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Health and Social Care
Mass Casualties Incidents:
A Framework for Planning

March 2018

Strategic Guidance for HSC

Version 1.0

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Description	**This framework document provides guidance and policy to assist the HSC sector to plan for a major incident involving large numbers of casualties beyond the capacity created by the local implementation of major incident plans.**
Cross Reference Documents	**See Annex A**
Superseded Documents	**Not applicable**
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COMMONLY USED ACRONYMS

AHP	Allied Health Professionals
BSO	Business Services Organisation
CAS	Controls Assurance Standards
CBRN	Chemical, Biological, Radiological and Nuclear
CCF	Civil Contingency Framework
CMO	Chief Medical Officer
COBR	Cabinet Office Briefing Room
DA	Devolved Administrations
DHSC	Department of Health and Social Care (England)
DoH	Department of Health (NI)
DHSC EPRR	Department of Health and Social Care (UK) Emergency Preparedness Resilience and Response Division
EPB	Emergency Planning Branch (DoH)
ED	Emergency Department
EOC	Emergency Operations Centre
ERP	Emergency Response Plan (DoH)
ESC	Emergency Support Centre
FRRC	Friends and Relatives Reception Centre
GDPR	General Data Protection Regulations
HALO	Hospital Ambulance Liaison Officer
HART	Hazardous Area Response Team
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSE	Health Service Executive
JREP	Joint Response Emergency Plan (HSCB/PHA/BSO)
LGD	Lead Government Department
MACA	Military Aid to Civil Authorities
MCP	Mass Casualty Plan
MICC	Major Incident Co-ordination Centre (DHSC England)
MIP	Major Incident Plan
MoD	Ministry of Defence
MOU	Memorandum of Understanding
MTFA	Marauding Terrorist Firearms Attack
NHS	National Health Service (England)
NI	Northern Ireland
NIAS	Northern Ireland Ambulance Service
NICCMA	NI Central Crisis Management Arrangements
PHA	Public Health Agency
PHE	Public Health (England)
PSNI	Police Service Northern Ireland
RHCC	Regional Health Command Centre
ROI	Republic of Ireland
SRC	Survivor Reception Centre
STAC	Scientific and Technical Advice Cell
TEO	The Executive Office
USaR	Urban Search and Rescue

CHAPTER 1 - INTRODUCTION

1.1 Purpose of Guidance

This framework provides guidance and policy to assist the Health and Social Care (HSC) organisations in Northern Ireland (NI) to plan for a major incident, of extremely serious proportions, involving potentially large numbers of casualties (i.e. casualty numbers that are beyond the capacity created by the local implementation of major incident plans), or other major disruptive challenges to the delivery of health care, regardless of the cause.

Conventional accidents, public health emergencies (such as outbreaks of infectious diseases), Marauding Terrorist Firearms Attacks (MTFAs) or the accidental or deliberate release of chemical, biological, radiological, or nuclear (CBRN) material might all cause incidents with mass casualties. Therefore there is a need to be prepared to respond to incidents of a different scale and nature than might previously have been thought. Although the probability of some of these events may be considered low, their impact would be significant.

The Northern Ireland Civil Contingencies Framework (CCF) (2011) sets the context for civil contingences planning in NI and seeks to ensure that all public service organisations have emergency preparedness plans in place that are built on the principles of risk assessment, co-operation with partners, communicating with the public and information sharing. Plans should link into the organisation’s arrangements for ensuring business continuity.

It will be the responsibility of HSC Chief Executives to ensure that planning for mass casualty events is included in their emergency response arrangements, and that the plans developed are made in consultation with partners and neighbouring Trusts, and are adequate and appropriate to local circumstances.

1.2 Target Audience

Planning for mass casualty events will need to reflect local circumstances, available capacity, and build on what is already in place. This document aims to provide guidance to inform and assist HSC organisations, in partnership with other agencies, to plan their response effectively.

Mass casualty incidents will involve a step change in the demands that are made on ***all*** parts of HSC organisations and on multi-agency partner organisations. Doing more of the same is unlikely to be adequate - organisations and their staff will need to adopt a different approach to their planning and response for such incidents in order to cope. For the response to work effectively there needs to be a whole systems approach in the way health and social care is delivered. Independent and voluntary sector partners also need to be engaged in emergency preparedness planning work, as well as in the operational response.

It is essential there is good communication between health care services in order to ensure the health response is structured and cohesive; thus primary care practitioners must be aware of any restrictions/limitations of secondary care that arise as a result of a significant event, to allow them to make appropriate decisions about the management and referral of patients.

This guidance outlines the strategic support the Department of Health (DoH) can provide to HSC organisations in responding to a mass casualty incident. Due to the varying and complex nature of mass casualty incidents, this guidance should be seen as a framework for emergency planners and incident managers to use when planning for and responding to such incidents at a regional and local level. It aims to assist responders to remain pragmatic and flexible during what will be a most challenging experience for all concerned. Specifically it sets out:-

- the definition of a mass casualty incident for HSC purposes (Chapter 2, Section 2.1);
- examples of types of mass casualty incident (Chapter 2, Section 2.2);
- the particular challenges mass casualty incidents present to HSC services (Chapter 2, Section 2.3);
- possible operational contingency measures, which should be incorporated into plans (Chapter 3);
- co-ordination and communication issues (Chapter 4); and
- command and control arrangements in the event of an incident occurring (Chapter 5).

This guidance must be read in conjunction with the following existing DoH plans and guidance:-

- The Role of the DHSSPS as Lead Government Department (LGD)
- DHSSPS Emergency Response Plan (ERP)
- HSCB/PHA/BSO Joint Response Emergency Plan (JREP)
- Trust Major Incident Plans (MIPs)
- Decontamination Guidance
- Hospital Lockdown Guidance
- Protocol for the Establishment of Emergency Support Centres
- DoH Emergency Planning and Business Continuity Controls Assurance Standards (CAS)
- CBRN Release Protocol
- Regional Acute Services Escalation Plan
- Regional Redirection Protocol
- Early Alert Protocol
- Department of Health, Social Services and Public Safety (Emergency Powers) Direction (Northern Ireland) 2010

CHAPTER 2 – MASS CASUALTY INCIDENTS

2.1 Definition of a Mass Casualty Incident

For the purposes of planning, a mass casualty incident is defined as:

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

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

2.2 Types of Incident Producing Mass Casualties

2.2.1. 'Big Bang' or 'No Notice' Incidents

A variety of types of incident can fall into this category. These can include terrorist attacks, civilian incidents and naturally occurring disasters. Recent terrorist attacks have occurred throughout Western Europe including the UK with large number of fatalities and injuries. In recent years these have included both the use of explosives, Marauding Terrorist Firearms Attacks (MTFA), and the deliberate use of vehicles travelling at high speed. Civilian incidents can include major transport accidents and fires.

Very recently in the UK terrorist attacks have included the use of improvised explosive devices (Manchester) knives and vehicles driven at high speed (Westminster and London Bridge) with significant numbers of fatalities and injuries. In respect of civilian incidents, the Grenfell fire of June 2017 was one of the most serious civilian incidents of recent times in the UK.

MASS CASUALTY EVENTS	FATALITIES	INJURED
Civilian Events		
Kegworth Air Crash (1989)	49	74
Bradford City Stadium Fire (1985)	56	265
Grenfell Tower Fire June 2017	Estimated 80	Estimated 70-80
Terrorist Events		
London Explosions 7 July 2005	52	700
Paris MTFA November 2015	136	300
Nice Vehicle Attack July 2016	86	384
Manchester Arena Attack May 2017	23	250

2.2.2 Implications of Big Bang Incidents

Caring for an increased number of potentially seriously ill or injured patients in the aftermath of a big bang incident is almost certain to require different response measures. Hospitals with Emergency Departments (EDs) should plan for a rapid expansion of the capacity of those facilities and for supplementing staffing.

Measures may include remodelling triage protocols, increasing treatment capacity at the scene and using all available resources and assets. Including utilising assets in the primary and community care settings. Exploring and developing all such options during the planning phase will be vital in support of the operational response.

2.2.3 'Rising Tide' or 'Cloud on the Horizon' Incidents

These tend to be one of the more challenging types of major incidents to respond to. These types of incidents evolve over a period of days or weeks, first with a slow impact, but then leading to a prolonged period of high impact disruption. They can develop for a number of reasons. Some might be the result of a 'no notice' incident (for example at a chemical installation) which initially produces no trauma casualties. However, in the days following, the immediate population around the incident may start to present to primary care with signs and symptoms which are the result of a plume from the incident.

2.2.4 Implications of Rising Tide Incidents

Rising tide incidents for example, those caused by a communicable disease such as Pandemic Influenza present different challenges to those of a 'big bang' incident. They need longer term crisis management arrangements to ensure a sustained and effective response and the demand on the primary care sector will be greater and more sustained, with the potential need to consider focusing treatment at home rather than within the hospital environment, freeing in-patient capacity for the most seriously ill. The availability of public information will be crucial in promoting self-help, enabling clinical staff to prioritise their time and patient treatment.

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

Effective and rapid public health monitoring and health intelligence will be vital in identifying and containing the escalation of any such incidents.

2.2.5 Chemical, Biological, Radiological and Nuclear (CBRN) Incidents

CBRN incidents can fall into either of the above categories. They can also be either accidental or deliberate. The latter category can also be "overt" or "covert". However they present complex challenges for all responders, and HSC organisations are no exception. In some CBRN scenarios the rapid decontamination and treatment of significant numbers of casualties will be critical both to the well-being of the patients and to the management of the incident. Recently, particularly in the London area, corrosive substances have been deliberately utilised to target individuals and larger groups of people. First responders will also have to be aware of the capabilities required to deal with such incidents.

The DoH holds strategically placed 'pods' containing extra equipment and drugs which can be deployed to such incidents. It is the responsibility of the NI Ambulance Service (NIAS) to deploy these pods on request, in support of an incident in NI. Trusts must ensure that all relevant staff are aware of the content of the countermeasures stockpile, the specific types of pod, and the relevant deployment procedures as identified in the CBRN Release Protocol. Plans are required in order to activate and appropriately deploy pods for treatment or mass prophylaxis, including the appropriate use of Patient Group Directions.

The NIAS must therefore maintain effective arrangements for the rapid deployment of trained Hazardous Area Response Teams (HART) and for supplementing or relieving those teams through mutual aid.

In the event of large numbers of people requiring decontamination, the fire service mass decontamination capability will be deployed to support the NIAS, in accordance with the Decontamination Policy. All hospitals with EDs have equipment, preparations and general capability for decontamination of small numbers of casualties, and this equipment (and staff training) must be maintained to allow for rapid deployment if required. However, it is accepted that most hospitals would be under severe strain by the scale and circumstances of an incident producing mass casualties that are contaminated.

HSC Trusts should have discussions with the Police Service NI (PSNI) about the public order and control issues which could be associated with a significant level of self-presenters, and should consider how they would handle such an influx of potential casualties.

Hospitals and primary care providers should consider, and where appropriate, develop arrangements to rapidly protect access to their facilities to ensure capacity can be maintained. This may require planning for enhanced security measures to ensure access can be restricted to single point of entry (in acute hospitals this is likely to be in the vicinity of the ED). Hospital Lockdown Guidance has been produced for HSC Trusts.

Plans should also ensure that messages to the public can be disseminated in an effective manner and link into media management plans both within the HSC organisations and with other partner organisations, especially the PSNI. All communications should take account of the Executive Information Service Communication Protocol.

In developing their mass casualty plan, HSC organisations will need to work in close collaboration with the emergency services and with neighbouring primary and secondary care providers. Issues that will need to be addressed include:-

- control of the site, (including lockdown);
- mass decontamination;
- dealing with self-referrals;
- public order and crowd management;
- a triage/assessment facility as an adjunct to the ED (to avoid cross contamination and unnecessary attendance within EDs); and
- health and safety of Trust staff.

2.3 Particular Challenges Presented by Mass Casualty Incidents

Some of the factors that distinguish a mass casualty incident from a more typical major incident are its likely scale, duration, intensity and the probability that there will be other compounding and complicating factors such as loss of services and infrastructure, shortage of essential supplies, or the possibility of civil dislocation. They are likely to involve greater numbers, both in terms of casualties and fatalities, and could involve either incidents occurring simultaneously, or at multiple sites (either in close proximity or more widely spread).

Each patient will present specific clinical and managerial challenges in the areas of triage/treatment, capacity, co-ordination and communication across a wide area. There are 5 typical groups of patients who are likely to present and this will include:-

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

- those patients in the community affected by the loss of service due to the impact of the incident and its response (i.e. dialysis patients, home oxygen patients).

Additionally there will be a requirement to increase capacity in the community care setting. Community nursing teams, Allied Health Professionals (AHPs), home helps and home carers can play an important part in ensuring that patients discharged early can be cared for in the home. This type of care will be vital in maintaining critical in-patient care capacity through reducing the need for patients to be re-admitted post discharge. However it must be remembered that these groups of carers may also be affected by the mass causalities event, caring for their own families or experiencing transport difficulties.

There may be a particular challenge for HSC organisations in ramping up capacity for a mass casualty response in view of the tenets of the 'Delivering Together' agenda. As this initiative embeds and resources are re-orientated towards the community sector from the acute sector there will be a need for Trusts to review all existing plans to establish if they can still be effective within the resources available to them.

Due to the additional demand on resources, HSC Trusts should have suitable business continuity management arrangements with suppliers of critical services and products to ensure that supply chains can be maintained during any major emergency and arrangements are in place to contact all key suppliers on a 24/7 basis.

In addition to the demand for information from families of patients, it is also likely that there will be significant media and public information challenges which should be considered in local planning. For example, following a high profile incident VIP visits may detract from the focus on clinical care and require dedicated resources for planning and facilitation.

When necessary, early provision of public health advice and appropriate public messaging will assist in reducing the numbers of self-referrals and alleviate pressure on the healthcare system.

2.4 Potential Evacuation Requirements

When considering incidents with the potential for mass casualties, there is a need to consider planning for the health consequences of the displacement of a significant number of the population. Whilst large scale evacuation will only be undertaken as a last resort, health emergency planning must recognise that for significantly disruptive incidents (e.g. wide spread flooding) large numbers of the population may need to be moved to a place of safety. Any large scale evacuation of a population will need a multi-agency response, and the health sector will play a vital role in the process. Reference should be made to 'A Guide

to Evacuation in Northern Ireland[1]' issued by TEO. The key elements which need to be considered by HSC organisations are:-

- maintaining primary care services to the population being evacuated, including special measures to offer support during the physical period of evacuation;
- treating those people who have been injured during the evacuation process;
- considering whether displaced patients have suitable access to the medication they need to control their chronic underlying conditions;
- through close working with the social services, identifying and giving support to vulnerable people and their families within the community being evacuated;
- all HSC Trusts should have plans in place to effect an evacuation if required. However such plans should ensure that any evacuation of a hospital is seen as a last resort; and
- HSC Trusts must have plans to accommodate the provision of health and social care services for an influx of significant numbers of the population that may have been evacuated from a wider geographical area than has been considered previously.

2.5 Data Sharing Requirements

All parties involved in health monitoring and surveillance must ensure that appropriate data is shared in a timely and efficient manner, mindful of any data protection issues. The NI Civil Contingencies Framework outlines the general principle that essential information should be shared freely, HSC organisations will need to make judgements about what information they will share, the format to be used, the security classification to be applied and the data sharing agreements required.

As mass casualty events will be of such a scale that the response will need to be co-ordinated on a regional basis it will be important that any data sharing and spatial mapping arrangements are planned and co-ordinated on a regional basis. Sensitive information, which includes personal data, needs to be subject to controls on the way it is handled and the purposes to which it is put. The General Data Protection Regulations (GDPR) will come into effect in May 2018. Therefore HSC organisations will have to ensure compliance with these. The restrictions that need to be placed on sharing information at the planning stages are different from those applying in an actual emergency. Further information on data sharing in an emergency, particularly around vulnerable people and meeting their needs, is also available within the CCGNI Vulnerable People Protocol.

[1] https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/ofmdfm_dev/a-guide-to-evacuation-in-ni.pdf

CHAPTER 3 – HEALTH AND SOCIAL CARE PLANNING FOR MASS CASUALTY INCIDENTS

3.1 Planning Principles

HSC organisations routinely deal with major incidents, but now need to prepare for, and be able to respond to events that may result in patient numbers well in excess of those used in past planning assumptions, and beyond the capacity created by the local implementation of major incident/emergency response plans.

The basic operational principles for dealing with an incident which results in mass casualties are the same as for a major incident and all HSC organisations must have major incident/emergency response plans that:-

- demonstrate that they fully understand the potential scale and nature of the disruptive threat(s) to their organisation and any actions that may be needed, through involvement in multi-agency risk assessments in their area;
- if possible, include appropriate measures to prevent an incident or to mitigate its effect on the health of the community;
- place particular emphasis on inter-operability and activating mutual aid between HSC organisations, and with counterparts in other parts of the UK and ROI, if appropriate;
- consider measures to utilise all existing HSC capacity in acute, primary, and community care settings more intensively, taking into account the need for a sustainable response;
- recognise the potential need to expand existing capacity to cope with larger numbers of patients, including the possibility of introducing revised treatment protocols;
- include proposals to utilise and deploy staff differently, where that is required;
- facilitate joint working by adopting common core systems and equipment, as far as that is practical;
- promote and support a return to normality as soon as feasible; and
- undertake a structured debrief after the event to identify lessons learned.

HSC Trusts should develop their Mass Casualty Plans (MCPs) in partnership with other organisations engaged in resilience planning and interface with the Public Health Agency (PHA), the Health and Social Care Board (HSCB) and the Business Services Organisation (BSO), and also DoH if required. Plans may need to include more specific arrangements such as responding to media interest. Depending on the type of incident, communication strategies will need to be agreed to help with the cascade of public health information and within the requirements of the Executive Information Service Communications Protocol.

Trust plans should be coordinated to facilitate an overarching Regional Mass Casualty Plan for Northern Ireland.

3.2 Developing Capacity and Sustaining Patient Care

During any type of mass casualty incident, managing capacity will be a significant challenge. HSC organisations must consider how they can increase and maintain extra capacity in the event of an incident requiring treatment of large numbers of patients.

Depending on the type of mass casualty incident there may be a need to expand certain types of specialities. For a ‘no notice’ incident, although the demand in EDs may peak after several hours it may still be very focused on one or two particular clinical specialities for example burns, critical care, trauma and orthopaedics. During a ‘rising tide’ incident, the impact would be less immediate, but build over a period, several days, weeks or months, affecting both clinical care and HSC business continuity.

Incidents producing mass casualties have the potential to cause pressure on a wide range of clinical and patient care services, all of which would need to be utilised to the maximum. Depending on the circumstances, capacity may be limited by significant damage to the HSC infrastructure, for example, hospital buildings damaged by the blast from the explosion, or the ability to operate without full utility services, for example loss of electricity supply.

It is therefore vital that all providers of HSC services develop effective business continuity management plans that reflect the need to maintain critical clinical managerial functions during periods of disruptive challenges. Controls Assurance Standard criterion, which covers business continuity management, will be of assistance to HSC organisations.

3.3 Managing Clinical Care

Every day the HSC sector manages the care and well-being of many people. On average there are almost 2,000 Emergency Department attendances daily across Northern Ireland. In addition there are over 600,000 day case and inpatient admissions annually. Decisions around the clinical care of patients is often made as part of multi-disciplinary teams of specialists, providing in depth and complex care within established clinical protocols and guidance. However, during an incident that produces mass casualties, there may be a need to expand the capacity of certain types of specialities due to the type of incident, for example burns, orthopaedics, ophthalmology and neurosurgery. Moreover, at a Regional level it is important to plan in advance where casualties of a particular triage category or requiring treatment from a particular specialty should be directed. The utilisation of regional patient distribution models and casualty capability charts will assist with this.

Under these circumstances there may need to be a temporary re-alignment of treatment protocols to reprioritise treatment care. Whilst this will be for senior clinical leads to decide, at the time, and considering the circumstances, the aim during an incident producing mass casualties is to provide the best care possible, under the circumstances, within the healthcare capacity available. This process already takes place in part during smaller incidents and utilises triage protocols to determine rescue, treatment and evacuation priorities. Whilst these are predominantly used in pre-hospital or emergency department settings, the principles may be useful to other areas of clinical work.

The table below shows illustrative planning assumptions that could be adapted for use to calculate the potential numbers of patients in each priority category. However, these assumptions will vary depending on the nature of the incident Planning assumptions may be utilised in order to ensure that the appropriate specialist capacity is available at the receiving centres.

Category	Patient Condition	% of Total
P1	Casualties needing immediate life-saving resuscitation and/or surgery	25%
P2	Stabilised casualties needing early surgery but delay is acceptable	25%
P3	Casualties requiring treatment but a longer delay is acceptable	50%

Consideration must be given to the fact that incidents could occur which would be beyond those for which hospital buildings are designed to cope, and that this, combined with potential staff constraints, would have an impact on the way in which patient care, could and would be delivered. Clinical input to identify the scope for adapting ‘normal’ clinical practices are essential to the development of an effective plan, which must recognise that in these circumstances, extraordinary measures will potentially mean doing something outside normal practice. For example, medical teams may have to work in support of their surgical colleagues in order to facilitate the creation of operating capacity. There should also be consideration of how the return to normal services will be achieved and managed, including the impact on staff morale.

HSC organisations should identify unused physical capacity which could be brought into use if required. This might include disused wards, intermediate or community beds. Potential capacity in independent or private sectors may also be pre-identified. Planning should also consider using existing capacity more intensively to create extra capacity for a higher level of dependency.

The HSCB needs to ensure that providers of health and social care services (e.g. General Practices, Community Services and independent sector providers) are

planning to manage the impact of an incident that results in a large number of casualties affecting their service and staff.

Plans should include developing integrated arrangements to set up and provide facilities - preferably away from acute hospital sites - to assist in the triage, diagnosis, treatment and support of those patients who are not obviously seriously ill or injured. They should also consider contingencies to maintain patients in the community and limit or avoid referrals to acute hospitals as far as possible. A further surge in demand may be experienced by Primary and community care in the weeks and months following a mass casualty incident (relating to post traumatic stress in survivors, for example). Such patients may require to be sign posted to appropriate services.

Arrangements for developing integrated arrangements in facilities not usually used for health and social care should include the legal requirements for holding and providing medication e.g. secure handling of controlled drugs under the Misuse of Drugs Regulations and other medication under the Human Medicines Regulations 2012.

Planning should also include using existing capacity more intensively to create extra capacity for a higher level of dependency. For example, some community or intermediate beds might be used to deliver acute care, or general acute beds used to create additional capacity for critical care or burns cases (with specialist staff). These plans should be consistent with plans to create additional hospital capacity for major outbreaks of infectious diseases.

Equipment and supplies issues, including the provision of medicines, bandages and specialist equipment, should be addressed through local plans. For example there may be short term high demand for specialist equipment such as chest drains or external fixators and planners should ensure that supply chains can meet this demand. These should be in conjunction with arrangements for stockpiling of CBRN countermeasures. The Northern Ireland Blood Transfusion Service will also have to ensure arrangements for adequate availability of blood products for the management of large scale incidents.

Plans should address both short-term and long-term issues and acknowledge that full recovery from the mass casualty incident may take a considerable period of time.

3.4 Protecting and Sustaining Capacity

The number of staff and the availability of other resources to deal with patients affected by a mass casualty incident can be substantially increased by redirecting the existing HSC resources, which are used to provide elective care, towards emergencies. It is essential that a clear audit trail be maintained for any decisions that would affect any organisation’s ability to deliver the full range of

‘normal’ services, including those against which organisations, are performance managed. However, it is also important that this does not impair the ability to deal with what is, by definition, a challenging and exceptional situation.

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

Plans for accelerated and temporary discharge of patients from acute beds should be developed in close partnership with primary care, social care and the NIAS. HSC Trusts should also have arrangements with primary care, community care and NIAS to minimise the number of patients presenting at EDs during the mass casualty incident and arrange to treat as many patients as possible in the community setting.

3.5 Staffing and Workforce Planning

The greatest constraint on expanding capacity is the availability of additional staff, and HSC Trusts need to have appropriate business continuity plans in place to bring in additional staff across their local area. However, such plans must recognise the possibility of transport and communication disruption, which has the potential to impact on the numbers of staff available. These plans should also recognise the fact that staff (or their families) may well be victims of the incident, particularly if it is in the locality. This could potentially have a considerable impact on staff attendance and this must be considered when planning.

Plans must also consider that staff of all grades may find it difficult to focus on the response (including leading the response) until they are reassured that their family and friends are safe and well. Consideration should also be given to the need for counselling and psychological support for staff involved in a response from an early stage.

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

There are issues about the sustainability of arrangements, which involve existing staff working longer hours or more intensively, and the health and safety aspects of such arrangements. It must be recognised that staff can work exceptional hours, but for only a short period. Staff should receive clear information about what would be expected of them in an emergency, including appropriate training. Plans should also consider further training that would be required by those who would play a leading role in responding to and managing such an incident. This must include command and leadership training across the full spectrum of staff grades in all HSC organisations.

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

Qualified staff working in non-patient contact areas should be identified and consulted on how their skills can be utilised within a clinical setting. Any discussions should also recognise that refresher training may be needed and may need to be programmed in to individual’s regular training calendars. Effective planning can identify a process for using staff in key roles which may not require clinically trained personnel.

Utilising retired health professionals or students is one option for producing additional resource. For students, the ability to gain experience during a major incident has the potential to be a useful, if very challenging, learning experience. It will be important that placement experience providers work in partnership with education providers to maintain the validity of the placement experience for the student and that adequate mentorship is available.

Decisions around deployment of staff and the placement and care of patients and clients will be led by service providers and will be made in response to current and emerging circumstances. Plans should also consider the extent to which community staff and general medical practitioners could be deployed to supplement acute services, if that is required. These plans need to consider issues around clinical indemnity and support for colleagues who may be working in a different environment to their normal place of work.

Following a mass casualty incident, large numbers of the public will seek information about friends and relatives who may have been affected by the incident(s). Hospitals should have, as part of their major incident arrangements, a mechanism to manage a significant number of people making contact either in person or by telephone and internet and consider the staffing requirements of this for the period required. The first priority of health and social care staff will be to reunite them with patients who have

been admitted. Further information on liaising with the Police Casualty Bureau is included at Section 3.9.

3.6 Northern Ireland Ambulance Service (NIAS)

NIAS need to have plans in place to develop capacity to rapidly deploy greater numbers of vehicles, staff and equipment to the scene(s). Establishing early command, control and triage arrangements at the scene(s) will be critical. Planning to supplement the resources available through rapid mutual aid and by additional steps such as the formation of ambulance service reserves will be vital to expanding capacity.

Learning from recent incidents has demonstrated that the Hospital Ambulance Liaison Officer (HALO) can greatly facilitate communication into receiving hospitals and assist in directing casualties appropriately. This can be of particular value when other avenues for communication may be compromised.

The use of non-emergency crews or support from local voluntary organisations (such as British Red Cross and St John's Ambulance) needs to be explored at a local level. The NIAS first responder scheme may also be a source of additional support staff for use during a major incident.

Developing these plans further is likely to be dependent upon local resources. However early discussions during the planning phase will allow local plans to reflect local capacity. NIAS along with other HSC Trusts must, as a matter of necessity, ensure that as soon as casualty receiving hospitals are identified the PSNI is informed in order that police documentation teams may be deployed to those hospitals. The primary responsibility for this will be the NIAS Incident Commander at the scene(s) in association with the Police Incident Commander. If local capacity is to be increased using volunteers, pre-incident training and exercising will be vital in developing an effective and sustained response.

Additional measures to release experienced ambulance personnel from the transport role would improve triage and treatment capability at the scene and make additional trained personnel available for specialist tasks such as decontamination. Emergency Care staff may be usefully tasked with more appropriate triage, treatment and discharge at the scene or supporting the primary care effort at Emergency Support Centres (ESCs). Effective use of medical care services including Immediate Care Scheme (BASICs) doctors at the scene will also make a key contribution as demonstrated by recent incidents.

Due to the potential scale and physical disruption to buildings and structures, releasing trapped casualties may take longer and be more complex than other types of incidents. The NIAS HART team is trained in the role of Urban Search and Rescue (USAR). This team of specialists will ensure that vital (and

potentially limited) clinical and rescue resources are used safely and to ensure the best outcome for the patient.

3.7 Mutual Aid and Support

Even with the highest level of planning, a hospital at the centre of a mass casualty incident may struggle with all the demands made to the extent that its ability to maintain basic functions is challenged. HSC Trusts should have established working relationships with neighbouring Trusts, which during a major incident should allow for any peak in capacity to be absorbed. Patients are often transferred to neighbouring hospitals if specialist capacity is required. However during a catastrophic incident involving mass casualties, there will probably be a need to utilise capacity over a much wider geographical area than would otherwise be considered, and this may have to be managed through the HSCB, guided by the Regional Acute Services Escalation Plan. This will facilitate the optimal use of Emergency Departments across the region as well as the effective utilisation of other relevant clinical networks, such as the Critical Care Network.

Mutual aid may take many forms including lending staff or equipment, providing specialist staff, e.g. as part of a Site Medical Team, or agreeing to take patients from the affected area. Mutual aid arrangements between HSC Trusts for the supply of sharing of services should be updated and exercised regularly.

To achieve the best possible care for the most people under the circumstances, patients may need to be transferred to different parts of the country. The UK now has a number of air ambulances. If utilised for inter-hospital transfers over greater distances they can make long distance transfers more clinically acceptable thus freeing up vital local ambulance and health and social care resources, however they may not be able to operate during adverse weather conditions.

HSC Trusts should engage with NIAS to develop, at the pre-planning stage, a casualty dispersal plan, which may be more geographically spread than originally considered. This should also include the ability to receive casualties from other regions.

Effective mutual aid across the health sector will require strong leadership and coordination. Many incidents resulting in mass casualties are likely to have an impact over a wider area than a single HSC Trust. It is essential that that effective mutual aid arrangements are in place between Northern Ireland, the Republic of Ireland (RoI), the UK or other countries as required.

Specific requests for mutual aid from other parts of the UK will be coordinated by DoH through counterparts in the other Devolved Administration Health Departments. Mutual aid to the Health and Social Care Sector required from

abroad will be co-ordinated by the Department of Health and Social Care (DHSC) England.

3.8 Emergency Support Centres

Plans to care for survivors of a mass casualty incident who are assessed as not needing hospital treat or to inform relatives and friends of casualties should take cognisance of the 'Protocol for the Establishment of Emergency Support Centres (ESC).

HSC organisations will need to ensure plans include contact details for key organisations and processes for activation of ESC Survivor Reception Centres (SRC) and Friends and Relatives Reception Centres (FRRC) as outlined in the ESC protocol.

3.9 Casualty Bureau

In the event of a mass casualty incident the PSNI may set-up a casualty bureau to specifically deal with survivors. The PSNI will deploy officers trained to document casualties to receiving hospitals to ensure that all known casualty information, including details of the deceased, is passed to the Casualty Bureau. HSC Trust emergency planners and the PSNI should work together to ensure that receiving hospitals have the necessary facilities for these police teams.

The PSNI's role will include:

- establishing the Police Casualty Bureau, documenting casualties and communicating with families;
- public disorder issues at the scene and hospitals; and
- managing fatalities at the scene.

HSC Emergency Planners should ensure that, as soon as casualty receiving hospitals are identified, the Police Casualty Bureau is informed, in order to facilitate information gathering. Identification of roles of those who will have primary responsibility for this should be clearly detailed in plans.

3.10 Temporary Mortuary Facilities

Whilst the focus of HSC organisations must be on the living, during any mass casualty event there is the potential for fatalities. Whilst the PSNI will manage any fatalities at the scene, those who die within the hospital setting will need to be managed in accordance with normal hospital procedures, considering any specific issues for infection control. Mass Casualty plans should therefore detail how hospital deaths resulting from a mass casualty event should be handled, including any multi-agency co-operation required. Depending on the nature of the event, the principle issue will be ensuring dignified and suitable temporary storage of the deceased. Sensitive and empathetic procedures will need to be put in place to ensure appropriate settings for viewing the deceased. Coroners

and bereavement support services will have to work closely together to ensure support for relatives.

Further consideration will be needed if the incident is CBRN related, and the implementation of any special arrangements (e.g. access to gas tight body bags). All acute hospitals should have plans that detail how excess deaths will be managed within the hospital environment. These plans will need to be developed in conjunction with the local council, the Coroner and the PSNI, and dovetail into other standing arrangements.

CHAPTER 4 – CO-ORDINATION AND COMMUNICATION

4.1 Co-ordination

The impact of a mass casualty incident is likely to challenge severely the management capacity of individual HSC organisations, therefore there needs to be in place a clear understanding of who will be responsible for directing resources and how key decisions will be made. A clear understanding of the chain of command, where control centres will be and how arrangements are to be activated is essential. Co-ordination and communication arrangements must be integrated throughout the response structure.

4.2 Communication

There must be effective communication with other agencies and the public. Communications on operational HSC issues, such as where to go for treatment or advice, must be closely tied to public health information provided by the PHA Director of Public Health. Multi-agency command and control arrangements would provide the basis for linking in the co-ordination of the local HSC response with partner agencies. However responding effectively to an incident on this scale is likely to require a degree of central health co-ordination and control which is beyond that seen in the day-to-day management of HSC organisations. The integrated health communications at local level must in turn be linked to the communications plans of DoH, local councils, the UK Government and, where necessary, the other DAs.

It should be decided at an early stage who would be the most appropriate spokesperson for public messaging. This could be the Minister, Chief Medical Officer (CMO) or the PHA Director of Public Health, depending on the scale of the incident. Previous emergency responses have highlighted the benefit of regular media briefs to communicate with the media simultaneously and provide an opportunity to ensure accurate and up to date information is being reported. All websites should be kept fully up to date with all key messaging. The use of social media networks should also be used to disseminate urgent information.

There will also be a strong desire from the public for authoritative information on all health aspects of the incident, including health risks arising from the original incident, self-care, how to get treatment and any further potential risks to health. There may be a great deal of inaccurate information circulating about the health impact of the incident and possibly some degree of public anxiety. This should form part of the co-ordination of the multi-agency command and control arrangements, to ensure that public anxiety is kept to a minimum.

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

CHAPTER 5 - COMMAND AND CONTROL ARRANGEMENTS

5.1 Public Health Agency (PHA)

In a major incident involving mass casualties the PHA will provide public health advice to HSC organisations, multi-agency partners and the public. The PHA will also provide an early risk assessment of the actual or likely impact on public health and safety. The Agency will also establish and run a Scientific and Technical Advice Cell (STAC), if required.

5.2 Health and Social Care Board (HSCB)

The HSCB will work closely with Trusts in a mass casualty incident to ensure that services continue to meet patient needs. The HSCB Regional Acute Services Escalation Plan has been developed and implemented by HSCB and is designed to assist Trusts and the wider health and social care system in the management of capacity and the effective implementation of escalation procedures when the whole system or one constituent part of the system is under pressure.

5.3 Joint Response Emergency Plan (JREP) and Activation of Health SILVER

The PHA, HSCB and BSO have collectively developed a Joint Response Emergency Plan (JREP) to co-ordinate health and social care across NI in an emergency.

The objectives of the JREP are to:

- rapidly mobilise sufficient staff and resources to deal with the emergency;
- establish and maintain good communications internal and external to the organisations;
- ensure good coordination exists across HSC organisations in the event of an emergency; and
- ensure expert advice and guidance is available in a timely manner.

If required PHA, HSCB and BSO will collectively convene Health SILVER providing a joint response capability. The HSCB/PHA/BSO balance in the decision-making team and the chair will depend on the specifics of the incident, however generally, the PHA will chair when the incident results in mainly public health issues and the HSCB will chair when the incident has mainly service continuity issues.

Health SILVER will also consider the recovery element of any mass casualty event, liaising with the DoH Regional Health Command Centre (RHCC) (Health GOLD), in relation to any post-crisis response.

As previously stated the basic operational principles for dealing with an incident which results in mass casualties are the same as for a major incident therefore any mass casualty planning must consider and build on existing plans and protocols, e.g. HSC Joint Emergency Response Plan, Regional Escalation Plan, Regional Redirection Protocol, Early Alert Protocol, Trust Major Incident Plans, etc.

Additionally the type of incident resulting in mass casualties may affect how and when Silver activate the command and control structures detailed in the HSC JREP and any associated mass casualty planning protocols.

For example when dealing with a '**no notice incident'** it is likely that the Early Alert System will be initiated by the affected Trust in order to seek mutual aid from other Trusts. On receipt of an Early Alert from a Trust, HSCB may consider, in discussion with PHA and BSO, given the severity of the incident, proactively establishing SILVER command and control structures (JREP) and any associated mass casualty planning protocols to deal with the incident rather than waiting for a Trust to have reached the trigger for Red or Escalation Level 3 of the Regional Unscheduled Care Escalation Plan.

With a '**rising tide event'** the activation of a Trust(s) level MIP or the Regional Unscheduled Care Escalation Plan may be the first step to dealing with the incident. Only when these plans have reached the relevant triggers within the Escalation Plan will HSCB in discussion with PHA and BSO, consider activating SILVER command and control structures (JREP).

5.4 The Role of DoH

5.4.1 Lead Government Department Role

DoH is the Lead Government Department[2] (LGD) in NI for responding to the health and social care consequences of emergencies from the following categories:-

- a CBRN incident brought about either through terrorism, industrial accidents or by natural causes;
- disruption of medical supply chains;
- human infectious diseases; and
- mass casualties.

The Department is responsible for the strategic leadership and co-ordination of the entire health and social care response in NI when an emergency has been categorised as serious or catastrophic. The Department may also play a role in significant incidents (if required). Any overall response will be on three levels, the Department (GOLD) will provide strategic advice and direction, HSCB working alongside the PHA and BSO (SILVER) will provide tactical management and the Health and Social Care Trusts and other front line services (BRONZE) will provide operational management.

The DoH Emergency Response Plan (ERP) sets out how the Department will deploy and operate in response to an emergency and sets out how the DoH's emergency response facility (the RHCC) will operate to support strategic decision-making. To support the RHCC and provide the required lines of

[2] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/epr-role-of-dhssps-as-lead-government-department.pdf V2.3 (Aug 2012)

communication the Departmental Emergency Operations Centre (EOC) will be established by EPB. This will provide a conduit for liaison with DHSC (England) and the other UK Health Departments and will establish arrangements for providing health briefings for the DoH Minister.

5.4.2 Emergency Powers Directions

A senior official of the Department of Health (for example the Permanent Secretary or CMO) may, if necessary, invoke the DoH Emergency Powers Directions to direct and redeploy HSC resources, including staff, to support the response to a mass casualty incident. The directions provide clarity on the established command and control structures and will only be signed (by a senior DoH officer) when an emergency warrants their activation.

5.4.3 Regional Stockpiles of Health Countermeasures

DoH holds emergency stockpiles of health countermeasures (both medicines and consumables) at strategic locations across NI. MCPs should include details of the procedures for accessing these stockpiles if required. Any such requests should be considered in liaison with BSO. DoH is responsible for all aspects of stockpile management. However, in view of the speed with which certain of the pharmaceuticals must be administered in order to save lives, in line with UK Policy, the DoH empowers NIAS, with the authority to release directly from the stockpile for all 'life-saving' health countermeasures. All remaining health countermeasures require formal release from DoH before being despatched.

5.5 Northern Ireland Central Crisis Management Arrangements (NICCMA)

In the event of a mass casualty incident DoH, as LGD for health emergencies, can request cross departmental co-ordination and support through the activation of NICCMA. These arrangements may be activated to ensure that the most efficient and effective response can be made to assist the public during and in the aftermath of a mass casualty.

5.6 Department of Health and Social Care (DHSC) England

Where an incident escalates outside the capacity of any one region of the UK, or where the incident has a UK wide impact, DHSC (England) will activate its Major Incident Coordination Centre (MICC) in London, and implement national co-ordinating arrangements. In fulfilling its responsibilities on behalf of the Secretary of State, DHSC will:

a) Ensure the coordination of the whole system response to high end risks impacting on public health and the wider health and social care system.
b) Support the UK central government response to emergencies including ministerial support and briefing.
c) Provide a data and information conduit between NHS England, Public Health England (PHE) and the Cabinet Office for emergency preparedness and response.
d) Liaise with other Government Departments on behalf of the NHS.

e) Coordinate mutual aid between the Devolved Administrations.

5.7 4 Nations Approach

5.7.1 Military Aid

With robust business continuity and flexible emergency planning arrangements in place DoH and HSC Organisations are expected to manage most crises without the need for military assistance. However, it is recognised that in certain situations, where all other avenues have been exhausted, DoH can request military assistance from the Ministry of Defence (MoD). It must be understood however, that this is merely a request – there is no guarantee that any military support or assets will be released.

Military personnel support in an emergency or crisis situation, in the UK, is officially known as **Military Aid to the Civil Authorities** (MACA). Any request for a MACA will be carefully considered and will be directed at the time of the incident by DoH.

5.7.2 Mutual Aid

Within the UK, the "National Memorandum of Understanding Concerning the Provision of Mutual Aid" provides a framework through which UK Ambulance Services (including the DAs) can request Mutual Aid. The objective of the MOU is to enable UK Ambulance Services to provide assistance with additional resources, i.e. people, vehicles, equipment (medical and communications), consumable medical and surgical supplies and specialist resources as necessary.

In the event that NIAS wish to activate the MOU, DoH will request formal approval from the relevant UK Health Department in writing, as each country will need to make its Minister/Senior Officials aware, and be assured the provision of mutual aid is not going to impact on delivery of services within their respective countries. NIAS will continue with activation of the MOU pending receipt of approval to DoH from the relevant Health Department.

NIAS also have an MOU with their counterparts in the Republic of Ireland for the provision of mutual aid which is facilitated through the Health Service Executive (HSE).

Mutual aid from overseas for mass casualty incidents occurring in the UK will be requested and co-ordinated via DHSC (England).

5.7.3 Repatriation of UK Residents involved in Mass Casualty Incidents Overseas

Recent global events have identified the need for the UK to be ready to receive UK citizens (both patients and worried well) who have been involved in a catastrophic incident outside of the UK. Whilst the immediate lifesaving element

of the response will be managed locally, depending on the type and scale of the incident there may be a need for NI health assets to be engaged in multi-agency reception arrangements, mainly at principal airports.

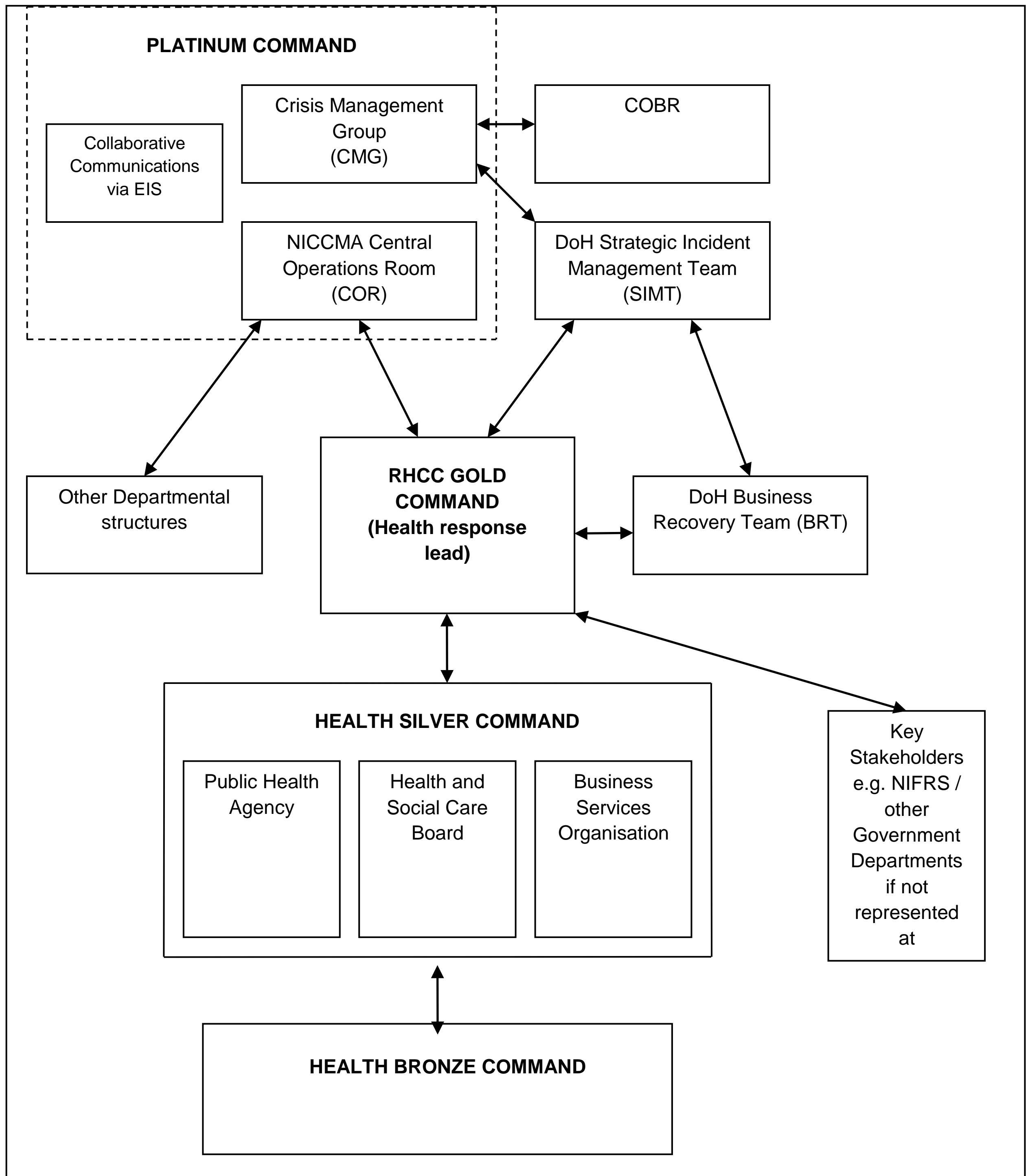
Although the majority of the people returning will present with only minor conditions, some people may have significant injuries which have been unnoticed during the evacuation process. Some may be suffering from mental health problems, post-traumatic stress disorders, or bereavement as a result of the incident(s) they were caught up in. Therefore it is important that suitable triage, clinical assessment processes and ambulance transport arrangements are established at the receiving air and sea ports.

Sometimes the level and scale of the disaster overseas may prompt medical professionals in the UK to consider how they may be able to give direct assistance to the country affected. Whilst it is for each individual to make that judgement, it must be considered how this offer of assistance will dovetail into other international relief efforts. DHSC (England) EPRR as part of the cross-government response, will work with colleagues in the DAs and other UK Government Departments to identify any support which may be needed, and where appropriate, circulate requests for assistance to the NHS within the UK.

Separate arrangements are in place for the reception and treatment of military personnel injured overseas. Mutual aid from overseas for mass casualty incidents occurring in the UK will be requested and co-ordinated via DHSC (England).

Mass Casualty Planning should ensure that suitable triage, clinical assessment processes and ambulance transport arrangements are established at the receiving air and sea ports.

5.8 Diagram of Command and Control Structures



CHAPTER 6 - CONCLUSION

Dealing with any incident that produces mass casualties will be a significant challenge to everyone who is engaged in the response. The impact on staff, patients and the public should not be underestimated. Whilst most people working in HSC organisations have experience of working during difficult and pressured incidents, responding to some of the more catastrophic events can only be achieved through pragmatic pre-planning and regular training and exercising.

Training and exercise programmes need to build on what is already in place. Key to this will be building and maintaining confidence in staff of all grades to work under extreme circumstances, and this will set the foundation for delivering the best patient care possible to all those affected.

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

ANNEX A

LIST OF RELATED GUIDANCE

1. The Northern Ireland Civil Contingencies Framework, (TEO)
2. The Role of the DHSSPS as Lead Government Department
3. DHSSPS Emergency Response Plan (ERP)
4. HSCB/PHA/BSO Joint Response Emergency Plan (JREP)
5. Trust Major Incident Plans (MIPs)
6. Decontamination Guidance
7. Hospital Lockdown Guidance
8. Protocol for the Establishment of Emergency Support Centres
9. DoH Emergency Planning and Business Continuity Controls Assurance Standards (CAS)
10. CBRN Release Protocol
11. A Guide to Evacuation in Northern Ireland, TEO
12. HSC Regional Acute Services Escalation Plan
13. Regional Redirection Protocol
14. Early Alert Protocol
15. Department of Health, Social Services and Public Safety (Emergency Powers) Direction (Northern Ireland) 2010
16. National Memorandum of Understanding concerning the Provision of Mutual Aid

The guidance referred to within this annex can be obtained from the relevant organisations responsible for publication, Emergency Planning Leads, or can be requested from Emergency Planning Branch, DoH.