PREPARING FOR EMERGENCIES
WHAT YOU NEED TO KNOW

# Yorkshire & the Humber Mass Casualty Framework for Health

## Version 1.0 FINAL – March 2019

## Version Control

| Date | Version | Status | Author(s) | Update comments |
|---|---|---|---|---|
| 29.05.2018 | 0.1 | DRAFT | Sarah Tomlinson | Adapted from North East & Cumbria Framework for implementation by Yorkshire & Humber Mass Casualty Steering Group |
| 06.09.2018 | 0.2 | DRAFT | Sarah Tomlinson | Discussion and amendments via consultation with Yorkshire and Humber Mass Casualty Steering Group |
| 21.11.2018 | 0.3 | DRAFT | Sarah Tomlinson | Updated to reflect discussions with Yorkshire Ambulance Service and ODN's |
| 27.12.2018 | 0.4 | DRAFT | Sarah Tomlinson | Updated to reflect amendments to pre-hospital care and Yorkshire & Humber Mobile Emergency Response & Intervention Teams |
| 11.03.2019 | 0.5 | DRAFT | Sarah Tomlinson | Review of document in conjunction with the National Clinical Guidelines for Major Incidents and Mass Casualties. |
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## References


| The references listed below have been used throughout this framework, therefore are not listed in any particular order. |
|---|
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| Developing Dynamic Lockdown Procedures, National Counter Terrorism Security Office; November 2015. |
| Joint Doctrine: The Interoperability Framework, Joint Emergency Services Interoperability Programme (JESIP) 2nd Edition July 2016. [ http://www.jesip.org.uk ] |
| Management of Conventional Mass Casualty Incidents Ten Commandments for Hospital Planning [ https://www.researchgate.net/publication/6796964 ] |
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## Table of Contents

## 1 Executive Summary

This Mass Casualty Framework for Yorkshire & the Humber brings together the work undertaken by both Local Health Resilience Partnerships across Yorkshire & the Humber and key individuals who have led this imperative work stream.

The Mass Casualty Framework will act as an overarching document for health in Yorkshire and the Humber will support all mass casualty plans across the various health economies. It highlights the key aspects that are required to be prepared and resilient in addition to giving the ability to respond in a cohesive, **co-ordinated**, effective and collaborative manner to a mass casualty incident.

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

In the development of this framework, looking to these recent tragic incidents and others to endeavour to ensure that our emergency preparedness, resilience and response to a mass casualty incident is as accurate and seamless as possible; incorporating Joint Organisational Learning (JOL) which has been highlighted and what actions need to be taken forward from the harsh lessons that have been learned.

## 2 Framework Structure

This framework is structured to provide and explain the background to mass casualty planning, the underlining planning assumptions and the specific roles of the NHS and local authority in their planning and response actions.

**Embedded within the framework's appendices are guidance cards for specific organisations to utilise within their individual incident planning.** The guidance cards outline the minimum that each organisation would deliver in response to a declared mass casualty incident.

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

## 3 Background

Global terrorist attacks and the ever changing tactics of terrorist groups across the World require the United Kingdom to continually review and improve arrangements for response to mass casualty incidents.

The NHS will have a significant role in the response to incidents that fall within this remit and as such need to maintain operations which support that response, putting in place arrangements which provide the best care possible and focus on the interests of all patients that are affected.

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

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

Similarly mass casualties may result from incidents not terror related such as multiple vehicle road traffic collisions or rail crashes. The NHS and its partners need to be prepared for such incidents.

This framework is primarily designed to **supplement** existing local and multi-agency emergency preparedness arrangements in Yorkshire and the Humber, to ensure that we can meet the Cabinet Office (2015) national planning assumptions in relation to mass casualties. It is focused on facilitating the response to conventional and non- conventional incidents.

Conventional incidents are normally a sudden impact event or an emergency, which may result in up to large numbers of casualties occurring in one or more locations simultaneously. In addition to this Yorkshire and the Humber has a supplementary Mass Casualty response which sees the deployment of Advanced Casualty Clearing Stations (ACCS) which provide support and care to those injured whilst waiting for transportation and capacity within receiving units.

Conventional incidents are defined as those that cause traumatic injuries (involving internal/external catastrophic haemorrhage, burns and fractures, etc.) and/or fatalities and **do not** contain any chemical, biological, radiological or nuclear elements. They also cover for example, incidents such as an influenza pandemic and major flooding. These types of incidents are not covered in the framework and should be part of specific local plans. Non-conventional incidents include those caused by Marauding Terrorist Attacks (MTA) including active shooters or explosions in crowded areas.

## 4 Aim

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

All NHS organisations and local authorities in Yorkshire and the Humber are expected to have plans that underpin this framework and address the requirements of these and other mass casualty scenarios. The requirements are explained in this document.

## 5 Objectives

This framework is intended to support commissioners and providers of NHS funded care and local authorities in preparing their plans to respond to a mass casualty incident. It takes the indirect format of a patient pathway and provides guidance on the:

- planning assumptions,
- declaration and activation procedures,
- key responses required of all organisations,
- command, control, coordination and communication structure,
- defined models of care,
- information on relevant capacity and clinical resources,
- information about supporting resources,
- psychological impact,
- ethical impact,
- legal issues,
- Forensic evidence.

It also provides insight into post incident matters such as legal issues, management of forensic evidence, management of the deceased and the recovery process; in particular psychological support.

## 6 Definition

NHS England defines a Mass Casualty incident for the health services as an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage.

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

## 7 NHS Planning Assumptions

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

- All NHS organisations and organisations providing NHS funded care have an up to date mass casualty plan in place or be part of a joint plan if appropriate,
- All NHS organisations and organisations providing NHS funded care have accelerated discharge and admissions criteria within their surge plans,
- All Acute Hospital Trusts will aim to empty 10% of their total bed base within 4 hours and a total of 20% of their total bed base within 12 hours from incident declaration in order to be able to receive large numbers of casualties (both directly and to support flow across the region)
- Critical Care Units must have plans in place to double their Level 3 equivalent bed capability and maintain this for a minimum period of 96 hours (Adults & Paediatrics)
- Receiving Hospital Trusts will have arrangements in place for routine contact / follow-up of all incident patients who receive treatment from them, including those with minor injuries and those discharged the same day.
- Receiving Hospital Trusts will have arrangements in place for contact/follow-up of all non-incident patients who leave their Emergency Department to seek alternative healthcare, or require additional follow up post discharge.
- All Acute Hospital Trusts must have the ability to provide those with minor injuries appropriate medical provision. Following triage all walking wounded casualties, Priority 3s, should be streamed to a predetermined designated location in a clinical area away from, but co-terminus with their emergency department for treatment.
- All ambulance services will manage appropriate health care at the scene; these may include Casualty Collection Points (CCP), Casualty Clearing Stations (CCS) and Advanced Casualty Clearing Stations (ACCS)
- Access to specialist services should be maintained during a Mass Casualty Incident – Casualties or Patients (BAU) requiring time critical interventions at a specialist centre (Burns, PPCI, Trauma, Vascular) should be communicated to the Yorkshire & Humber Health Gold Cell where NHS England and YAS will identify a receiving hospital and transport plan for the patients (including staffing plans and transfer requirements) in order that the Trauma Unit clinician can liaise directly with the specialist clinician at the receiving site

- NHS England will liaise with the Northern Trauma Network, Critical Care Network, Paediatrics and Burns networks to consolidate patient pathways at local levels,
- NHS England will coordinate any requests for mutual aid from provider organisations in conjunction with Regional and National C3 arrangements
- Providers of NHS funded community services have plans to rapidly enable community services to respond to assist with accelerated discharge and to help avoid admissions into acute settings,
- All NHS organisations and organisations providing NHS funded care have business continuity management plans for their critical functions. Those arrangements include mechanisms for redeploying staff and resources to services under the most severe pressure,
- All NHS organisations have policies and practiced plans for the lockdown of buildings and sites and for partial and complete evacuation,
- Mutual aid arrangements between NHS organisations will be managed at local, regional and strategic levels depending on the need,
- All NHS organisations have training and exercising programmes in place for existing plans which dovetail into the LHRP and Local Resilience Forum (LRF) multi–agency work programmes,
- The North (NHS England) regional communications team will liaise to form common internal and external messages, which will be cascaded to local teams,
- NHS Blood and Transplant, NHS Supply Chain and the UK Reserve National Stock for Major Incidents are integral to local plans.
- All Health Economies should have arrangement in place to facilitate the rapid discharge of patients requiring transport without the reliance on the local ambulance provider

### 7.1 Scenario Specific Planning Assumptions

The scenarios considered in this framework are ‘sudden impact’ or ‘big bang’ events, for example a serious transport incident, explosion or series of incidents that have an immediate effect on health services. However, incidents elsewhere involving marauding terrorist attacks (MTA) have demonstrated that the numbers of casualties may be difficult to determine.

Casualty movement into acute settings may take many hours and Acute Hospital Trusts may experience peaks of activity over a drawn-out period that are not typical of other sudden impact incidents that may involve mass casualties. Receiving hospitals and other responders should plan to sustain their initial response phase for up to 48 hours.

Likewise, the management of Casualty Clearing Station (CCS) at the scene will be vital for treatment of casualties as the incident progresses.

It may be necessary to identify a separate treatment and holding area for the management of P3 casualties dependent on the size and nature of the incident

Casualty numbers related to the two incident scenarios below are difficult to determine exactly so consequence management must always prevail, however:

- A marauding terrorist attack using explosives in a crowded area can result in an undetermined number of casualties with ballistic/fragmentation injuries.
  These injuries may be caused by high velocity firearms munitions and/or fragments of explosive devices and debris,

- A conventional explosive attack or attacks at one or more locations in an urban area can result in over a hundred casualties with bomb and blast injuries.

### 7.2 National Planning Assumptions for Mass Casualty Triage

| Priority (P) number category | Percentage |
|---|---|
| **P1 Immediate** | 25% of total casualty figures |
| **P2 Urgent** | 25% of total casualty figures |
| **P3 Walking wounded** | 50% of total casualty figures |

The characteristics associated with these scenarios can be summarised as:

- Large number of casualties,
- Ballistic injuries,
- Delays in moving casualties to appropriate acute settings.

## 8 Reasons for Declaring a Mass Casualty Incident

Declaring a mass casualty incident will be a judgement based on a combination of factors, including the number and types of casualties; but also the ability of local services to become overwhelmed. This declaration will then initiate the NHS England Yorkshire & the Humber command, control, co-ordination and communications arrangements, which will as a process step, ensure contact is made with the North Region EPRR Team or on-call officer.

The early involvement of strategic and national partners will support local services in getting access to expertise and resources for example military support from outside the area if required and will be the conduit into the overarching response.

The ability of local services to cope with demand may itself be affected if an incident has a direct impact on NHS sites or staff. The ambulance service will be the likely conduit for the declaration of a mass casualty incident in Yorkshire and the Humber.

An NHS organisation should consider an early declaration of a mass casualty incident if the number of casualties requiring non-specialist treatment is not manageable by the local NHS services without additional support from partners in ensuring the optimal treatment of casualties and in supporting the recovery of Business as Usual activities.

## 8.1 Specific Considerations on Declaring a Mass Casualty Incident

Once a mass casualty incident has been declared, there will be other considerations to be made alongside actual casualty numbers and pressures on clinical services that will support a decision to declare a mass casualty incident.

These considerations are:

- Media interest and scrutiny – is likely to be intense and reactive, it is vital that in conjunction with the LRF the Health sector provides information and support not only in response to the media enquiries but to those receiving hospitals
- Government interest – a situation reporting (SitRep) cycle will be influenced or decided by central government information requirements,
- Police response – not allowing access to casualties in the hot zone of the incident as this would put responders at risk, the responsibility to investigate crime and apprehend offenders which may affect the provision of care by NHS services.

***A mass casualty incident must be declared when the number of casualties caused by an incident or incidents threatens to overwhelm the combined resources of the NHS.***

A marauding terrorist attack or a conventional attack with explosives crowded area may cause this number of casualties and/or other pressures and should be declared a mass casualty incident at the earliest opportunity.

## 8.2 Responsibility for Declaring a Mass Casualty Incident

Any NHS organisation can declare a 'mass casualty incident'. However, as blue light responders, the Yorkshire Ambulance Service will usually be the primary NHS organisation that makes this declaration.

Without an ambulance service declaration, any other NHS organisation will ensure that their executive director on-call (or equivalent) and/or medical director is consulted before declaring a mass casualty incident.

The organisation must then inform the relevant:

- Ambulance service for cascading as normal,
- NHS England Yorkshire and the Humber on-call manager (as the NHS lead);
- Clinical Commissioning Group/s (CCG);

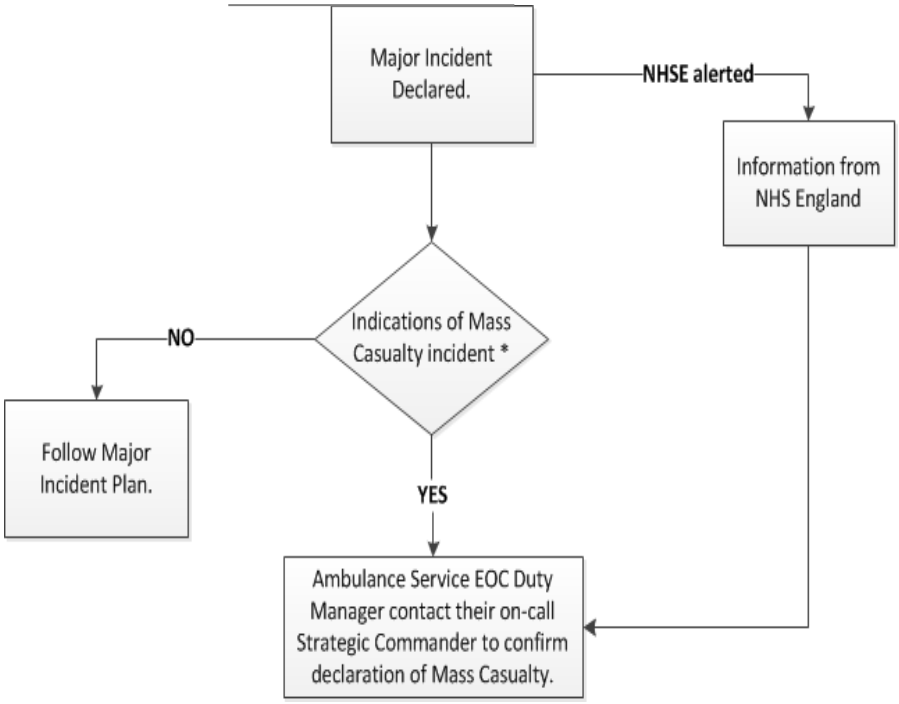
As with a major incident there will be procedures in place for the organisation to record the declaration, the reasoning behind it and for subsequent actions.

## 8.3 Declaration of a Mass Casualty Incident

Ambulance service staff will often be among the first to attend an incident scene and therefore will, in most cases, be the organisation that notifies NHS organisations of a mass casualty incident and will usually follow a major incident standby or declared notification.

This declaration will be cascaded in the same way as in a major incident. (The supporting EPRR National operating model response can be found in section 10.4.1 of this document).

### 8.3.1 Declaration of a Mass Casualty incident diagram.




*May include:

- Immediately apparent casualty numbers which would overwhelm standard major incident capacity,
- Immediately apparent requirement for national specialist assets (e.g. major structural collapse, significant firearms event, Chemical, Biological, Radiological, Nuclear and Explosive (CBRNe) attack, significant infrastructure disruption).

The initial mass casualty incident message will be issued as a 'METHANE' report in accordance with JESIP principles and the NHS England Emergency Preparedness Resilience and Response Framework. (*PDF version embedded below*)

https://www.england.nhs.uk/wp-content/uploads/2015/11/eprr-framework.pdf

### 8.4 Outcomes from Declaring a Mass Casualty Incident

In Yorkshire & the Humber, once a Mass Casualty Incident has been declared by the ambulance service, all 3 Major Trauma Centres, Leeds Teaching Hospitals, Sheffield Teaching Hospitals and Hull Royal Infirmary, will be informed by ambulance Emergency Operations Control (EOC) and will declare a 'Major Incident / Mass Casualty Incident' including the establishment of the hospitals' Incident Coordination Centre and Command & Control.

All Trauma Units (TU's) and Local Emergency Hospitals (LEH's) within the Yorkshire & Humber Trauma Network will be informed of "Major Incident Standby/ Mass Casualty Incident" by ambulance control. Trusts will move to a standby position, establishing their Incident Coordination Centre and Command & Control but awaiting further instruction upon actions to be taken, which will be determined when further assessment of the incident is undertaken by the ambulance service.

In addition, it is anticipated that as a minimum, the three geographically closest TU's/LEH's will **declare** a major incident and activate their Trust Major Incident Plan as they are close enough to the scene that they may receive casualties from first responders, or there is potential for casualties to self-present.

Trusts outside of this immediate area should establish their ICC and determine if a hospital Major Incident should be declared. Where agreed pathways are in place with the ambulance service, these must be adhered to.

Declaring a mass casualty incident will initiate NHS England Local and Regional command and control arrangements and establish coordination with other regions through the NHS England national office.
NHS England North Regional command and control arrangements will support the Yorkshire and the Humber Director of Commissioning Operations (DCO) office and their relevant commissioners and providers of NHS funded care to:

- Contribute to and receive information and reports (this may be in various forms)
- Receive consistent information from regional and national partners,
- Have a route to escalate issues that cannot be resolved locally,
- Implement a route for mutual aid,
- Work together to produce and issue communications messages,
- Stand up the National Ambulance Coordination Centre.

### 8.5 Restricted Access & Lockdown Arrangements

It is the responsibility of each organisations to dynamically assess the risk to their organisations and activate their associated lockdown plans accordingly in the event of any intelligence or incident which warrants it.

Depending on the nature of the incident, the ambulance services or police may also advise 'lockdown' takes place, it is however recommended that those receiving hospitals consider restricting access to their site as part of their incident response plans.

Where organisations undertake restricted access of formal lockdown of their sites this should be communicated to supporting organisations and staff who may be integral to the incident response.

Lockdown is the process of controlling the movement and access – both entry and exit – of people (NHS staff, patients and visitors) around a hospital site or other specific Trust building/area in response to an identified risk, threat or hazard that might impact upon the security of patients, staff and assets or, indeed, the capacity of that facility to continue to operate.

A lockdown is achieved through a combination of physical security measures and the deployment of security personnel. All Trusts must therefore ensure that arrangements are in place to cascade that message from their initial point of contact to all relevant services.

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

## 9 Activation & Command, Control, Coordination and Communication (C4)

Receiving hospitals notified of a mass casualty incident, or declaring a mass casualty incident themselves, must inform the appropriate local NHS England office and local CCG (or on-calls out of hours).

Command, Control, Coordination and Communication (C4) of the NHS response will be through the normal major incident response model with all organisations adopting the principles for joint working as documented in the Joint Emergency Services Interoperability Principles (JESIP). **Please refer to Appendix 1 and 2 for definition of incident levels and management of those incident levels.**

If declaring a Level 4 incident NHS England will enact its powers under section 252A of the NHS Act 2006 as amended by the Health and Social Care Act 2012 to take National Command and Control of the NHS and providers of NHS funded care. NHS England will direct these services to respond to the incident with National direction communicated through Regional and Director of Commissioning Operations (DCO) Offices, and direct to providers where necessary.

The multi-agency strategic command will normally be established at the local Police Headquarters and will be the Strategic Coordination Centre (SCC) for the Strategic Coordinating Group (SCG). In the early stages of any mass casualty incident all organisations are expected to manage their individual response using local Incident Response Plans.

CCGs may be asked to support NHS England by providing representation at NHS England's Incident Coordination Centre (ICC) working alongside the Incident Manager and reporting into the multi-agency Tactical Coordinating Group (TCG).

In the event of a Mass Casualty incident occurring in Yorkshire and the Humber the CCG in which the incident geographically occurs will take on the role of lead CCG.

Events of this nature will extend for a significant period of time and so it is imperative the level of command and control arrangements that are required over such a protracted period are sustainable. More broadly, releasing staff to undertake these duties and to maintain an effective rota will undoubtedly impact other services. Business Continuity arrangements will therefore have to be invoked.

### 9.1 Incident Coordination Centres

All affected health organisations and local authorities will need to establish their Incident Coordination Centres (ICC) in order to manage an incident of this nature.

The ICCs will serve as a focal point for all liaisons between the NHS and partner organisations regarding the incident.

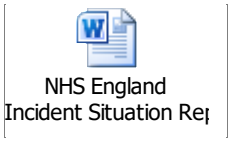
The main role of the local NHS England DCO ICC will be to:

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

### 9.2 Situation Reporting

Situation Reports (Sitreps) in a mass casualty incident will be as used for major incidents. The cycle of command will ultimately be determined by Cabinet Office Briefing Room (COBR) however in the early stages of the incident this is likely to be to a 'battle rhythm' established by the Strategic Coordinating Group linking into the multi-agency Tactical Coordinating Group and the DCO ICC management.

A copy of the national SitRep issued by NHS England is embedded below.



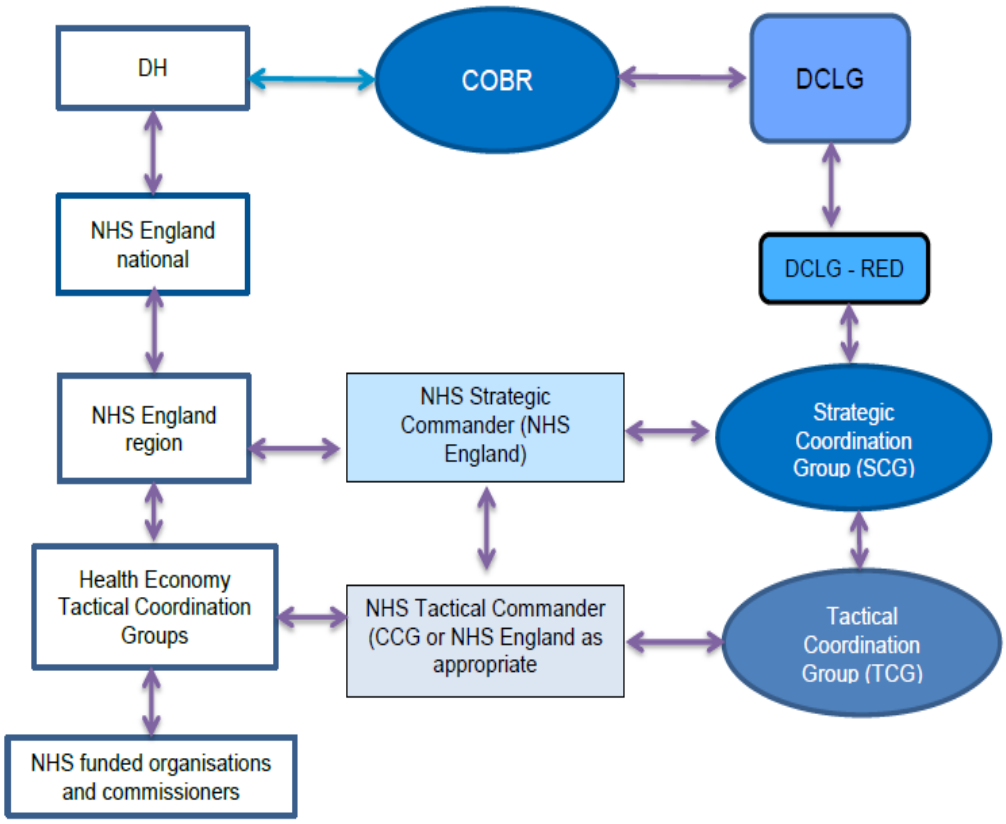

### 9.3 Performance Standards

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

### 9.4 Operating Model Response

The operating model response of all partners to a mass casualty incident will follow the national framework detailed in the EPRR Operating Model Response diagram below.

### 9.4.1 NHS EPRR Operating Model Response Diagram




## 10 Capacity and Capability Planning

When considering the numbers of casualties following declaration of a mass casualty incident, this will bring an immediate operational challenge to all health and social care systems, many of which are already functioning at or above capacity, placing a huge burden on the system.

Every effort will be made to maximise the outcome for the casualties including consideration for different ways of working. This will include the triage, treatment and transfer of some casualties to areas outside the local NHS facilities.

Equally a large number of casualties will have significant traumatic injuries and as such will be triaged in the Priority 1 category and transferred to the nearest major trauma centres (MTCs) and possibly trauma units as appropriate as the MTCs will be quickly overcome. More widespread MTCs across England will be invoked through the NHS England region and national command & control functions, alongside use of the other trauma units for initial stabilisation before transfer.

## 11 Mutual Aid

All requests for mutual aid will be coordinated through the local NHS England Incident Coordination Centre (ICCs) to the regional NHS England ICC for regional and possibly national management.

Given the numbers of casualties involved it is anticipated that the lead Ambulance Service will implement a request for mutual aid at the initiation of the incident affecting the National Memorandum of Understanding for Ambulance Services.

Upon activation of the NHS England Concept of Operations for the Management of Mass Casualties, the National Ambulance Resilience Unit (NARU) is responsible for activating the National Ambulance Coordination Centre (NACC). (*NARU on call will fulfil the functions of the NACC until mutual aid is fully established*).

The NACC will be responsible for:

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

### 11.1 Incident scene clinical support

Any clinical teams responding from other regions (for example out-of-area Air Ambulance services) must follow scene command procedure. Air ambulances will be briefed and tasked by the host ambulance service commander according to the nature and type of incident and in relation to the capability of organisations to receive casualties across the North of England.

Additional support will be sought through the existing agreements which may be in place with Community First Responders, British Red Cross, St. John Ambulance and spontaneous volunteers.

## 12 Critical, Trauma and Burns Care

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

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

Standard Operating Procedures (SOPs) published cover:

- Adult critical care services,
- Paediatric intensive care services,
- Burns services (adults and children),
- Adult respiratory extra corporeal membrane oxygenation (ECMO) services,
- Paediatric respiratory extra corporeal membrane oxygenation (ECMO) services.

### 12.1 Adult Critical Care (ACC)

The day to day operational management of ACC capacity is the responsibility of the Adult Critical Care Units with the 3 Yorkshire and Humber Critical Care Networks, having sight of the network footprint capacity.

The National Standard Operating Procedures (SOP) published by NHS England clarifies that all NHS Acute Hospital providers with Adult Critical Care facilities on site should follow these SOPs. In addition, the National SOP guidance should be incorporated within Critical Care Network and local Acute Hospital Trust escalation plans and viewed as part of the overall response to surge events.

### 12.2 Paediatric Critical Care (PCC)

The day to day operational management of PCC capacity is the responsibility of the Paediatric Critical Care Units with the Yorkshire & Humber Paediatric Critical Care ODN having oversight of the network footprint capacity.

The National Standard Operating Procedures (SOP) published by NHS England states that all NHS Acute Hospital providers with Paediatric Intensive Care facilities on site should follow these SOPs. In addition, the National SOP guidance should be incorporated within local Acute Hospital Trust escalation plans and viewed as part of the overall response to surge events.

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

In order to support patient pathways in response to severe periods of surge, the PICUs will work in liaison with Acute Hospital providers, Regional Leads and NHS England ensuring engagement with any telephone conference calls.

All ensuing relevant information will be managed through the normal Command, Control, Coordination and Communication (C4) arrangements.

### 12.3 Trauma Networks

Trauma networks have been established nationally from 2013 and operating within the Yorkshire & Humber.

This consists of 3 Adult Major Trauma Centres (MTC) & 1 Children's Major Trauma Centre:

- Hull Royal Infirmary
- Leeds Teaching Hospitals
- Sheffield Teaching Hospitals, and
- Sheffield Children's Hospital

Supporting and feeding into the MTCs are 12 Trauma Units:

- Airedale Hospital
- Barnsley Hospital
- Bradford Royal Infirmary
- Diana Princess of Wales Hospital, Grimsby
- Doncaster Royal Infirmary
- Harrogate District Hospital
- Huddersfield Royal Infirmary
- Pinderfields Hospital
- Rotherham Hospital
- Scarborough General Hospital
- Scunthorpe General Hospital
- York Hospital

The region is also supported by a number of Local Emergency Hospitals, Walk –in Centres, Urgent Care Centres and Minor Injuries Units.

In the event of a mass casualty incident the established ambulance bypass tool should be followed.

However it is appreciated that P1 and P2 patients may arrive at a Trauma Unit and these units should follow their own Trust Major Incident Plans, mindful of the fact that secondary transfer may not happen in the usual timely fashion.

### 12.4 Burns Networks

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

The inability of a burn service to maintain effective routine burn care to their local population because of a sudden demand on the service could also result in a burn service declaring a burn major incident. A burn major incident is an event which results in a significant increase in the demands placed on a specialised burn service and as a consequence the service cannot deliver optimal level of burn care using the routine resources available to the local burn service.

If a patient has other acute life threatening injuries they will be transferred on to the appropriate service which is required by their clinical needs (detailed in the table below).

Specific details of the management of burns patient can be found in the burns networks plans.

## 13 Responding to a Mass Casualty Incident

This framework contains details of the expected service provision from each stakeholder, acute hospitals, community hospitals, local authority and transportation agencies in responding to a mass casualty incident. The details are contained in separate organisation guidance cards accessible within Appendix 6 of this document.

Each organisation should seek to demonstrate within their Incident Response Plans the provision of the outline services.

## 14 Pre-hospital Care

The ambulance service is responsible for the management and coordination of an incident involving mass casualties. Their role is to ensure those that have been injured are triaged, treated and transported to the most appropriate receiving hospital or healthcare facility.

At the scene they will establish a comprehensive command structure, designed to ensure the safety of all medical personnel at the scene, provide access and egress for staff, vehicles, equipment and patients coming to and leaving the scene and establish a casualty clearing station.

Away from the scene the ambulance service will be working closely with NHS England colleagues to determine the receiving hospitals within the region and beyond where appropriate. Between them, they will identify the capacity across the Major Trauma Centres and Emergency Departments, the specialist bed availability and advise the Medical Incident Advisor (MIA), who will advise the Ambulance Incident Commander (AIC) at scene. This will determine where the casualties are conveyed to.

### 14.1 Scene Assessment

The first care will be provided as part of the triage process where immediate lifesaving interventions will be made in line with the triage process, however further care will be carried out by other clinicians that will be on their way to support casualty care.

It is not intended to go into the detail of the clinical care that will be provided at the scene within this document, rather a description of the resources and facilities that will be made available at the scene of a mass casualty event.

Clinical care may take place in a designated area such as a Casualty Clearing Station (CCS) and an Advanced CCS. Equally should persons be trapped, care will be given in their location by suitably trained and equipped staff (ie HART staff, Critical Care Doctors).

Wherever possible care will be of the highest standard given in all other circumstances, however this may have to be modified to suit the needs of the casualty and their surrounding environment. Any deviation from expected care will be decided by the Medical Incident Advisor (MIA).

The phases of care and be categorised as follows:

- Lifesaving first aid: By those involved or nearby to the incident before the emergency responders arrive and become established and as part of the triage process.
- Appropriate medical care: As you would expect from a Health Care Professional under normal circumstances proportionate to the patient's needs (this may need to be adapted to meet the casualty and/or environmental needs). This could range from supervision of minor injuries unit to advance life support.
- Advanced life support: As above however these casualties may need additional resources, medical interventions and support, especially if trapped.
- Specialist: In incidents where there are specific types of injuries and/or patient groups such as burns or children.
- Blood Borne Viruses (BBVs): It is a recognised complication of bomb injuries that implantation of human body projectiles, derived from other victims and from suicide bombers can occur; and that these projectiles create a potential risk of transmission of blood borne viruses (BBVs). All patients with lacerations resulting from a bomb blast should be advised to attend hospital for X-ray examination of their wounds and potential wound debridement, with onward vaccination and monitoring as required.
- Treat and refer: If directed to do so by the MIA and as the health economy will be under additional pressure, where it's safe to do so casualties with injuries suitable to be referred may be treated at scene or a designated casualty clearing station by a suitably qualified clinician and then advised to seek medical assistance later, such as their own GP practice or local minor injuries unit. This would reduce the impact locally in these exceptional circumstances without undue detriment to the referred casualty.
- Discharged: If directed to do so by the MIA, some casualties' physical injuries may be assessed as minor and therefore may be discharged by a suitably qualified clinician and provided with appropriate medical advice and passed over to the police and/or survivor reception centre.

### 14.2 Casualty Management

As soon as reasonably practicable casualties will be transferred from the incident via a variety of routes and methods such as;

- Self-evacuating and presenting at a medical facility: Often in the initial phase's casualties will leave the scene either under their own volition, or by others at the scene and seek the nearest medical care. This is well known to those involved in major incident management and reinforces the need to warn and inform the nearest hospitals first in the event of a major incident declaration.
- Direct to definitive care: Wherever possible this will always be the preferred action in order to provide the most appropriate care for the patient and minimize secondary transfer of casualties. However in a mass casualty incident, capacity to treat casualties is likely to be at a premium, so coordination of hospital capacities, particularly specialist beds will be overseen and coordinated by NHS England, in conjunction with YAS.

- Conveyance to an Advanced Casualty Clearing Station (ACCS): In a mass casualty incident the ACCS will be deployed and act as a buffer to the local health economy until the casualties can be transported to definitive care. The ACCS is designed to utilise the expertise of hospital-based staff (MERIT, with the appropriate equipment), in a pre-hospital setting, to enable sufficient time to identify and coordinate the transfer of patients to hospitals further afield, without detriment to patient care.

- Casualty Collection Point (CCP): In certain incident types, such as a marauding terrorist attack or chemical incident, there may be a need for specialist assets such as the Hazardous Area Response Team (HART), the Ambulance Intervention Team (AIT), or the Special Operations Response Team (SORT), to retrieve patients from areas not deemed safe for other responders and bring them to a CCP to be retrieved and conveyed to either a CCS, ACCS, or direct to a receiving hospital. This will usually be located near to the “warm/cold” zone.

### 14.3 Transport Options

There are several vehicle resources that can be considered to transfer patients from incidents, most commonly known are the ambulances that perform this duty every day for the Trust. However careful consideration has to be given by the Incident Commanders to ensure the appropriate transport method is utilised, even if this is not a traditional ambulance vehicle or vehicle operated by YAS.

Consideration must be given in these exceptional circumstances to maximising the available casualty carrying opportunities on vehicles providing safety and casualty dignity (including confidentiality) is not compromised e.g. carrying more than one patient on an ambulance, using the front passenger seat for casualties with injuries that allow them to travel there safely.

A summary of transport options is as follows:

- Standard A and E vehicles
- Patient Transport vehicles
- Other emergency service vehicles
- Air Ambulance Helicopters
- Other Helicopters such as Search and Rescue
- Public transport vehicles
- Local Authority vehicles, including social care vehicles
- Private and voluntary ambulance vehicles

At any scene it’s vital that access and egress routes are chosen that can make it easy to load patients with privacy where possible and that can be maintained as clear routes. Incidents can generate a large amount of vehicle movement most of which will not leave until the incident is resolved; the ambulance service is the exception and need to be able to move freely. This will be managed by the YAS Command team and usually will look to establish an ambulance circuit, to provide a free flow for transport in and out of the site.

## 14.4 Specialist Resources

In order to have robust resilience arrangements in place, all specialist skills are made up of people across YAS and the region and no specific skill is held by any one person. Where possible YAS adopts national policies, procedures and processes so that it can call upon other ambulance services in the form of mutual aid.

### 14.4.1 – HART

HART is the specialised small team of service staff who have been trained to administer lifesaving medical care in hostile environments such as industrial accidents, natural disasters, terrorist incidents and CBRN/Hazmat incidents. They are able to deliver this care whilst using a range of Personal Protective Equipment (PPE) which is not normally available to Ambulance Personnel and which supplements the YAS response to an incident as part of the wider team.

It must be recognised however that HART is a finite resource within each region so mutual aid may be required from outside of the Yorkshire & Humber for such large scale incidents or those of a long duration in order to respond to the incident and maintain business as usual service provision.

### 14.4.2 - Yorkshire Air Ambulance (YAA)

The YAA provide two helicopters for the Yorkshire region. They are staffed by two paramedics and a consultant level doctor. They can be activated to any incident to support the clinical care of patients.

### 14.4.3 - Decontamination Provider

Specially trained YAS staff that can wear the appropriate PPE, operate the national standard decontamination equipment and perform full wet decontamination on patients that require it.

### 14.4.4 - Ambulance Intervention Team (AIT)

These YAS staff have been selected and trained to provide clinical assistance to patients that have been involved in incidents where ballistic and or explosive devices maybe present and require the wearing of ballistic protection.

### 14.4.5 - HAZMED

Part of the HART team, the development of the HAZMED Advisor role has been driven by a need to offer support at incidents involving unusual elements such as chemicals, gas leaks, unexploded devices and major fires. The HAZMED usually works closely with the Fire Service equivalent HAZMAT whose role is to identify the substances and their potential impact as well as advising on the appropriate action to make safe.

The HAZMED can offer support and advice to operational crews, managers and communications staff as well as ensuring the wider health community is involved in real-time information dissemination from the scene through arrangements that have been put in place with Public Health England.

### 14.4.6 - Radiological Protection Supervisor (RPS)

The primary function of the RPS is to advise the AIC/MIA with regards to the health effects and potential risks to staff and patients at an incident involving ionising radiation.
This advice will be based on the type of radiation, the amount of energy emitted by source, the time exposed and any shielding between the source and the staff/patient. The RPS is available 24/7 and forms part of the national mutual aid arrangements. Support is available to the RPS from the Public Health England on call Radiological Protection Advisor.

### 14.4.7 - Medical Emergency Response Incident Team (MERIT)

This is a team of hospital-based clinicians, equipped and trained to support casualty care in a pre-hospital setting. In a mass casualty incident, the Medical Incident Advisor (MIA) would activate the Advanced Casualty Clearing Station (ACCS), the MERIT resource will be collected from the appropriate supporting hospitals and deployed to where they are required.

### 14.4.8 - British Association of Immediate Care Specialist (BASICS)

Should BASICs doctors be available their control/deployment will come under the command of the MIA and be deployed where they are deemed most effective. Their use may not necessarily be restricted to a scene; they may also be able to provide support to normal operations or the hospitals involved across the YAS region.

### 14.4.9 - Emergency and Urgent Care and Paramedic Practitioners

Emergency & Urgent Care Paramedic Practitioners are an ideal resource for treating P3 casualties (minor injuries), as they can then be discharged without the need to attend hospital. They can also be used to good effect in a Casualty Clearing Station including the Advanced Casualty Clearing Station or used to triage normal emergency calls with a view to deferring transportation to hospital or arrangement of an alternative care pathway.

### 14.4.10 - Patient Transport Services (PTS)

PTS can provide an integral part of the Trusts response to a major incident, however consideration wouldneed to be given to their contractual conditions, as some PTS are outsourced to commercial organisations and not under the command or control of YAS and would require the support of NHS England.

## 15 Casualty Triage

Triage of multiple casualties at the scene of the incident presents unique problems for those undertaking the initial assessment. This is largely due to the difficulty in assessing the large numbers of injured and dying. This initial triage is vital to reduce the need for secondary transfer of patients.

Effective triage of patients is a key component in ensuring that the right patients are sent to the right service and that the best interventions are done for the most. It should be noted that triage **categories** do change and that all patients should be re-triaged at each step in the casualty management chain until their initial triage on arrival at hospital at which point the organisations normal clinical escalation tools will apply.

### 15.1 Triage Priorities diagram

| | |
|---|---|
| P1 25% | Priority 1 – Most severely injured casualty requiring immediate lifesaving and invasive medical intervention |
| P2 25% | Priority 2 – Seriously injured requiring invasive medical intervention within a short period. |
| P3 50% | Priority 3 – Least seriously injured casualty requiring medical attention in the next few hours, commonly referred to as 'walking wounded' |
| P4 Expectant | Priority 4 – Those casualties identified as expectant are those thought to be for palliation and not active treatment. Use of this category can only be authorised by NHS England at a National level. |
| Deceased | Deceased victims must be left until last and must remain in situ at the scene until movement is possible |

## 16 Casualty Care Pathway

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

Casualty Collection Points (CCP's) can be used as an area where casualties can be moved to in order to undergo triage and life-saving treatment prior to moving into the Casualty Collection Station (CCS).

CCP's are not always required dependent on the nature and scale of the incident.

The aim of casualty dispersal is to deliver casualties to a place where definitive care can occur without overwhelming health resources and ensuring optimal treatment is provided to those injured.

The key strategic aim of casualty dispersal is **"Right patient, Right Place, First time".**

Casualties will be clinically assessed at scene to ensure they are dispersed to the site which can meet their specific health needs.

This clinical assessment is key to maintain the strategic aim of casualty dispersal.

For example – this does not dictate that the majority of P1 casualties will go to an MTC and most P2 casualties will be transferred to a TU or LEH – but that those casualties requiring specialist clinical intervention(Cardiothoracic, Neurosurgical, Vascular, Burns etc.) will go to an MTC for specialist care and those who may require invasive medical intervention but not requiring MTC intervention may be transferred to a TU or LEH who is able to meet their needs.

A regional plan for the casualty dispersal in the initial 2 hours of an incident has been agreed and Casualty Dispersal Chart is stated in Appendix 7.

During this early stage of an incident it is agreed that those managing the scene do not need to clear the transfer for patients to a hospital with the receiving unit.

Prior to the arrival of a Hospital Ambulance Liaison Officer (HALO) at the receiving hospital, casualties may well be transported without formal pre-alert due to the significant demand on services.

Wherever possible YAS crews will attempt to contact the receiving unit upon leaving scene, to provide an overview of the casualty's condition and an estimated time of arrival - **for clarity this is to share situational awareness and not to discuss the acceptance of the casualty with the receiving clinicians**.

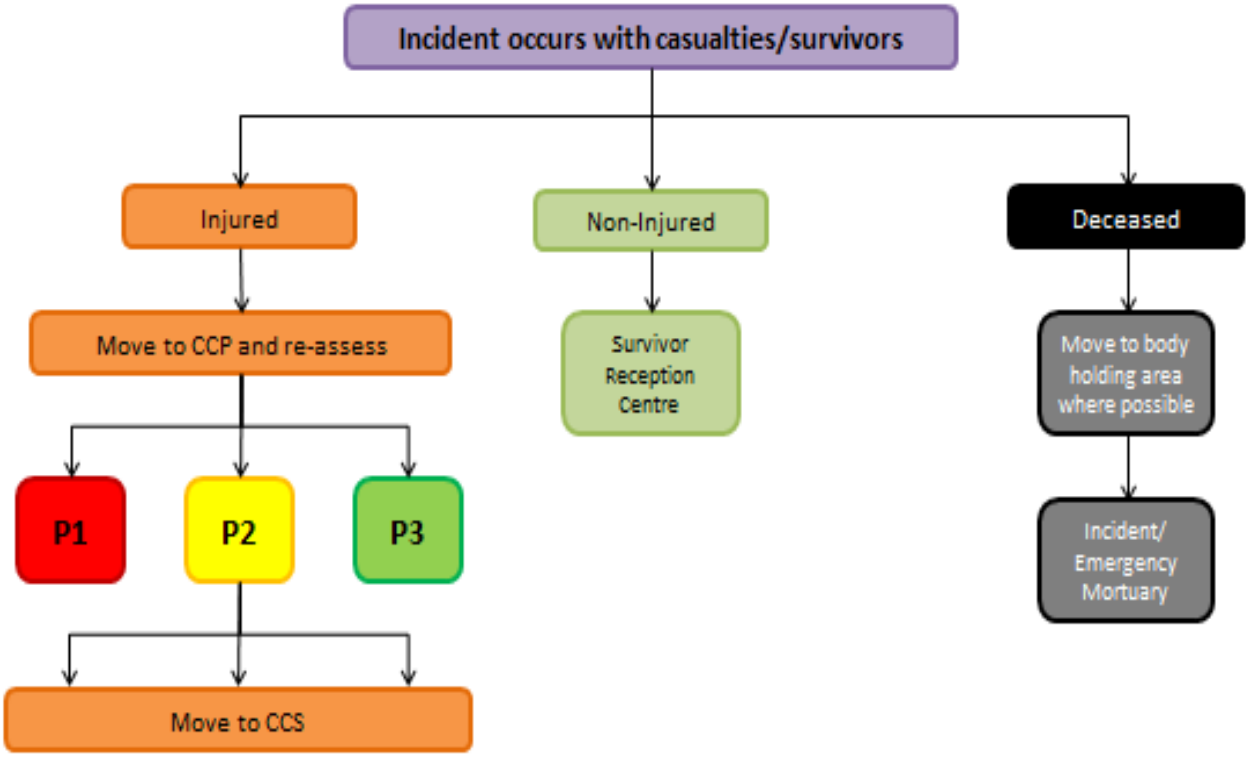
Current workload, availability of specialities (also detailed in appendix 9) and capacity of receiving locations must also be considered, along with the need to use extra-regional Major Trauma Centres.

Uninjured survivors should proceed to the Survivor Reception Centre.

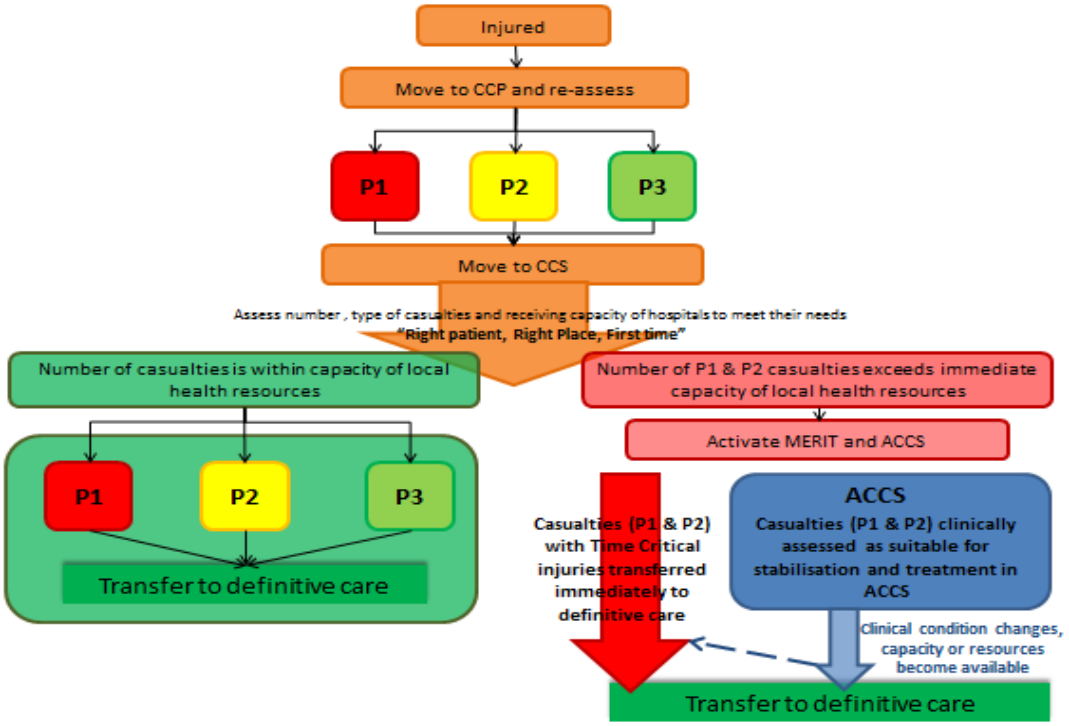
It is worth recognising as part of the Casualty pathway that there will continue to be patients requiring medical assessment and intervention irrespective of the incident occurring.

Business as usual activity – those patients will continue to present or be conveyed to receiving hospitals – patient dispersal during a mass casualty incident will be at the discretion of the lead ambulance service who will continue to transfer to nearest appropriate facility/make dynamic decision on resources across the wider regional footprint.

### 16.1 Casualty and Survivor Pathway diagram



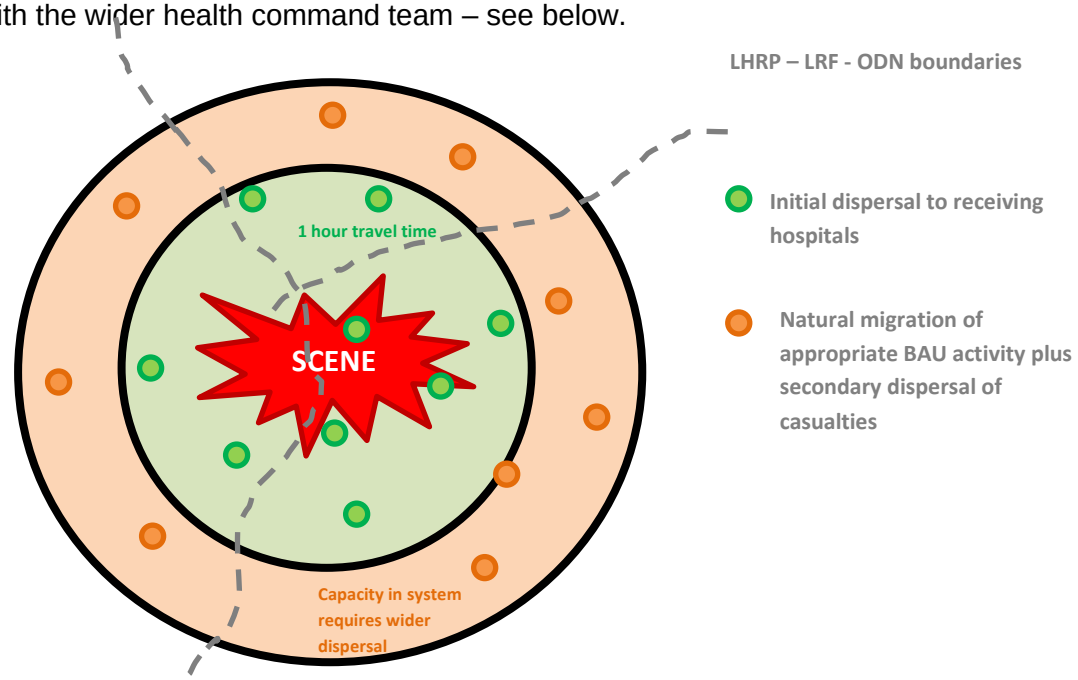
## 16.2 Casualty Pathway Diagram




## 16.3 Casualty Dispersal from scene

Casualties will be dispersed to receiving hospitals irrespective of organisational boundaries and in order that the strategic aim of "Right Patient, Right Place, First Time" can be maintained.

The YAS commander at scene will be able to transfer casualties to those receiving MTC's, TU's and LEH's closest to the incident irrespective of which ODN or NHS footprint the incident occurs in and without prior discussion with the wider health command team – see below.



## 17 Liaison with Police Services

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

## 18 Management of ballistic Injuries

In addition to the number of casualties, the number of ballistic injuries will require specific clinical expertise. Blast, burn, crush and fragmentation are wounds that are seen infrequently within the UK and are challenging to manage due to the various complications and the complex treatment required.

An agreement is in place between the Ministry of Defence (MoD) and the Department of Health & Social Care (DHSC) that in the event of a major National incident resulting in blast and high velocity injuries, that DHSC can request MoD to make available personnel with recent operational experience from within the Defence Medical Services (DMS). These individuals would be able to provide expert advice and guidance on treatment of these types of wounds.

In order to activate the military assistance process, the relevant Trust will need to reach a decision in conjunction with NHS England to identify any likely or actual gaps in capability where specialist resources are needed in addition to, or instead of, mutual aid arrangements with other Trusts. Once the requirement for military assistance has been agreed the request for activation must be made through the Regional NHS England Incident Coordination Centre.

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

Appendix 4 shows the Gateway document which outlines the procedure to access military support.

## 19 Supplies

As the consequence of a mass casualty incident is difficult to determine with accuracy the amount and type of extra supplies and equipment required by an ambulance service or Acute Hospital Trust cannot be predicted.

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

Also available is the NHS Supply Chain 24/7, 365 days a year, if, or when, urgent supplies are required. See Appendix 3 for the NHS Supply Chain Emergency Procedure.

Ambulance services will mobilise their local mass casualty vehicles when either NHS regional or national mutual aid is requested or the NACC coordinates the response. A number of national Mass Casualty Vehicles (MCV) are also available to respond.

## 20 NHS Blood and Transplant Services (NHSBT)

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

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

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

## 21 Ethics

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

This may include the decision by the Strategic Medical Advisor to invoke the P4 expectant triage category at the scene. This decision will be time limited, continually under review and only used at a time when resources are overwhelmed. Those in the P4 category are nominally P1 patients who by the nature and severity of their injuries are unlikely to survive despite intensive treatment. Treatment will be of a palliative care basis whilst resources are re-deployed to achieve the most benefit for the most number of casualties.

The ethical principles that need to be considered in weighing different sorts of harm, and in trying both to minimise harm and to be fair, are summarised below.

The principle of:

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

## 22 Forensic Evidence

The NHS also needs to mindful that in some mass casualty incidents the gathering of evidence or forensic evidence from the scene and from casualties may be required by the police. Where fatalities have occurred this is the role of the Disaster Victim Identification (DVI) Teams (police) and the Coroner.

Forensic evidence is obtained by scientific methods such as ballistics, blood tests and DNA test and is used in legal proceedings.

Evidence and forensic evidence often helps establish the guilt or innocence of possible suspects but can also provide the science behind any weapons that may have been used.

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

The gathering of forensic evidence is vital in a mass casualty incident and must be understood, respected and not forgotten by multi-agency partners.

Ambulance services and Acute Hospital Trusts must have local procedures in place to protect effects or samples from casualties that may assist this process despite this being a difficult task to consider at the time.

## 23 Stand Down and Recovery

On scene stand down for health services following a mass casualty incident will follow normal command and control processes but will be initiated by the ambulance service.

It must be recognised that although ambulance services have declared a stand down from the scene, Acute Hospital Trusts may not be in a position to do so; therefore ‘stand down’ will then be decided at a local level in consultation with NHS England Yorkshire & the Humber Incident Manager.

Formal stand down from the whole incident will be led by the SCG in conjunction with its multi-agency partners.

## 24 Beyond Day One - Potential impact on capacity for Acute Trusts.

Planning beyond day one and considering recovery early in the response phase is key.

An early assessment on the likely impact – not only on services being delivered but on staff and its community is essential. Prior to fully moving over from the response to the recovery phase there should be a clearly articulated assessment of whether the incident should be stood down, and this needs to consider the impact on services (such as theatres and critical care) who may continue to see a significant impact on service delivery for days if not weeks after the incident.

## Appendix 1 Incident Levels

| NHS Level | Description | No of casualties | Local NHS Response | Regional NHS Response | National NHS Response |
|---|---|---|---|---|---|
| **Major (Incident Alert Level 2)** | An incident that Individual trusts can manage implementing their Incident Response/Major Incident Plans in conjunction with the relevant CCG, local regional office and the comms teams | 10's | Activate command, control coordination and communication arrangements; Participate in local multi- agency response arrangements | Advised for information only | Advised for information only |
| **Mass (Incident Alert Level 3/4)** | A large scale incident involving many acute trust facilities including the local trauma Centres and other NHS providers; Incident that spreads over local area boundaries; Mutual aid required for robust response; Incident protracted and attracting high levels of media interest. | 100's | Mass Casualty Framework to be invoked; Y&H Health Gold Cell (ICC) to be established to allow incident to be coordinated jointly by YAS & NHS England in conjunction with the NHSE Regional Team, Health will also be required to partake in the multi-agency response and attend TCG/SCGs;<br>To provide sitreps to the region as required;<br>To liaise with the comms team. | Mass Casualty Framework to be invoked; Regional Office to take over leading the response if indicated; To lead on mutual aid requests;<br>To report to the national team when requested; To lead on the comms Response. | Advised of incident and its potential to require a national response and national support;<br>To determine a battle rhythm/cycle of command if required;<br>Brief ministers;<br>Assists in mutual aid requests;<br>To work and participate in the cross government response;<br>Lead on national comms messages. |

| NHS Level | Description | No of casualties | Local NHS Response | Regional NHS Response | National NHS Response |
|---|---|---|---|---|---|
| **Catastrophic (Incident Alert Level 4)** | An incident that is of such proportions that it severely disrupts health and social care and other supporting functions. The response required needs national leadership and COBR to determine the response and actions required. | 1000's | All plans invoked across health and its multi-agency partners;<br><br>Command, control, coordination and communications being lead nationally;<br><br>Regional SCGs in place<br><br>Battle rhythm/cycle of command lead by COBR. | To be part of national response liaising directly with affected local regional offices; Support the brokering of mutual aid requirements; Report directly into national team;<br>Be part of national comms response. | Lead on national response; Brief ministers/COBR; Relay battle rhythm/cycle of command to regional offices; Coordinated distribution of national assets if required; Invoke military aid processes; Coordinate the national comms response. |
| **MTA Incident Should be considered in all three categories listed above** | A marauding, terrorist attack producing varying numbers of casualties with ballistic and velocity type injuries. An incident that threatened national security | **Unknown** | Mass Casualty Framework to be invoked (noting MTA section) | Mass Casualty Framework to be invoked (noting MTA section) | Lead on national response;<br>Brief ministers/COBR;<br>Relay battle rhythm/cycle of command to regional offices; Coordinated distribution of national assets if required;<br>Invoke military aid processes; Coordinate the national comms response; |

## Appendix 2 Management of Incident Levels

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

| | |
|---|---|
| Level 1 | An incident that can be responded to and managed by a local health provider organisations within their respective business as usual capabilities and business continuity plans in liaison with local commissioners |
| Level 2 | An incident that requires the response of a number of health providers with a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office |
| Level 3 | An incident that requires the response of a number of health organisations across geographical areas within an NHS England region.<br><br>NHS England to coordinate the NHS response in collaboration with local commissioners at a tactical level |
| Level 4 | An incident that requires NHS England National Command and Control to support the NHS Response.<br><br>NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical evel. |

## Appendix 3 Voluntary Aid Societies

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

This process will therefore be overseen and controlled by NHS England Yorkshire and the Humber and the relevant SCG's.

**Roles**

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

- Support responding organisations to continue critical services (business continuity)
- Support implementation of Emergency Plans;

Responding organisations will:

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

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

## Functions

| Functions | Examples |
|---|---|
| **1**<br><br>**Supporting responding Organisations to continue Critical Services (Business Continuity)** | • Provision of additional vehicles (including air ambulances) and staff to support ambulance/other trust sector types<br>• Provision of telecoms equipment to enable robust and extensive communications<br>• 'Home from hospital' re-settlement schemes to support patient discharge or admission avoidance<br>• Transport and escort of homeless, outpatients, next-of- kin, etc., to and from airports, railway stations, hospitals, mortuaries, rest centres, hostels, etc. *(also function 2)*<br>• Supply of properties *(also function 2)*<br>• Essential supplies *(also function 2)*<br>• Signposting-support lines/drop-in centres *(also function 2)* |
| **2**<br><br>**Supporting implementation of Emergency Plans** | • First-aid and advanced clinical support within Casualty Clearing Stations, Reception and Rest Centres<br>• Search and rescue, including coordination of smaller agencies<br>• Documentation/administration<br>• Psychosocial/welfare intervention and support; spiritual care & religious services<br>• Coordination of spontaneous volunteers<br>• Provision of point of contact for multi-agency command and control groups e.g. Strategic Coordinating Group/Tactical Coordinating Group<br>• Contact with 'out of area' voluntary agencies to determine whether they are able to support arrangements<br>• Link between communities and NHS organisations/other statutory services |

The above is not exhaustive and regular engagement with the sector/organisation is needed to build up the necessary relationships to determine if other activities could be offered.

**Responsibilities-Planning, Response and Recovery**

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

## Appendix 4 NHS Supply Chain Emergency Procedure

NHS Supply Chain

**Our emergency service - there when you need it**

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

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

It is available to all NHS funded organisations in an emergency,

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

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

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

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

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

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

Once authorisation has been obtained, you (or your supplies team depending on your trust's procedure) should contact NHS Supply Chain using the emergency contact telephone numbers.

Our duty security officer will answer and you must clearly state that it is an **emergency situation** and that you require an urgent delivery.

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

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

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

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

| Area | Telephone |
|---|---|
| North Midlands | 01623 587173 |
| South Midlands | 01623 587183 |
| North East England | 01924 328751 |
| South West England | 01623 587187 |
| Southern England | 01622 402669 |

## Appendix 5 Gateway Letter, Expert Military Support to the NHS

DH Department of Health

27 April 2011

**Gateway reference number: 15835**

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

Dear Colleagues:

**Subject: Expert Military Support to the NHS**

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

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

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

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

Yours sincerely

Bruce Keogh

**Professor Sir Bruce Keogh**
**NHS Medical Director**

## Summary

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

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

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

The selected individuals will only respond in the following circumstances:

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

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

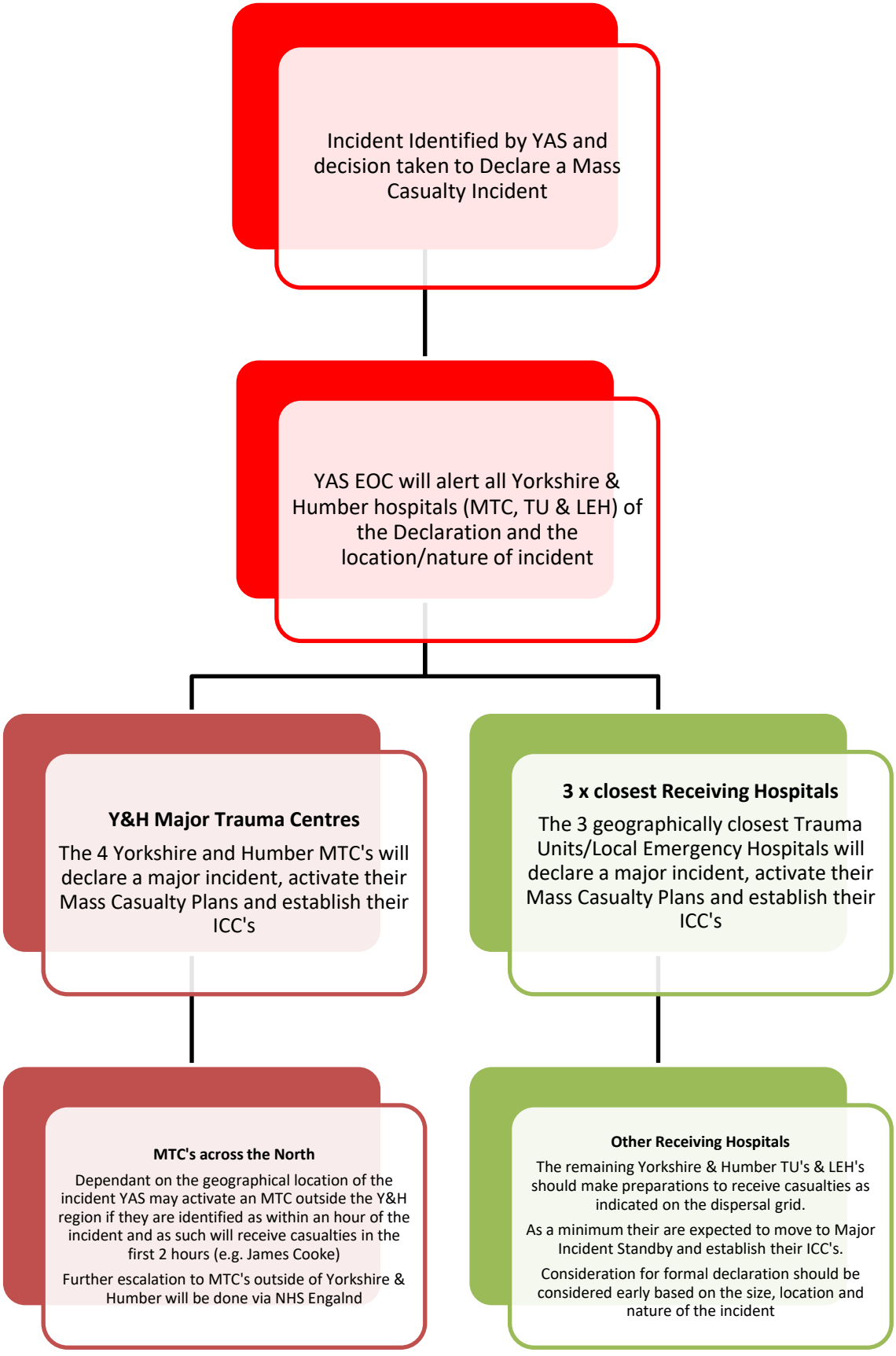
3. When immediate significant clinical responsibilities can be covered locally.

## Appendix 6 Guidance Sheets

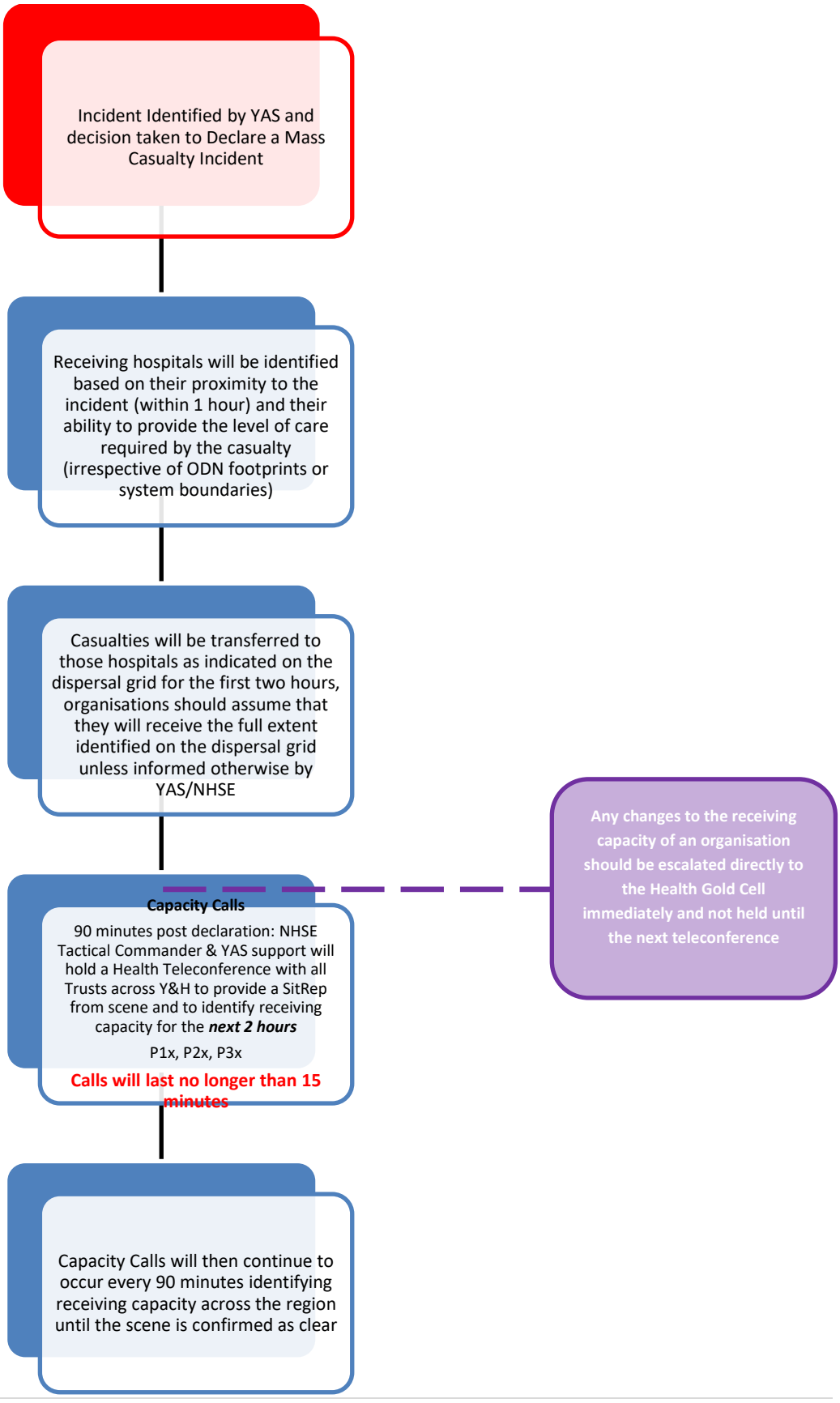
Organisation guidance sheets are included within the following pages, listed in the order stated in the table below.

| Number | Organisation |
|---|---|
| 1 | Activation & Cascade |
| 2 | Ongoing Casualty Dispersal |
| 3 | Ambulance Service |
| 4 | MERIT |
| 5 | Acute Hospitals |
| 6 | Community Hospitals |
| 7 | Patient Transport Services |
| 8 | NHS England Yorkshire & the Humber |
| 9 | Critical Care Network |
| 10 | Local Authority |
| 11 | Clinical Commissioning Group |
| 12 | Trauma Network |
| 13 | Mental Health |

## Guidance Sheet 1: Activation & Cascade



## Guidance Sheet 2: Casualty Dispersal (see casualty dispersal grid for numbers)



## Guidance Sheet 3 - Ambulance Service

| GUIDANCE SHEET No 3 – AMBULANCE SERVICE | | |
|---|---|---|
| Role | Ambulance services will work with other NHS organisations to ensure that casualties receive the most suitable pre-hospital care and are conveyed to the most appropriate location for treatment. | |
| | Ambulance services should consider the following elements when developing their local mass casualty response strategy: | |
| 1 | Consider declaring a Mass Casualty incident | |
| 2 | Cascade notification of a mass casualty incident as indicated on guidance sheet 1 | |
| 3 | Invoke mass casualty plan which includes mobilisation of specialist assets and establish Command and Control at all levels – to include pre-hospital care clinicians. | |
| 4 | Consider location of incident and number & type of casualties as to whether MERIT should be activated early (better to mobilise and stand down due to the time required to deploy to scene) | |
| 5 | Management of casualties and casualty flow to the receiving hospitals. | |
| 6 | Introduce revised treatment protocols when necessary to provide the most appropriate pre-hospital care with the resources available. | |
| 7 | Invoke and coordinate ambulance service mutual aid when necessary. | |
| 8 | Mobilise the mass casualty vehicles and other incident support vehicles. | |
| 9 | Provide Hospital Ambulance Liaison Officers at receiving hospitals. | |
| 10 | Provide appropriate representation at multi-agency Strategic and Tactical Coordinating Groups. | |
| 11 | Retain appropriate forensic evidence. | |

## Guidance Sheet 4 - Medical Emergency Response Incident Team (MERIT) Service

| GUIDANCE SHEET No 4 – MERIT Service | | |
|---|---|---|
| Role | Yorkshire & Humber MERIT sees teams of clinical staff deployed to run an Advanced Casualty Clearing Station close to the scene of the incident.<br>The 5 Trusts who will provide teams are –<br>• Bradford Teaching Hospitals<br>• Leeds Teaching Hospitals<br>• Mid Yorkshire Hospitals<br>• Sheffield Teaching Hospitals<br>• Hull & East Yorkshire Hospitals | |
| | Consideration should be given to those MTC's who will be receiving casualties in the longer term establishment of ACCS's | |
| 1 | Activation of MERIT is the responsibility of the MIC | |
| 2 | In the initial assessment of the incident (especially where the nature, type or location of the incident will impact its access and egress – e.g. remote locations such as Scarborough) should be considered early (as indicated in Guidance Sheet 3) | |
| 3 | The following elements should be considered in planning for MERIT activation | |
| | Availability of teams – contact with Trusts identified above | |
| | Any specific requirements of the teams and a rendezvous time | |
| | MERIT teams remain under the command of the MIC for all clinical care delivered within the ACCS | |
| | The AIC is responsible for the briefing, deployment and welfare of the teams whilst working in the ACCS | |

## Guidance Sheet 5 - Acute Hospitals

| GUIDANCE SHEET No 5 – ACUTE HOSPITAL | | |
|---|---|---|
| Role | The role of every acute hospital in a mass casualty incident is to provide optimum care to the maximum number of casualties possible. | |
| | All acute hospitals should consider the following elements when developing their local mass casualty response strategy: | |
| 1 | Establish effective command, control, co-ordination and communications arrangements ("C4") within a flexible major incident response hierarchy. | |
| 2 | Provide a clinical response to all arriving casualties. This will include the requirement to hold patients at Trauma Units for initial care as much as possible and unless specialist services are required at tertiary centres. | |
| 3 | System in place to call extraordinary internal tactical and operational escalation meetings / teleconferences initially and at appropriate regularity. | |
| 4 | Process to conduct an internal tactical SITREP or equivalent to identify all medically fit and Delayed Transfers of Care (DToC) at appropriate regularity. | |
| 5 | Process to conduct initial and regular internal tactical SITREP to identify and monitor capacity including in health community and social care settings. | |
| 6 | Initiate a ward-level consultant review of all patients that would be suitable for accelerated discharge in order to create new capacity. | |
| 7 | Ensure availability of CT scanners and radiology consultants for reporting. | |
| 8 | Process to move patients into existing capacity at earliest opportunity to support target of 10% bed capacity creation within the first 4 hours of the response (in line with NHS England EPRR guidance). *See point 16*. | |
| 9 | Process in place to report gaps in capacity and escalate to commissioners. | |
| 10 | Process in place to request additional funding for spot commissioned beds. | |

| | | |
|---|---|---|
| 11 | Establish an appropriately resourced and staffed Emergency Treatment Centre for receiving P3 (“walking”) casualties which should be co-terminus with the ED. | |
| 12 | Establish a major incident discharge lounge, or equivalent facility, as the single collection point for accelerated discharges. | |
| 13 | Process to monitor and inform the relevant Ambulance Service and NHS England office of any limits to capacity at the earliest opportunity. | |
| 14 | Implementation of mass casualty and surge capacity plans including the doubling of Level 3 (ventilated) Intensive Care capability for up to 96 hours. | |
| 15 | Utilise major incident clinical guidelines and documentation according to local protocols with resilient options to cover IT failure or internal incidents. | |
| 16 | Processes to create bed capacity with a target of 10% within the first 4 hours and a total of 20% within 12 hours from the time of incident declaration. | |
| 17 | System in place to monitor capacity and manage local resource allocation. | |
| 18 | Process to inform the relevant NHS England office with regular SITREPS. | |
| 19 | System in place to inform relevant NHS England office of the need for any specialist clinical resources or advice required at the earliest opportunity. | |
| 20 | Process to retain, store and label potential forensic evidence appropriately. | |
| 21 | Facilities in place to ensure appropriate hospital site security, ensuring that sites can be “locked down”* if required. IF THE MASS CASUALTY INCIDENT IS BELIEVED TO BE TERRORIST RELATED THEN THE TRUST SHOULD SEEK TO LOCK DOWN THE WHOLE SITE WITHIN 10 MINUTES OF NOTIFICATION. In some incidents a lock down of ED only may suffice. | |
| 22 | Process to monitor and notify the CCG and NHS England of any difficulties in accessing and sustaining adequate staff or resources. | |

| | | |
|---|---|---|
| 23 | Ensure a safe environment for staff, visitors and patients with appropriate secure access and survivor/family reception facilities away from the ED. | |
| 24 | Establish liaison and communication with ambulance services and other healthcare providers to ensure casualties are treated at the most appropriate location and in a timely manner. | |
| 25 | Provide support to other healthcare providers in accordance with mutual aid agreements: where possible, accredited pre-hospital doctors working in acute hospitals should be released to assist at scene if required. | |
| 26 | Ensure resilient stock items are held and are available to meet the expected clinical needs, and that supply chain processes are in place to obtain additional stocks as required in a timely fashion – including access to UK National Reserves. | |
| 27 | Ensure a system is in place to routinely contact / follow-up all incident patients treated by each provider and any patients involved in their rapid discharge activity (not involved in the incident) | |

## Guidance Sheet 6 - Community Hospitals

| GUIDANCE SHEET No 6 – Community Hospitals | | |
|---|---|---|
| Role | | |
| | All community hospitals should consider the following elements when developing their local mass casualty response strategy: | |
| 1 | Arrange urgent attendance of consultant/GP to review all amber patients to agree those suitable for accelerated discharge. | |
| 2 | Advise incident coordination team of all medically fit and Delayed Transfer of Care (DToC). | |
| 3 | Establish major incident discharge lounge as single collection point for accelerated discharges. | |

## Guidance Sheet 7 - Patient Transport Services

| GUIDANCE SHEET No 7 – PATIENT TRANSPORT SERVICES | | |
|---|---|---|
| Role | | |
| | Patient transport providers should consider the following elements when developing their local mass casualty response strategy: | |
| 1 | Decision required between PTS providers, commissioners and ambulance trusts about ensuring patient transport resource is assigned to all the acute trusts for accelerated discharge. | |
| 2 | To free up PTS services the focus must be on non-ambulatory transfers as other transport options will be sought for ambulatory patient's i.e. family members; community based voluntary service; other specialised transport resources from within the local authority, e.g. education/day centre vehicles; local taxis. | |

## Guidance Sheet 8 - NHS England Yorkshire and the Humber

| GUIDANCE SHEET No 8 – NHS ENGLAND YORKSHIRE AND THE HUMBER | | |
|---|---|---|
| Role | The role of NHS England Yorkshire and the Humber (CNE) in a mass casualty incident is to coordinate the response of all health organisations | |
| | NHS England Yorkshire & Humber should consider the following elements when developing their local mass casualty response section of their incident response plan: | |
| 1 | Establish command, control, co-ordination and communications arrangements in accordance with its Incident Response Plan (IRP) establishing an Incident Coordination Centre and Incident Management Team (IMT). | |
| 2 | In conjunction with YAS facilitate the transfer and dispersal of casualties to receiving hospitals | |
| 3 | Establish, maintain and disseminate the best possible understanding of the incident and its impact on the health sector using sit reps or teleconferencing. | |
| 4 | Analyse reports received to identify strategic priorities and support required. | |
| 5 | Liaise with the North Regional Office to implement mutual aid arrangements to identify resources and capacity inside and outside Yorkshire & the Humber | |
| 6 | Liaise with media/communications colleagues. | |
| 7 | Provide appropriate representation at multi-agency Strategic and Tactical Coordinating Groups. | |
| 8 | Ensure arrangements are in place to support the psychosocial welfare of casualties, staff and families of all involved | |
| 9 | Support the information requirements of relatives and families of those injured or missing in conjunction with the Police and the Police Casualty Bureau | |

## Guidance Sheet 9 - Critical Care Network

| GUIDANCE SHEET No 9 – CRITICAL CARE NETWORK | | |
|---|---|---|
| Role | ODNs do not provide an on call service and it is acknowledged that they do not have a role in the initial response, but will have a key role to play in the ongoing response and management of service delivery.<br>However, where available the Critical Care Networks will endeavour to support:<br>• Co-ordination of the wider network response, including local supply management[1]<br>• Patient transfer arrangments[1]<br>• Provide advice where required<br><br>[1]NHS England, Concept of Operations for Managing Mass Casualties | |
| | Critical Care Operational Delivery Network Management Teams should consider the following elements when developing their Network escalation frameworks: | |
| 1 | Support units in the identification of areas that could be utilised for Level 2 or 3 care during a mass casualty event. Suitable arrangements might include planning to utilise level 2 areas for level 3 patients, in areas such as theatre recovery or ward areas with appropriate staffing and monitoring equipment. | |
| 2 | Identify the number of designated adult and paediatric Intensive Care (Level 3) and High Dependency (Level 2) beds. | |
| 3 | Provide assurance that all units are able to increase Level 3 ventilator bed capacities by up to 100% and the concurrent potential ability to discharge patients to lower levels of care. | |
| 4 | Ensure systems are in place to enable timely data and rapid reporting of information:<br>• Numbers of beds available across network and location<br>• Numbers of patients admitted to units from mass casualty | |
| 5 | Liaise with surrounding critical care networks. | |
| 6 | Provide advice on critical care transfers and repatriation of patients as required. | |

## Guidance Sheet 10 - Local Authority Social Care

| GUIDANCE SHEET No 10 – LOCAL AUTHORITY SOCIAL CARE | | |
|---|---|---|
| Role | | |
| | Local authorities should consider the following elements when developing their local mass casualty response strategy: | |
| 1 | Start log of actions and communications. | |
| 2 | Ensure that systems are in place to ensure timely data collection (on a daily basis) and rapid reporting of information. | |
| 3 | Seek notification of number of patients requiring accelerated discharge from acute SITREP/teleconference. | |
| 4 | Seek notification of additional resources required e.g. vehicles / specialised transport to support ambulance / PTS service. | |
| 5 | Confirm strategic command structure established within the Council, open incident room. | |
| 6 | Implement local accelerated discharge policy and procedures. | |
| 7 | Identify gap in existing bed capacity and number of medical fit / DToC. | |
| 8 | Agree additional funding for spot purchasing beds. | |
| 9 | Identify additional personnel from all sites to construct a dedicated 'Resource Team' and task them to spot purchase beds. | |
| 10 | Identify additional personal from offsite social work teams (across entire local area) and to construct a "rapid assessment team". | |
| 11 | Rapid assessment team to attend Acute and Community Hospitals to implement accelerated discharge including arranging of family / other forms of community transport. | |
| 12 | Liaise with media / communications colleagues | |

## Guidance Sheet 11 - Clinical Commissioning Group

| GUIDANCE SHEET No 11 – CLINICAL COMMISSIONING GROUP | | |
|---|---|---|
| Role | In the event of a mass casualty incident the Clinical Commissioning Group(s) will support NHS England in discharging its EPRR functions and duties locally including supporting health economy tactical coordination groups during incidents. | |
| | Clinical Commissioning Groups should consider the following elements when developing their incident response plans: | |
| 1 | Mobilising resources from locally commissioned services. | |
| 2 | Providing local NHS leadership and coordinating the local health & social care response to the incident | |
| 3 | Liaison with relevant partner organisations. | |
| 4 | Cascading information to relevant service level providers. | |
| 5 | Inform and maintain dialogue with neighbouring CCGs when appropriate and identify the lead CCG (the CCG in which the incident occurs) | |
| 6 | Support CCG commissioned organisations with any local demand, capacity and systems resilience issues. | |

## Guidance Sheet 12 - Mental Health Provider Trusts

| GUIDANCE SHEET No 13 – MENTAL HEALTH PROVIDER TRUSTS | | |
|---|---|---|
| Role | In the event of a mass casualty incident the community and mental health providers will assess the immediate, short term and long term mental health needs. | |
| | Mental health providers should consider the following elements when developing their incident response plan: | |
| 1 | Increase capacity in order to receive patients from acute trusts. | |
| 2 | Ensuring central lines/messages are being communicated to staff and patients. | |
| 3 | Providing situation reports as required by NHS England and CCG's. | |
| 4 | Providing mutual aid where appropriate and capacity permits. | |
| 5 | Increase ED Psychological Liaison resource where necessary. | |
| 6 | Providing psychosocial support to victims and staff members affected by the incident. | |
| 7 | Retain appropriate forensic evidence. | |

## Appendix 7 Casualty Dispersal Chart

P1 - immediate care needed
P2 - urgent care needed (2 to 4 hours)
P3 - needs medical treatment, but this can safely be delayed
Children considered 12 and under
MTC = Major Trauma Centre,
(P) = Paediatric,
TU = Trauma Unit,
LEH = Local Emergency Hospital

| | | | | West Yorkshire | | | | | | | | | North Yorkshire and Humber | | | | | | | South Yorkshire and Bassetlaw | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Airedale Hospital | Bradford Royal | Calderdale Royal | Dewsbury Hospital | Huddersfield Royal | St. James' Hospital | Leeds General | Pinderfields Hospital | Harrogate Hospital | York Hospital | Scarborough Hospital | DPOW, Grimsby | Scunthorpe Hospital | Castle Hill Hospital | Hull Royal | James Cook | Doncaster Royal | Barnsley Hospital | Bassetlaw Hospital | Northern General | Royal Hallamshire | Rotherham Hospital | Sheffield Children's |
| | Hospital designation | | | TU | TU | LEH | LEH | TU | LEH | MTC (A&P) | TU | TU | TU | TU | TU | TU | N/A | MTC (A) | MTC (A&P) | TU | TU | LEH | MTC | N/A | TU | MTC (P) |
| CAPABILITY (First 2 hours) | P1 | Adults | Or Total | 3 | 6 | 0 | 0 | 3 | 0 | 10 | 6 | 3 | 6 | 4 | 4 | 4 | 0 | 10 | 10<br>4 | 4 | 0 | 0 | 10 | 0 | 4 | 5 |
| | P1 | Children | | | | | | | | | | | | | | | | | | | | | | | | |
| | P2 | Adults | Or Total | 8 | 10 | 0 | 8 | 8 | 0 | 10 | 10 | 8 | 6 | 4 | 4 | 4 | 0 | 10 | 10<br>4 | 10 | 10 | 0 | 10 | 0 | 10 | 0 |
| | P2 | Children | | | | | | | | | | | | | | | | | | | | | | | | |
| | P3 | Adults and children | | 30 | 30 | 30 | 25 | 30 | 20 | 30 | 30 | 30 | 20 | 30 | 15 | 15 | 0 | 50 | 20 | 0 | 25 | 20 | 50 | 0 | 30 | 20 |
| | HELICOPTER<br>H = helipad,<br>T = transfer from landing site,<br>N = No (Max Capacity) | | | T | N | N | N | N | N | H (1) | T | T | N | H (1) | N | N | T | T (2) | H (4) | T | T | N | H | T | N | T |
| AVAILABILITY OF CLINICAL SERVICES | ED | | | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | Y | Y | Y | Y | Y | N | Y | Y (P) |
| | Neurosurgery | | | N | N | N | N | N | N | Y | N | N | N | N | N | N | N | Y | Y | N | N | N | Y | Y | N | Y (P) |
| | General Surgery | | | Y | Y | N | N | Y | Y | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | Y (P) |
| | Vascular Surgery | | | N | Y | N | N | Y | N | Y | N | N | Y | N | N | N | N | Y | Y | Y | N | Y | Y | N | N | N |
| | Interventional Radiology | | | N | Y | N | N | Y | N | Y | Y | N | Y | N | Y | Y | N | Y | Y | N | N | N | Y | Y | N | N |
| | Cardiothoracic Surgery | | | N | N | N | N | N | N | Y | N | N | N | N | N | N | Y | Y | Y | N | N | N | Y | N | N | N |
| | Hepatobiliary Surgery (Transplant) | | | N | N | N | N | N | Y | N | N | N | N | N | N | N | N | N | Y | N | N | N | Y | N | N | Y (P) |
| | Orthopaedics | | | Y | Y | N | N | Y | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | Y (P) |
| | Pelvic | | | N | Y | N | N | Y | N | Y | N | N | N | N | N | N | Y | Y | Y | Y | N | Y | Y | N | Y | Y (P) |
| | Spinal | | | N | N | N | N | N | N | Y | Y | N | N | N | N | N | N | Y | Y | Y | N | Y | Y | N | N | Y (P) |
| | General Paediatrics | | | Y | Y | Y | N | N | N | Y | Y | Y | Y | Y | Y | Y | N | Y | Y | Y | Y | Y | N | N | Y | Y (P) |
| | Burns | | | N | N | N | N | N | N | N | Y | N | N | N | N | N | N | N | Y | N | N | N | Y | N | N | Y (P) |
| | Plastic Surgery | | | N | Y | N | N | N | N | Y | Y | N | N | N | N | N | Y | Y | Y | N | N | N | Y | N | N | Y (P) |
| | Critical Care | | | Y | Y | Y | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y (P) |
| | Maternity (Consultant) | | | Y | Y | Y | N | N | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | Y | Y | Y | Y | N | Y | Y | N |
| | Neonatal ICU | | | N | Y | Y | N | N | Y | Y | N | N | Y | Y | Y | Y | N | Y | Y | Y | N | Y | N | N | N | N |
| | ENT | | | N | Y | Y | N | N | N | Y | Y | N | Y | N | Y | Y | Y | Y | Y | Y | Y | N | N | Y | N | Y (P) |
| | Maxillofacial | | | N | Y | N | N | N | N | Y | Y | N | Y | N | Y | Y | N | Y | Y | Y | Y | N | N | Y | Y | Y (P) |

*** All Organisations should expect to receive self presenting patients who could be P1, P2 or P3*