NHS capacity in acute, primary and independent care settings more intensively, taking into account the need for a sustainable response.
- recognise the potential need to expand existing capacity to cope with larger numbers of patients, including the possibility of introducing revised treatment protocols.
- include proposals to utilise and deploy staff differently where that is required.
- facilitate joint working by adopting common core systems and equipment as far as that is practical.
- promote and support a return to normality as soon as feasible.
- undertake a structured debrief

SOME PARTICULAR CHALLENGES

20. Mass casualty incidents will involve a step change in the demands that are made on **all** parts of the NHS and partner organisations. Doing more of the same is unlikely to be adequate - organisations and their staff will need to adopt a different approach to their planning and response for such incidents in order to cope. For the response to work effectively there needs to be a whole systems approach into the way healthcare is delivered. This means all sections of the NHS, including Primary Care Organisations, Foundation Trusts, the independent sector, and voluntary sector partners need to be considered in any strategic emergency pre-planning work as well as the operational response.

21. Some of the factors that distinguish a mass casualties incident from a more typical major incident are its likely scale, duration, intensity and the probability that there will be other compounding factors such as loss of services/infrastructure, shortage of essential supplies or the possibility of civil dislocation. They are likely to involve greater numbers, both in terms of casualties and fatalities, and could involve either incidents occurring simultaneously, or at multiple sites (either in close proximity or more widely spread). It is also likely that there will be significant media and public information challenges, which should be considered in local planning.

22. In any of these incidents four typical groups of patients are likely to make demands upon the NHS. In addition, the demand for information from families of patients also needs to be considered. Each patient will present specific clinical and managerial challenges in the areas of triage/treatment, capacity, co-ordination and communication across a wide area. Local NHS contingency measures therefore need to arrange for:-

- Treatment of those seriously ill or injured as a direct result of the incident- who requires immediate treatment and care – will probably need admitting in to an acute setting.
- Those affected by the incident who - although not obviously or immediately suffering any serious illness or injury, need assessment and diagnosis, advice or treatment, may need subsequent monitoring and ongoing support that can often be better provided in a non acute or primary care setting.
- Those people who are neither ill nor injured but require information, advice and reassurance. Often referred to as the ‘worried well’
- In addition, planning and response will need to ensure continued services for those who fall acutely ill (e.g. heart attack etc) but are not part of the major incident.

However, it must be remembered that all patient types including patients who are being admitted from the wider population, will need to be treated against a back drop of available healthcare capacity.

Types of Incidents producing mass casualties

23. **Big Bang Incident** – a serious transport accident, explosion, or series of smaller incidents:

Caring for an increased number of potentially seriously ill or injured patients in the immediate aftermath of an incident(s) is almost certain to require different response measures. These may include remodelling triage protocols and increasing treatment capacity at the scene, or using all available resources and assets. This may include the use of non-NHS estate through the improvised use of other buildings and structures. This type of response could include buildings in the primary or community care settings or local authority or private premises with whom local agreements should have been made in planning for such incidents. Exploring and developing all such options during the planning phase will be vital in supporting the operational response.

24. Rising Tide Incidents, sometimes referred to as '**Cloud on the Horizon**'
Rising Tide– a developing infectious disease epidemic, or a capacity/staffing crisis. Cloud on the Horizon – a serious threat such as a major chemical or nuclear release developing elsewhere and needing preparatory action

One of the more challenging types of major incidents to respond to is a 'rising tide' event or 'cloud on the horizon'. These types of incidents evolve over a period of days or weeks, first with a slow impact, but then leading to a prolonged period of high impact disruption. These types of incidents can develop for a number of reasons. Some might be the result of a 'big bang' incident (for example at a chemical installation) which initially produces no trauma casualties. However, over the proceeding days, the immediate population around the incident may start to present to primary care with signs and symptoms which are the result of a plume from the incident. Specific types of rising tide incidents could include emerging infectious diseases, such as Severe Acute Respiratory Syndrome (SARS) or an influenza pandemic. These types of incidents will present very different challenges to those of a big bang and will need longer term crisis management input to ensure a sustained and effective response. The demand on the primary care sector will be greater and more sustained, with the potential need to consider focusing treatment at home rather than within the hospital environment, freeing in-patient capacity for the most seriously ill. During any rising tide incident there will be a need to ensure public information is available, and this will be crucial in promoting self-help advice allowing clinical staff to prioritise their time to the neediest patients.

25. The NHS will need to consider not only the clinical response, but also the wider impact of the incident on healthcare resilience. A rising tide event will place extreme resilience challenges on NHS infrastructure and support services, It is vital that all healthcare providers have robust business continuity management plans particularly regarding around the issue of staff resilience.

For further information, see www.dh.gov.uk/emergencyplanning

- 26. Chemical, Biological, Radiological and Nuclear (CBRN) incidents** present different challenges for all responders, and the NHS is no exception. In some CBRN scenarios the rapid decontamination of significant numbers of casualties will be critical both to the well being of the patients and the management of the incident. All Ambulance Services must therefore maintain effective arrangements for the rapid deployment of trained ambulance teams and for supplementing or relieving those teams by mutual aid.

27. In the event of large numbers of people requiring decontamination, fire service mass decontamination capability will be deployed to support the ambulance service. A local memorandum of understanding (MoU) should be

in place between the regional ambulance service and the fire & rescue services within the region, and should clarify roles and responsibilities. The memorandum and associated procedures must make clear how NHS staff use fire service decontamination facilities to process casualties where that improves throughput of injured patients. In addition, SHAs should ensure that all acute trusts (including Foundation Trusts with A&E departments) within the region have similar MoUs in place with fire & rescue services to agree procedures to support hospitals capability to decontaminate large numbers of self-referrals.

28. Every NHS Acute Trust needs to develop internal plans for implementing rapid action to protect their capacity available by ensuring it retains control over access to its facilities. This may require planning for enhanced security measures to ensure access can be restricted to a single point of entry (likely to be in the vicinity of the Emergency Department). Hospitals with Emergency Departments should plan for a rapid expansion of the capacity of those facilities, and for supplementing staffing. Such plans will need to link to, and complement, the emergency services and Local Authority plans for multi-agency “command and control” of major incidents.
29. Trusts should have discussions with police forces locally about the public order and control issues which could be associated with this level of self presenters, and should consider how they would handle such an influx of potential casualties. Any such plan must take into account that casualties may also be contaminated, and therefore the health & safety of NHS staff needs to be maintained. Plans should also ensure that messages to the public can be disseminated in an effective manner and link into media management plans both within the NHS but also with other partner agencies especially the police.
30. Responding to a CBRN incident will often require a wider health response than just at the scene. There will also be a need to pass vital information to the public, which provides ‘self help’ advice. Providing this advice early in an incident will assist in reducing the numbers of self-referrals to other parts of the healthcare system. Staffed by senior nurses and guided by clinical decision support software, NHS Direct is ideally placed to rapidly implement sleeping algorithms which can be activated either on information that an incident has occurred, or when increased numbers of patient types are identified.
31. A covert CBRN incident will only first become apparent due to an increase in patients presenting for treatment. These patients may self refer over many days at several different locations, often within a primary care settings such as GP surgeries. Effective and rapid public health monitoring and health intelligence will be vital in identifying and containing the escalation of any such incidents. NHS Direct will play an important part in health surveillance

identifying trends in illness across the population. This work will be further enhanced through pre-agreed GP sentinel practices, which are in place across the UK to support enhanced monitoring of the health of the population. Wider health monitoring is also carried out by the Health Protection Agency, principally through local health protection units. All parties involved in health monitoring and surveillance must ensure that any data, that needs to be shared during an incident, is shared in a timely and efficient manner. Further guidance on how responding agencies can share data is available from the Cabinet Office website.

www.cabinetoffice.gov.uk/ (TBC)

32. All hospitals with Emergency Departments will have equipment, preparations and general capability for decontamination of small numbers of casualties, and this equipment (and staff training) must be maintained to allow for rapid deployment if required. However, it is accepted that most hospitals would be put under severe strain by the scale and circumstances of an incident producing mass casualties that are contaminated. In developing their mass casualty plan, NHS organisations will want to work in close collaboration with the emergency services and with neighbouring NHS primary and secondary care providers. Issues that will need to be addressed will include -
- control of the site (including lockdown),
 - mass decontamination
 - dealing with self-referrals.
 - crowd management
 - the ability to create triage/assessment facility as an adjunct to the Emergency Department to avoid cross contamination and unnecessary attendance within Emergency Departments.
33. A hospital at the “heart of the storm” may particularly struggle with these demands, to the extent where its ability to maintain basic functions is challenged. The Strategic Health Authority will have a role to take an overview of the incident and the response and then help determine locally how the consequences are to be managed as part of the multi agency command and control response. This responsibility may be delegated to a PCO by explicit agreement depending on local circumstances and the nature of an incident.

Evacuation of the local population

34. When considering incidents with the potential for mass casualties, there is a need to consider planning for the health consequences of the displacement of a significant number of the population. Whilst large scale evacuation will only be actioned as a last resort, health emergency planning must recognise, that for significantly disruptive incidents (e.g. wide spread flooding) then large numbers of the population may need to be moved to a place of safety. Any large scale evacuation of a population will need a multi-agency response, and

the health sector will play a vital role in the process. Whilst separate specific guidance will be issued on evacuation planning, the key elements which need to be considered by the NHS are:

- Maintaining primary care services to the population being evacuated, including special measures to offer support during the physical period of evacuation.
- Treating those people who have been injured during the evacuation process
- Considering whether displaced patients have suitable access to the medication they need to control their chronic underlying conditions.
- Through close working with social services, identifying and giving support to vulnerable people and their families within the community being evacuated.
- All acute trusts and in-patient care facilities should have plans in place to effect an evacuation if required. However, such plans should ensure that any evacuation of a hospital is seen as a last resort.
- All SHAs and the constituent NHS organisations must have plans to accommodate the provision of healthcare services for an influx of significant numbers of the population that may have been evacuated from a wider geographical area than have been considered previously.

For further information on large scale evacuation can be found at www.ukresilience.info

And health specific guidance at
www.dh.gov.uk/emergencyplanning

Case Study

Thousands of race goers were evacuated from the 1997 Grand National meeting at Aintree. More than 1500 people were accommodated in emergency rest centres in Liverpool. GPs from the deputising service were deployed to make sure that people had emergency replacement medicines and their other health cares needs were met.

Case Study

Following the terrorist attacks in the USA in September 2001 and the disruption to air travel, a number of people were stranded at UK airports. The local PCT and ambulance services had to provide healthcare support to members of the public, with a special focus on chronic illnesses (e.g. diabetics etc) and provision of routine medication. Medical teams in association with social services also needed to manage the care and welfare of those people who returned to the UK having lost relatives in the attack.

35. Currently across the UK there are strategically placed 'PODs' which contain extra kit and equipment which can be deployed to a wide range of catastrophic incidents. These PODs are arranged to cover CBRN exposure,

equipment (e.g. ventilators, dressings) and drugs. In addition, extra kit and equipment is also stored at some rail and transport hubs. It is the responsibility of nominated regional ambulance services to maintain this kit and equipment at a high state of readiness and be in a position to deploy these PODs when requested. All requests from health professionals for these PODs to be dispatched should be made via the regional ambulance service control rooms (currently under review).

36. Whilst the PODs are held within regions, it must be remembered that each POD is part of a national resource and as such can be called upon to be used anywhere in the UK. Mobilisation and transport plans should reflect this requirement.
37. NHS Supply Chain the principle supplier of consumables and equipment to the NHS, has contingency plans in place to increase re-supply to trusts during a major incident. All trusts should ensure that suitable arrangements are in place to contact their suppliers on a 24/7 basis to ensure that supply chains to trust can be maintained during an incident.

Incidents overseas

38. Recent global events have identified the need for the UK to be ready to receive UK citizens (both patients and worried well) who have been involved in a catastrophic incident outside of UK shores. Whilst the immediate life saving element of the response will be managed locally, depending on the type and scale of the incident there may be a need for UK health assets to be engaged in multi-agency reception arrangements, mainly at principle airports. Experience suggests that these types of incidents are infrequent and each one will require a different response. Therefore for these types of incidents, Department of Health Emergency Preparedness Division (DH EPD) will link into the wider cross government response and liaise direct with the relevant SHA(s) which may be affected by any repatriation or evacuation of UK citizens back to the UK, post incident. Although the majority of the people returning will present with only minor conditions, some people may have significant injuries which have been unnoticed during the evacuation process. Therefore it is important that suitable triage and clinical assessment processes are established at the receiving air and sea ports.
39. Sometimes the level and scale of the disaster overseas may prompt medical professionals in the UK to consider how they may be able to give direct assistance to the country affected. Whilst it is for each individual to make that judgement. It must be considered how this offer of assistance will dovetail into other international relief efforts. DH EPD as part of the cross government response, will work with colleagues in other government departments to identify any support which may be needed, and where appropriate circulate requests for assistance to the NHS.

40. Separate arrangements are in place for the reception and treatment of military personnel injured overseas.

Case Study

On the morning of 26 December 2004 an earthquake measuring 9.3 on the Richter scale occurred off the coast of north-west Sumatra in Indonesia. The earthquake triggered a tsunami (a large sea wave) that struck the coasts of thirteen countries. The disaster struck during a peak holiday season and it is thought that approximately 10,000 British nationals were in the affected region when the tsunami struck. The Department of Health worked with other government departments and the NHS to coordinate the health and social care response to people returning to the UK on aircraft coordinated by Foreign and Commonwealth office.

Developing capacity and sustaining patient care.

41. During any type of incident, producing mass casualties, managing capacity will be a significant challenge. NHS organisations must consider how they can increase and maintain extra capacity in the event of an incident involving large numbers of patients requiring treatment. For a 'big-bang' incident, although the demand in Emergency Departments may peak after several hours, it may still be very focused on one or two particular clinical specialities including theatres, critical care etc. During a 'rising tide' incident, the impact would be less immediate, but build over a period, peaking after several days affecting both clinical care and NHS business continuity. Both types of incidents will have a longer term impact on healthcare and staff which will need to be managed.
42. Incidents producing mass casualties have the potential to cause pressure on a wide range of clinical and patient care services, all of which would need to be utilised to the maximum. Depending on the circumstances of the incident, capacity may be limited by significant damage to the NHS infrastructure, for example, hospital buildings damaged by the blast from an explosion or the ability for the NHS to operate without full utility services, for example loss of electricity supply. It is therefore vital that all providers of healthcare services and NHS organisations develop robust Business Continuity Management plans that reflect the need to maintain critical clinical and managerial functions during periods of disruptive challenges.
43. Commissioners of healthcare services should ensure, as part of the contracting process, that providers have a clear and agreed understanding of what would be expected of them during a major incident, especially one involving mass casualties. Further to this, commissioners and SHAs should include providers of healthcare in any pre-planning and exercise and testing.

Further guidance can be found in the National Contracting Framework for Commissioners and Providers.

website link tbc

The best care under the circumstances.

44. Every day, the NHS manages the care and well-being of many people. Decisions around the clinical care of patients is often made as part of multi-disciplinary teams of specialists, providing in depth and complex care within established clinical protocols and guidance. However, during an incident that produces mass casualties, there may be a need to expand the capacity of certain types of specialities due to the type of incident, for example burns, paediatrics, etc. Under these circumstances, there may need to be a temporary re-alignment of treatment protocols to reprioritise patient care. Whilst this will be for senior clinical leads to decide at the time and considering the circumstances, the aim during an incident producing mass casualties is to provide the best care, under the circumstances, for the greatest number of people. The process already takes place in part during smaller major incidents and utilises triage protocols to determine rescue, treatment and evacuation priorities. However, this is predominantly used in the pre-hospital or emergency department settings.

45. Figure 2 shows illustrative planning assumptions that can be used to calculate the potential numbers of patients in each category. It is also vital for Trust plans to consider early in the activation stage of a major incident what the real-time point of criticality is, as internal factors (e.g. theatre closed for maintenance) will have an impact on the numbers of patients categories a trust may be able to manage.

Fig 2. Illustrative planning assumptions for preparing for mass casualties.

Category	Patient condition	% of total
<i>P1</i>	Casualties needing immediate life-saving resuscitation and/or surgery	25%
<i>P2</i>	Stabilised casualties needing early surgery but delay is acceptable.	25%
<i>P3</i>	Casualties requiring treatment but a longer delay is acceptable	50%

Managing Clinical Care

46. Doing the greatest good for the greatest number will require changes to clinical practices and acceptance that it may not be possible to deliver patient care to the same standards, clinical protocols and guidelines that normally apply. Consideration must be given to the fact that incidents could occur which would be beyond those for which hospital buildings are designed to cope, and that this, combined with potential staff constraints, would have an impact on the way in which patient care could, and would, be delivered. Clinical input to identify the scope for adapting 'normal' clinical practices are essential to the development of an effective plan, which must recognise that in these circumstances, extraordinary measures will mean doing something outside normal practice. There should also be consideration of how the return to normal services will be achieved and managed, including the impact on staff morale.
47. Contingency plans should also include active measures to supplement the maximum bed capacity available in acute hospitals. Plans must consider and discuss the use of non- acute NHS facilities, any independent sector capacity and/or the pre-identification of suitable accommodation that could be utilised if required in conjunction with Local Authorities.
48. All Primary Care Organisations need to ensure that providers of healthcare for their populations (e.g. General Practices and Community Services, independent sector providers) are planning to manage the impact of an incident that results in a large number of casualties affecting their service and staff. Plans should include developing integrated plans to set up and provide facilities - preferably away from acute hospital sites - to assist in the triage, diagnosis, treatment and support of those patients who are not obviously seriously ill or injured. They should also consider contingencies to maintain patients in the community and limit or avoid referrals to acute hospitals as far as possible. Plans should also consider the extent to which community staff and general medical practitioners could be deployed to supplement acute services if that is required. These plans need to consider issues around clinical indemnity and support for colleagues who may be working in a different environment to their normal place of work. Consideration must also be given to the role of NHS Direct in both the provision of advice and the triage of those patients using the service. NHS Direct is an essential part of the response to any incident, ensuring that appropriate advice can be provided and that only those patients who need to access primary or secondary care in an emergency do so. The aim of this whole systems approach to healthcare under these circumstances must be to admit to hospital only the most seriously ill or injured.

For further information, see www.dh.gov.uk/emergencyplanning and www.dh.gov.uk/Consultations/LiveConsultations/LiveConsultationsArticle/fs/en?CONTENT_ID=4137699&chk=kW4mza

Staffing and Workforce Planning

49. The greatest constraint on expanding capacity is staff, and NHS organisations need to have appropriate Business Continuity Plans (BCP) in place to bring in additional staff across their local area. However, such plans must recognise the possibility of transport and communication disruption, which has the potential to impact on the numbers of staff available. These plans should also recognise the fact that staff (or their families) may well be victims of the incident, particularly if it is in the locality. This could potentially have a considerable impact on staff attendance and this must be considered when planning. Plans must also consider that staff of all grades may find it difficult to focus on the response (including leading the response) until they are reassured that their family and friends are safe and well. Consideration should also be given to the need for counselling support for staff involved in a response from an early stage.

Case Study

Following the bomb attacks in London on the 7th July 2005, the entire London Underground system was shut down. Whilst the system needed to shut for public safety reasons, this had a knock on impact to the NHS as a number of staff used the underground to get to work.

50. Workforce contingency plans should also focus on pre-identifying (and enhancing) the emergency care potential/skills of all staff, directing staff effort to key emergency roles, and sustaining activity levels well beyond the initial response phase. Careful planning should ensure that all available extra staff are not utilised within the first few hours/or days of an incident, but staggered and rolling increases are considered to follow the peak demands which may appear throughout the incident.

51. These plans should also consider further training that would be required by those who would play a leading role in responding to and managing such an incident. This must include command and leadership training across the full spectrum of staff grades in all NHS organisations.

52. Staffing contingency plans should consider including pre-identified part-time staff who are willing to work additional hours. This may include staff employed by other organisations, including independent sector providers, qualified non-practising staff and those who have recently retired. However, planning assumptions of numbers of staff available you should be considered against the fact that part-time staff may have already been considered in the 'head count' of another organisation.

53. Qualified staff working in non-patient contact areas such as R&D, clinical audit or education and training should also be identified and consulted on how their skills can be utilised back within a clinical setting. Any discussions should also recognise that refresher training may be needed and may need to be programmed in to individual's regular training calendars. Effective planning can identify a process for using staff in key roles such as the "Voluntary Services Co-ordinator" or equivalent. These roles are critical support functions, but may not require a clinically trained member of staff.

Case Study

During the bombings in London on the 7th July 2005, a number of doctors and clinicians from the London Helicopter Emergency Medical Service (HEMS) were attending a clinical review meeting in the capital. When the bombing occurred, the group reported for duty and deployed by land and air to the numerous incident sites.

Creating additional capacity

54. There are issues about the sustainability of arrangements, which involve existing staff working longer hours or more intensively, and the health and safety aspects of such arrangements. It must be recognised that staff can work exceptional hours but for only a short period. Staff should receive clear information about what would be expected of them in an emergency and include appropriate training.

55. Trusts and PCOs should identify unused physical capacity which could be brought into use in an emergency. This might include disused wards within NHS hospitals or intermediate care or community beds, or capacity in the independent or private sectors. Other less conventional options such as utilising hotels or schools or colleges may also need to be considered for less clinically dependant patients, and where appropriate included in local planning. Local Authority emergency planning officers will be able to provide further advice in utilising other types of buildings.

Case Study

On the 28th February 2001 in North Yorkshire, a commuter train derailed after hitting a car on the East Coast Main Line and collided with a goods train. Ten people died and many more injured. The ambulance service utilised a large agricultural building near the scene of the crash to set up a Casualty Clearing Station (CCS) to triage and treat patients before transferring them to hospital. Seventy patients were finally transferred from the scene to six hospitals across two regions. Through establishing a temporary treatment centre in the near-by building, this allowed the most appropriate patients to be transferred in an appropriate manner by both ground and air ambulances.

56. Planning should also include using existing capacity more intensively to create extra capacity for a higher level of dependency. For example, some community or intermediate beds could be used to deliver acute care or general acute beds to create additional capacity for critical care or burns cases (with specialist staff). These plans should be consistent with plans to create additional hospital capacity for major outbreaks of infectious diseases.
57. Equipment and supplies issues should be addressed through local plans. These should be linked to national arrangements for stockpiling of CBRN countermeasures. Supply chains for critical items should be assessed and where necessary made more robust with consideration being given to the establishment of local stores holding a limited stock of priority items for use in an emergency.

Freeing existing capacity

58. The number of staff and the availability of other resources to deal with patients affected by a mass casualty incident can be substantially increased by re-directing the existing NHS resources, which are used to provide elective care towards emergencies. It is essential that a clear audit trail be maintained for any decisions that would affect any organisation's ability to deliver the full range of "normal" services, including those against which organisations is performance managed. However, it is also important that this does not impair the ability to deal with what is, by definition, a challenging and exceptional situation.

Case Study

On the 5th October 1999, two trains collided outside Paddington Station London. 31 people were killed and 500 were injured. The London Ambulance Service declared a major incident and within 2 hours, 250 beds were made available across the NHS in London. Due to the incident occurring early morning, theatre lists could be cancelled or amended.

59. Capacity in hospitals should be freed by accelerating discharges where this is not to the detriment of the care of the patient. This should include bringing forward the discharge of elective patients, wherever possible, for example, by providing post-operative care in community settings. Plans should also include the prompt discharge of patients whose transfer from hospital care to the community has been delayed eg where suitable long-term community placement is not available. Arrangements should be made for discharge to the community of as many such patients as possible including temporary discharge to community settings without prejudice to their preference for their long-term care.
60. Plans for accelerated and temporary discharge of patients from acute beds should be developed in close partnership with primary and social care

providers. Trusts and PCOs should also make plans with primary, community and ambulance services to minimise the number of patients presenting at Emergency Departments during the mass casualty incident and arrange to treat as many patients as possible in the community setting.

61. The demand for increasing capacity in the community setting will require PCOs to plan closely with social care providers and local authorities to develop and utilise capacity outside the hospital environment. Community nursing teams, home helps, and home carers can play an important part in ensuring that patients discharged early can be cared for in the home. In addition, this type of care will be vital in maintaining critical in-patient care capacity through reducing the need for patients to be re-admitted post discharge. This would be crucial during a rising tide incident.

Mutual Aid and wider support.

62. Most NHS organisations have good working relationships with their immediate neighbouring Trusts, which during a major incident allows for any peak in capacity to be absorbed. However, for a mass casualty incident it may be more appropriate to have formalised mutual aid frameworks agreed in advance. Community teams support the early discharge of patients from hospital to allow beds to be released for critically ill patients to be admitted. Patients are often transferred to neighbouring hospitals if specialist capacity is needed, for example, critical care beds. However, during an incident with mass casualties, there will probably be a need to utilise capacity over a much wider geographical area than would otherwise be considered. Mutual aid may take many forms including lending staff or equipment, providing specialist staff, for example, as part of a Burns Assessment Team or MERIT team, or agreeing to take patients from the affected area. Many existing arrangements such as clinical and Critical Care Networks already have the characteristics of mutual aid arrangements and any new arrangements for dealing with incidents involving mass casualties should not cut across these.
63. All mutual aid arrangements must be produced in advance of any incident and regularly updated and tested through exercises. Issues such as compatibility of systems and procedures and interoperability of equipment should be addressed at this planning stage. Consideration should also be given to ensure professional clinical governance issues are also addressed.
64. To achieve the best possible care under the circumstances, patients may need to be transferred to different parts of the country. The UK now has a number of air ambulances, which if utilised for inter-hospital transfers over greater distances, can make long distance transfers more clinically acceptable, freeing up vital local ambulance and healthcare resources. It is therefore recommended that trusts and ambulance services engage with local air ambulance organisations to develop, at the pre-planning stage, a casualty

dispersal plan, which may be more geographically spread than originally considered. This should also include the ability to receive casualties from other regions. Where possible, air ambulance organisations should consider the need to develop cross regional co-ordination of aero-medical assets during incidents with mass casualties, ensuring their potential patient benefits can be maximised. Consideration needs also to be given at the planning stage to the use of air assets to transfer resources rather than patients, for example, specialist staff and equipment.

Case Study

In June 1998, an inter-city passenger train crashed near the German town of Eschede 100 people were killed and nearly 300 people seriously injured in the incident. A number of air ambulances responded to the scene and air lifted the patients to numerous hospitals. Due to the location of the incident, a small number of patients were air lifted to hospitals outside Germany, as air ambulances returned to their base hospital. The police then had to spend time tracing where patient had been transferred. This identified the need for more co-ordination of air assets deployed to the scene of major incidents.

65. Effective mutual aid across the health sector requires leadership and co-ordination by SHAs who must take the lead in guaranteeing availability of practical mutual aid within their region and across boundaries into neighbouring SHAs and the Devolved Administrations. Many incidents with mass casualties are likely to have an impact over a wider area than a single PCO or NHS Trust. It is essential that Strategic Health Authorities are satisfied that robust arrangements are in place within their region, and with neighbouring SHA regions.

Military Assistance

66. The UK government has an established mechanism for requesting assistance from the UK military during major incidents. However, it should never be assumed that military assistance would automatically be available or would be available without a lead in time. With the exception of immediate life saving action, any requests for UK military assistance will need to be carefully considered and should be directed at the time of the incident via the regional SHA strategic command teams. Certain requests for military assistances need to be directed via the requesting government department. Therefore, SHAs will need to work closely with DH EPD to ensure that any requests are processed in a timely and effective manner.

For further information on military aid to civil authorities can be found at <http://www.mod.uk/NR/rdonlyres/66E32920-1B30-4E37-A057-9FA26E07CC/0/ijdp02.pdf>

Acute Trusts

67. Acute Trust plans should build on local specific contingency measures that allow them to maximise their bed availability and rapidly free up capacity in conjunction with community and primary care partners. Those plans should include procedures for-

- ceasing all elective activity,
- identifying patients suitable for rapid discharge
- supplementing available equipment, and
- alternative use of specialist/ day care beds.

68. It is recognised that the capacity within specialties such as burns, paediatrics etc, during an incident with mass casualties may need to draw on support from further a field than local mutual aid plans cover. Some of this type of capacity may be best co-ordinated nationally through DH EPD's Major Incident Co-ordination Centre.

69. Whilst the focus of effort by the NHS must be to the living, during any major incident, including a mass casualty incident, there is the potential for a number of fatalities. The police will manage those fatalities at the scene however, those who die within the hospital setting will need to be managed in accordance with normal hospital procedures, but considering any specific issues for example infection control. However, depending on the nature of the incident, the principle problem will be the dignified and suitable temporary storage of the deceased. This is especially the case during an influenza pandemic. Further consideration will need to be given if it is the result of a CBRN incident, and special arrangements for example access to gas tight body bags. All Acute Trusts should develop plans that detail how excess deaths would be managed. These plans will need to be developed in conjunction with the local authority and the police, and dovetail into other standing arrangements.

Further information on managing fatalities can be found at the Home Office website <http://www.ukresilience.info/publications/fatalities.pdf>

70. Following a mass casualty incident, large numbers of the general public will be seeking information about friends and relatives who may have been affected by the incident(s). Therefore, hospitals should have, as part of their major incident plans, a mechanism to manage a significant number of people making contact either in person or via telephone and internet access, seeking information about patients that have been admitted. Whilst sharing information may be difficult or inappropriate, working with the police, plans should be in place to handle those seeking information in an effective and sympathetic manner. If people seeking information are handled in a positive

way, this will give confidence that whilst their enquiry may not be able to be answered fully at the time, they will be confident that their concerns are being managed. Any such plans must be developed in association with local police forces and Local Authorities to dovetail with any provision of Family Assistance Centres (or Humanitarian Assistance Centres) and the activation of the Casualty Bureau, which maybe established. Failing to achieve this will only increase the anxiety of those seeking reassurance about relatives, and increase their search for information.

Ambulance Services

71. Ambulance services need to have plans in place to develop capacity to rapidly deploy greater numbers of vehicles, staff and equipment to the scene(s). Establishing early command, control and triage arrangements at the scene(s) will be critical. Planning to supplement the resources available through rapid mutual aid and by additional steps such as the formation of ambulance service reserves will be vital to expanding capacity. The use of non-emergency crews or support from local Voluntary Aid Societies (St John and British Red Cross²) needs to be explored at a local level. Most ambulance services operate first responder schemes, and this may be a source of additional support staff for use during a major incident.
72. Developing these plans further is likely to be dependant on local resources, which will vary around the country. However early discussions during the planning phase will allow local plans to reflect local capacity. As with using other volunteers, pre-incident training will be vital in developing a robust response.
73. Additional measures to release experienced ambulance personnel from the transport role would improve triage and treatment capability at the scene and make additional trained personnel available for specialist tasks such as decontamination. Emergency Care Practitioners may be usefully tasked with more appropriate triage, treatment and discharge at scene or supporting the primary care effort at local authority rest centres. Effective use of medical care services including Immediate Care Scheme (BASICs) doctors at the scene will also make a key contribution.
74. Due to the potential scale and physical disruption to buildings and structures, releasing entrapped casualties may take longer and be more complex than other types of incidents. It is important therefore that medical personnel, co-ordinated and led by the ambulance service, develop and train to work with fire and rescue service personnel who are practiced in the role of Urban Search and Rescue (USaR). Working as a team of specialists, this combined fire and medical skill will ensure that vital (and potentially limited) clinical and rescue resources are used to the patients best affect, safely. Due to the

² Also includes St Andrew Association in Scotland.

complex nature of this work, a Memorandum of Understanding (MoU) between the fire and rescue service and the regional ambulance service should be agreed which clearly states the roles and responsibilities of the two services when engaged on USaR work. The MoU should also clearly specify how joint training should be established between the two services and how a robust and resilient response capability will be maintained. Whilst the MoU for USaR is different to the CBRN MoU, the two must complement each other.

Protecting and sustaining capacity

75. A high priority during mass casualty incidents is to limit the extent to which the incident, or its consequences degrades, and affects the care of victims of the incident. An incident may disrupt essential public infrastructure and plans may need to include the protection of hospitals and other NHS resources at a time of civil dislocation.
76. Plans should address both short term and long-term issues and acknowledge that full recovery from the mass casualty incident may take months or even years. Short-term issues will include the sustainability of arrangements which involve staff working additional hours and the ongoing care of critically ill patients within the hospital prior to the mass casualty incident.
77. Local NHS organisations should develop their plans in partnership with other Category 1 and 2 responders (police, fire and rescue services, Health Protection Agency (HPA) Local Authorities etc) and interface with local and regional resilience forums, and other organisations. Plans may need to include more specific plans such as media handling arrangements, or the interface with social services which details helping to care for patients decanted from hospital. Depending on the type of incident, in association with the HPA and the Regional Director of Public Health/SHA Director of Public Health, communication strategies will be needed to be agreed to help with the cascade of public health information.
78. Utilising retired medical staff or medical students may produce some additional capacity. For medical students, the ability to gain experience during a major incident has the potential to be a valuable part of their training. However, there is the need to ensure that clinical governance issues, including insurance indemnity is considered before these staff groups are operationally deployed. Trusts who rely on these staff groups to support and increase capacity must ensure that suitable and effective training (including refresher training) is provided.

Strategic Command Arrangements

79. Whilst it is recognised that for the majority of major incidents, local inter-agency command & control mechanisms will be sufficient, for bigger, more wide spread incidents, further strategic co-ordination of the NHS may be needed.
80. For incidents producing mass casualties, there is a need for the NHS response to be co-ordinated as a whole system, each provider of healthcare services playing an important, but interlinked, part in the response to the incident. Due to the complex nature of the response, Strategic Health Authorities and their Regional Directors of Public Health will have a pivotal role in this co-ordination.

Strategic Health Authorities

81. All SHAs must have plans in place to co-ordinate healthcare across their region. The principle foundation to this will be the ability to provide strategic direction and leadership during, what will be, very challenging times for all responding agencies. SHAs should have a robust around the clock capability to establish an NHS strategic command group that will draw together senior representatives from local healthcare providers. During the planning phase, it will be important that agreement is reached between all healthcare providers that due to the magnitude and potential level of disruption to essential services, the SHA needs to have consensus to set the strategic priorities for the NHS and healthcare for the duration of the incident. The SHA will also need to consider the recovery element of any mass casualty incident and any post crisis response, not only to the health of the population but also to healthcare staff.
82. In providing strategic co-ordination, the SHAs plan must ensure that any arrangements dovetail in with regional resilience structures at regional government offices, and recognise that local resilience arrangements, potentially through lead PCOs, may have already been up and running for sometime prior to the escalation of the incident. This will usually be through a multi-agency Strategic Coordinating Group (SCG) or multi-agency 'gold command'. Further information on the Regional Civil Contingencies Committees and Local Resilience Forums can be found at the Cabinet Office website www.ukresilience.gov.uk

Case Study

Yorkshire & Humber SHA produced a strategic plan that clearly sets out how the local and regional health economy will interface with resilience mechanisms. Through local lead PCTs, interface with local resilience forums is maintained with links back to other local PCTs, Mental Health trusts and acute/FT trusts. The SHA represents the NHS at a regional level as a member of the Regional Resilience Forum (RRF). A regional health emergency planning forum, chaired by the Deputy RDPH, has been established as a sub-group of the RRF which brings together all sections of the health economy (including the HPA) to ensure a multi-health approach to resilience planning is achieved through sharing of best practice from both a local and regional level.

83. Conversely, the SHAs may be briefed by the Department of Health Emergency Preparedness Division of the certain threats and hazards that might have an impact on the delivery of healthcare. In these circumstances, it will be for the SHAs to assess this information and cascade to local healthcare partners as necessary.
84. A senior director, usually the Chief Executive, will need to take the management lead with appropriate senior clinical support, and along with their senior management team, will need to ensure that testing and exercising of the strategic command arrangements routinely takes place. Any exercises must be developed to reflect the fact that during the incident, there may be many disruptive challenges to overcome, and accurate and timely information may be in short supply. Exercising and testing should also include interfacing with neighbouring SHAs as it would be reasonable to assume that due to the scale of the incident, more than one region could be affected at anyone time.

Linking the Regional Response to National Co-ordination.

85. It has already been stated that major incidents are best co-ordinated at a local level. Even incidents which affect a whole region are often best left to those regions to respond using local networks and resources. However, due to the scale, duration, or level of disruption, local and regional NHS responders may well be overwhelmed and need to call on mutual aid from areas and organisations who they do not normally interface or exercise with. An example of this may be the need to utilise a particular medical speciality such as burns beds, which requires a response from across the UK. In these circumstances, the Department of Health's Major Incident Co-ordination Centre (MICC) in London may need to be activated to give support to SHAs. Alternatively, a number of simultaneous incidents may have occurred across the UK or internationally, which collectively require a national overview of the impact and demand on healthcare resources. Again, the MICC would fulfil this role, but would be sharing information back to regions as necessary.

86. In the event of a national health emergency, for example influenza pandemic, then the MICC would be established to act as the lead government department's co-ordination centre and would link into local and regional response structures via the SHAs.
87. Due to the nature of the incident, it may also be necessary to provide accurate and timely briefing as part of the central government response to an incident. In these circumstances, the Department of Health's Emergency Preparedness Division (EPD) may need to liaise with SHAs, but not formally activate a full MICC in the first instance.
88. A 24-hour major incident line number (0845 000 5555) is operational which, out of hours, ensures the on-call DH EPD duty officer is contactable and the appropriate response can then be actioned.

Co-ordination and communication

89. Multi-agency command and control arrangements (known as the Strategic Coordinating Group or 'gold command') across police force areas would provide the basis for linking in the co-ordination of the local NHS response with partner agencies. However, responding effectively to an incident on this scale is likely to require a degree of central health co-ordination and control which is beyond that seen in the day to day management of the NHS.
90. The impact of a genuine mass casualty incident is likely to severely challenge the management capacity of individual NHS organisations. Local NHS organisations must understand the need for a management structure in a mass casualty incident to make decisions beyond those which could possibly be planned for. However, they will want to have a clear understanding of how things will be organised and particularly who is directing resources.
91. The NHS Emergency Planning Guidance 2005 makes clear that the Department of Health will establish national co-ordinating arrangements if an incident escalates outside the capacity of an SHA region or where the incident has a national impact. This will involve a national operations room to support SHAs management of the incident at local level and to act as a focal point across Government, including with the Devolved Administrations.
92. Whether the response to an incident is being co-ordinated by the SHA or the Department of Health centrally there needs to be a clear understanding of the chain of command, where control centres are and how arrangements are to be activated. SHAs must make it clear with all NHS organisations within its boundaries what would be the trigger points for escalation of local health command arrangements to regional health coordination, including for how long they were intended to apply, and also the process to be used for a return to normal arrangements.

93. There must be clear co-ordination and communication throughout the structure and at all stages. This will involve:

- Co-ordination across organisations within SHA or regional plans to link the various NHS parts of the response to the incident.

- Prioritisation at the centre and then clear communication to the NHS so that organisations can respond in relation to those priorities.

94. There must be effective communication with other agencies and the public. Communications on operational NHS issues, such as where to go for treatment or advice, must be closely tied to public health information provided by the SHA Directors of Public Health and HPA. This must include NHS Direct, as a vital element of any communications strategy. These integrated health communications strategies must in turn be linked to communications plans of the Government Offices for the Regions and local government, and where necessary with the Devolved Administrations.

95. There will also be a strong desire from the public for authoritative information on all health aspects of the incident: health risks arising from the original incident, self care, how to get treatment, and any further potential hazards to health. Consideration needs to be given to the use of NHS Direct to ensure that consistent health messages are available and to help reduce the pressure on other health services. There may be a great deal of inaccurate information circulating about the health affects of the incident and possibly some degree of public anxiety. This should form part of the co-ordination of the multi agency Gold Command, to ensure that public anxiety is kept to a minimum.

96. Following any major incident, it is crucial that a full debrief is completed to identify lessons learnt. This should be seen as an important milestone in the process of returning to normality.

Summary

97. Dealing with any incident that produces mass casualties will be a significant challenge to everyone who is engaged in the response. The impact on staff and patients and the public should not be underestimated. Whilst most people working in the NHS have experience of working during difficult and pressured incidents, responding to some of the more catastrophic events can only be achieved through pragmatic preplanning and regular training and exercising. Any training and exercising needs to be built on what is already in place. Key to this will be building and maintaining confidence in staff of all grades to work under extreme circumstances, and this will set the foundation for delivering the best patient care possible to all those affected. There will be

interdependencies between teams internally within the NHS but also multi-agency teams externally, but only through viewing the response as a whole systems approach to delivering health care during a crisis of this scale will the most appropriate treatments be delivered to the most number of people. It must be remembered that each and every member of staff will play an important part in the overall response to a mass casualty incident.

Members of the Mass Casualties Working Group

Phil Storr* (Chair)	Department of Health EPD
Dr Colin Pollock*	Regional Public Health Group
Mike Saunders*	East of England HPA
Helen Braithwaite & Chris Gohlich*	West Midlands Regional Resilience Team
Mandy Mackenzie*	Civil Contingencies Secretariat
Mike Lindley	Confederation of Helicopter Ambulance Services
Ian Shuttleworth	Local Government Association
Rachel Hitchman	Department of Culture, Media and Sport
Adrian Crowe	South Manchester NHS Trust
Harry Scott	Scottish Executive Health Department
Claire Ellis	Welsh Assembly
Gary Locker	Association of Chief Police Officers
Mike Hayward	Royal College of Nursing
Nick Morgan	Ministry of Defense
Siobhan Jones	Department of Health GHP
Will Snell*	Department of Health EPD
Steve Conroy*	Department of Health EPD
Russ Mansford*	Department of Health EPD
Verity Kemp	Department of Health EPD
Gordon MacDonald	Centre for Emergency Preparedness & Response HPA
Kerry Chaplin	Home Office

* Also members of the core project group