Planning for Emergencies

MERSEYSIDE RESILIENCE FORUM

Mass Casualty Plan

Prepared by

Merseyside Local Health Resilience Partnership (LHRP)

Please note:
This is a NHSE Merseyside Plan that has been adopted by the MRF

NHS England

Merseyside LHRP Mass Casualties Plan

Merseyside LHRP Mass Casualties Plan

Version number: 4

First published: 3 November 2014

Review date: 3 November 2015

Prepared by: Jonathon Butler

Classification: Official

This plan outlines the arrangements in place in relation to a mass casualty incident requiring a coordinated response from health and social care providers across Merseyside. All stakeholders to raise awareness of this plan and take ensure that multi-agency plans and internal major incident plans are updated to reflect this plan, as appropriate.

The plan should be referenced during workshops and exercises during 2014/15 and reviewed annually.

DOCUMENT CONTROL

Plan version	Pages	Issued to	Date of amendment

ASSOCIATED WEBLINKS

The lexicon is updated regularly and is available on line at-
https:www.gov.uk/government/publications/emergency-responder-interoperability-lexicon
https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

Civil Contingencies Act 2004 (CCA)
(http://www.legislation.gov.uk/ukpga/2004/36/pdfs/ukpga_20040036_en.pdf),

Health and Social Care Act 2012
(http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf),

Mass Casualty Incidents: A Framework for Planning
(http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063393.pdf)

A map showing all the Major Trauma Centres in England is available at:
http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Documents/2012/map-of-major-trauma-centres-2012.pdf

DEFINITIONS

For the purpose of this plan the following terminology is defined as shown:

Casualty –
A person affected by a mass casualty incident that has caused them to have an injury or resulted in them requiring medical assistance.

Survivor –
A person affected by a mass casualty incident who has not been injured and does not require medical attention but may need non-medical support / to be evacuated from the scene following an incident.

Fatality –
A person who has died as a result of the incident.

Emergency –
An event or situation which threatens serious damage to human welfare in a place in the UK; the environment of a place in the UK; or the security of the UK or of a place in the UK

Major Incident –
An event or situation requiring a response under one or more of the emergency services' major incident plans.

Mass Casualty Incident –
A disastrous or simultaneous event(s) or other circumstances where the normal major incident response of Category One Organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response.

Command –
The exercise of vested authority, that is associated with a role or rank within an organisation, to give direction in order to achieve defined objectives.

Commander –
Personnel who, by function or rank, are charged with ensuring the readiness of their teams, forces or organisations to discharge their stated duties and obligations.

Control –
The application of authority, combined with the capability to manage resources, in order to achieve defined objectives.

Coordination-
The integration of multi-agency efforts and available capabilities, which may be interdependent, in order to achieve defined objectives.

Common Terminology in Emergency Management
A lexicon of common terminology has been established to define and promote commonly understood terms in emergency management.
The lexicon is updated regularly and is available on line at-
https:www.gov.uk/government/publications/emergency-responder-interoperability-lexicon
https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

ACRONYMS

CCA	Civil Contingencies Act
CCG	Clinical Commissioning Group
CCP	Casualty Collection Point
CCS	Casualty Clearing Station
DoH	Department of Health
DPH	Director of Public Health
EOC	Emergency operations Centre (Ambulance Control)
EPRR	Emergency Preparedness Response and Recovery
ETC	Emergency Treatment Centre
FMA	Forward Medical Adviser
HALO	Hospital Ambulance Liaison Officer
HART	Hazardous Response Team
HAZMAT	Hazardous Materials
HSCG	Health Strategic Coordinating Group
HTCG	Health Tactical Coordinating Group
ICC	Incident Control Centre
JESIP	Joint Emergency Services Interoperability Programme
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MERIT	Medical Emergency Response Incident Team
MERM	Merseyside Emergency Response Manual
MFRS	Merseyside Fire and Rescue Service
MRF	Merseyside Resilience Forum
NHS	National Health Service
NME	North Midlands and East Communications Service
NWAS	North West Ambulance Service
PHE	Public Health England
PTS	Patient Transport Service
RICC	Regional Incident Control Centre
SCG	Strategic Co-ordinating Group
STAC	Science & Technical Advice Cell
TCG	Tactical Co-ordinating Group (multi-agency)
RCG	Recovery Co-ordinating Group
SCG	Senior Coordinating Group (multi-agency)
USAR	Urban Search and Rescue
VAS	Voluntary Aid Society

CONTENTS

ACRONYMS 6
PLAN OVERVIEW AND ROLES 10
1. EXECUTIVE SUMMARY 10
2. INTRODUCTION 10
3. AIM OF THE PLAN 10
4. OBJECTIVES OF THE PLAN 11
5. SCOPE 11
6. TERRITORIAL EXTENT 12
7. PLAN OWNERSHIP 12
8. PLAN AUDIENCE 12
9. TESTING AND VALIDATION 12
10. LEGISLATION, NATIONAL AND MRF GUIDANCE AND LOCAL PROCEDURES 12
11. RISK ASSESSMENT 12
12. PLAN AUDIT AND REVIEW 13
13. CONTEXT 13
13.1 Background 13
13.2 Casualty Planning Assumptions 14
13.3 The Local NHS Response 15
13.4 Trauma Cell and Networks 16
14. MRF/LHRP STRUCTURE OF PLANS 18
ALERT AND ACTIVATION 19
15. DEFINITION OF MASS CASUALTY INCIDENT 19
16. ACTIVATION 19
17. ESCALATION LEVELS 20
18. ROLE PROFILES 21
18.1 NHS Tactical Commander (1st on Call) 21
18.2 NHS Strategic Commander (2nd on Call) 21
19. AREA TEAM ICC 21
20. STANDARD MESSAGES USED BY NHS ORGANISATIONS 22
21. NHS ACTIVATION – 24/7 24
RESPONSE 25
22. LEVELS OF COMMAND 25
22.1 Strategic Command 25
22.2 Tactical Command 25
22.3 Operational Command 25
22.4 Subsidiarity 25
23. COMMAND AND CONTROL OF THE NHS 25
24. NHS ORGANISATIONS' RESPONSE ROLES 26
24.1 NHS England Merseyside Area Team 26
24.2 NHS Acute Providers 27
24.3 Other NHS Providers and Specialist Services 27

24.4 CCGs....28
24.5 PHE Centre for Cheshire and Merseyside....28
25. NWAS RESPONSE ROLE....28
26. NORTH WEST AIR AMBULANCE SERVICE....30
27. NHS CONFERENCE CALL ARRANGEMENTS....30
28. HTCG....30
29. HEALTH STRATEGIC COORDINATING GROUP (HSCG)....30
30. MULTI- AGENCY COMMAND AND CONTROL....31
30.1 SCG....31
30.2 TCG....31
KEY RESPONSE ISSUES....34
32. PRELIMINARY ASSESSMENT....34
33. URBAN SEARCH AND RESCUE (USAR)....34
33.1 Hazardous Area Response Team (HART)....34
33.2 Hazardous Materials (HAZMAT) Response....35
34. CASUALTY MANAGEMENT AT THE SCENE AND PRE-HOSPITAL CARE....35
35. INCIDENT DIAGRAM....37
36. CASUALTY COLLECTION POINT....38
36.1 NWAS Hospital Ambulance Liaison Officer (HALO) - Call sign 'Hospital Ambulance Liaison' (hospital name)....39
36.2 Medical Advisor - Call sign 'Silver Medic'....40
36.3 Forward Medical Advisor - Call sign 'Bronze Medic'....40
36.4 Casualty Clearing Medical Advisor (CCMA) - Call sign 'Casualty Clearing Medic'....40
37. RECEIVING HOSPITALS....41
37.1 Accelerated Hospital Discharge....41
37.2 Cancellation of Outpatient Services –....41
38. EMERGENCY TREATMENT CENTRES (ETCs)....41
39. TRANSPORT ARRANGEMENTS....42
40. HUMANITARIAN ASSISTANCE (EVACUATION AND SHELTER)....43
41. PUBLIC SAFETY....44
42. MASS FATALITIES....44
43. PSYCHO-SOCIAL SUPPORT FOR RESPONDERS....45
44. THE JOINT DECISION MODEL....45
45. COMMUNICATION AND PUBLIC INFORMATION....50
45.1 Multi-agency....50
45.2 NWAS....50
45.3 North Midlands and East Communications Service (NME)....50
45.4 Communications – Agencies' Roles....52
45.5 Hospital Communications....53
46. COMMUNICATING PATIENT IDENTIFICATION....53
47. STAND DOWN....53
48. STAND DOWN CASCADE AND ACTIONS NOTE:....54

RECOVERY AND BUSINESS CONTINUITY 55
49. RECOVERY 55
49.1 Multi-agency Recovery Process 55
49.2 NHS Recovery Process 55
49.3 Role of NHS England (Merseyside) 56
49.4 NHS Roles and Responsibilities 57
50. STAFF WELFARE 57
51. DEBRIEFS AND REPORTS 57
52. MULTI-AGENCY DEBRIEF 57
53. BUSINESS CONTINUITY MANAGEMENT 57
APPENDIX 1 59
LHRP AGENCIES ROLES – GENERAL 59
NHS England (Merseyside) Area Team 59
Primary Care Services 59
NHS England Regional Team 59
NHS England Corporate Team 60
Acute Trusts and Foundation Trusts 60
Community Health Services 60
Primary Care Services 60
Public Health England (PHE) 61
Port Health Authority 61
Local Authority Public Health Function 61
Clinical Commissioning Groups (CCGs) 62
NWAS 62
CATEGORY 1 RESPONDERS 62
CATEGORY 2 RESPONDERS 63
OTHER SUPPORT AGENCIES 63
THIRD SECTOR ORGANISATIONS/GROUPS 63
APPENDIX 2 65
NATIONAL GUIDANCE AND LEGISLATION 65
APPENDIX 3 67
NHS CONFERENCE CALL - SUGGESTED AGENDA 67
APPENDIX 4 68
TELECONFERENCE ROLL CALL 68
APPENDIX 5 70
HSCG/HTCG MEETING – STANDING AGENDA 70

PLAN OVERVIEW AND ROLES

1. EXECUTIVE SUMMARY

This plan outlines the operational arrangements to be undertaken in response to an incident in Merseyside or in support of an incident in neighbouring communities, involving mass casualties.

The plan has been prepared in line with:

- Civil Contingencies Act 2004 (CCA) (http://www.legislation.gov.uk/ukpga/2004/36/pdfs/ukpga_20040036_en.pdf),
- Health and Social Care Act 2012 (http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf),
- Merseyside Resilience Forum (MRF) plans and procedures, and Local Health Resilience Partnership (LHRP) plans and procedures.

The plan contains procedures for activation; alert and mobilisation of staff and sets out clear command and control structures.

It is important that all relevant officers of organisations in the LHRP and the Resilience MRF are aware that the plan exists and understand fully their contribution to the implementation of the plan.

This plan should be read in conjunction with the Merseyside Emergency Response Manual 2013 (MERM).

2. INTRODUCTION

The Health and Social Care Act 2012 has made significant changes to the health system in England. Arrangements for Health Emergency Preparedness, Resilience and Response (EPRR) from April 2013 (published in April 2012), sets out the arrangements for delivering safe and consistent EPRR in the health sector in England from April 2013.

Local Health Resilience Partnerships were established to deliver national EPRR strategy in the context of local risks. These bring together the health sector organisations involved in EPRR at the MRF level. Building on existing arrangements for health representation at Local Resilience Forums (LRFs), the LHRP is a forum for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies.

The Merseyside LHRP footprint maps the MRFs' and provides a coordinated point of contact with the MRF and reflects a national consistent approach to support effective planning of health emergency response.

3. AIM OF THE PLAN

The aim of this plan is to describe the arrangements agreed by Merseyside LHRP as part of a multi-

agency response to a mass casualty incident arising from a sudden, focal, time-limited event - such as a rail / plane crash, an explosion or a terrorist attack - which overwhelms normal local response capabilities.

The incident may occur outside of Merseyside, but may still require Merseyside's resources to be utilised.

4. OBJECTIVES OF THE PLAN

The objectives of this plan are to:

- provide an overview of the mechanisms available to deliver the local response in the event of a mass casualty incident;
- explain how these mechanisms can be activated;
- describe command and control within across NHS organisations and other co-ordination arrangements within Merseyside for a mass casualty incident, and;
- provide an overview of the roles and responsibilities of individual agencies involved in a response to a mass casualty incident.

5. SCOPE

This plan provides operational concepts unique to a mass casualty event, confirms the responsibilities of relevant agencies, and describes the agreed co-ordinated response efforts that will be required to meet the needs of local communities following a mass casualty-producing incident.

The development of this plan builds upon current Department of Health (DoH) guidance on planning for mass casualty incidents:
Mass Casualty Incidents: A Framework for Planning
(http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063393.pdf) and its relationship to command and control, and linkages to resilience structures.

The plan recognises that the NHS in Merseyside may be asked to provide support to an incident elsewhere, which may require the establishment of a Health Strategic/Tactical Coordinating Group (HSCG/HTCG) and/or a multi-agency Strategic/Tactical Co-ordinating Group (SCG/TCG) to be established to support the NHS response.

This plan does not cover the response to widespread and slow onset events such as a flu pandemic or a sustained period of severe weather;

Whether this plan is used is not dependent upon the number of casualties, but will depend on:

- the nature and severity of the injuries;
- the circumstances of the incident, and;
- the particular features of the group(s) of people affected by the incident.

6. TERRITORIAL EXTENT

This plan outlines the multi-agency arrangements which may be established when managing:

- a response to a mass casualty incident taking place in Merseyside;
- a response to multiple mass casualty incidents outside of Merseyside, including simultaneous incidents in Merseyside, and;
- the effects of mass casualty incident(s) taking place outside Merseyside but that may impact upon Merseyside.

7. PLAN OWNERSHIP

This plan has been developed at the request of the Merseyside LHRP and ownership rests with the group and its individual member agencies.

8. PLAN AUDIENCE

This plan is intended for all LHRP organisations and their staff at each level of the command structure.

9. TESTING AND VALIDATION

This plan will be tested and validated through exercises developed as part of the LHRP training and exercising programme.

10. LEGISLATION, NATIONAL AND MRF GUIDANCE AND LOCAL PROCEDURES

A list of associated legislation, national guidance and local procedures is included in Appendix 2.

11. RISK ASSESSMENT

The CCA places a duty on all Category 1 Responder organisations to develop and maintain a Community Risk Register. This multi-agency duty is delivered through the MRF.

The LHRP agenda is driven by risk and capability and the LHRP utilises the MRF Community Risk Register to map and assess the risk profile against local health sector capability, which is developed into the LHRP Work Programme.

Also, the LHRP has produced the LHRP Risk Register to identify the potential risks that affect its work and progress. This Risk Register provides the basis for the responder agencies to develop emergency plans.

Mass casualty incidents can occur without warning and can broadly fall within:

- Natural events such as flooding and severe weather;
- Major accidents such as transport, industrial and fire;
- Malicious attacks such as terrorism and criminality, and;
- Crowd related incidents involving disorder and overcrowding.

It will be necessary to take into account the dynamics of the incident, the nature and severity of the trauma suffered, the ratio of ambulance/medical resources available, and the accessibility and appropriateness of clinical expertise/resources available, within the critical timeframe, in order to reduce mortality from injury.

It is therefore, difficult to map options against fixed casualty thresholds and the options that are implemented will vary from one scenario to the next.

Examples of complex incidents which could produce numbers on a scale that could be described as mass casualties include:

Incident	Location	Fatalities	Injured
Terrorist attack on the World Trade Centre	New York	2993	8700
Bomb in a Nightclub	Bali	202	300
Multiple bombing attacks to a transport system	Madrid	191	1900
Multiple bombing across a city	London	52	650

Incidents and the number of casualties (Department of Health, 2007)

12. PLAN AUDIT AND REVIEW

This plan will be subject to audit and on-going review and revision in the light of learning from exercises, changes in partner agency plans and changes to NHS and other appropriate guidance.

Any revision of the plan will be aligned to the MRF Risk Register and the LHRP Risk Register.

13. CONTEXT

13.1 Background

Mass casualty incidents involve a step change in the demands that are made on all parts of the NHS and partner organisations. Doing more of the same is unlikely to be adequate - organisations and their staff need to adopt a different approach to their planning and response for such incidents in order to cope. For the response to work effectively there needs to be a whole systems approach into the way healthcare is delivered.

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

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

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

All patient types, including patients who are being admitted from the wider population, will need to be treated against a backdrop of prioritisation and available healthcare capacity and resources

The most common injuries caused as a result of a mass casualty incident are eye injuries, sprains, strains minor wounds and ear damage.

The most severe injuries are multiple fractures, burns, lacerations and crush injuries.

13.2 Casualty Planning Assumptions

The table below shows illustrative planning assumptions that can be used to calculate the potential numbers of patients in each category. It is vital for NHS provider organisation plans to consider early in the activation stage of a local/significant emergency (major incident) what the real-time point of criticality is, as internal factors (e.g. theatre closed for maintenance) will have an impact on the numbers of patients in each category a NHS provider organisation may be able to manage.

Priority	Category	Patient Condition	% of total
P1	Immediate	Casualties needing immediate life-threatening resuscitation and / or surgery	25%
P2	Urgent	Stabilised casualties needing early intervention within 6 hours	25%
P3	Delayed	Less serious cases that require treatment but not within a set time i.e., 'walking wounded	50%
P4	Expectant	Casualties who cannot survive treatment or for whom the degree of intervention required means their treatment would seriously compromise the treatment to others	N/A
Dead	Dead	Dead	N/A

13.3 The Local NHS Response

In a response to an emergency, the NHS in Merseyside will often consider its response and actions using five distinct local health economies, each based upon an acute trust with an accident and emergency unit (or Local Trauma Unit):

Name of Acute Trust Provider	Community Service Provider	Mental Health Provider	Clinical Commissioning Group	Local Authority
Royal Liverpool	LCH	Mersey Care	Liverpool CCG	Liverpool
Southport and Ormskirk	Integrated Care Organisation and LCH	Mersey Care	Southport and Formby South Sefton	Sefton
Aintree	LCH	Mersey Care	Liverpool and South Sefton CCG	Liverpool
St Helens and Knowsley	Bridgewater 5 Borough's Partnership	5 Boroughs Partnership	St Helens, Knowsley and Halton	St Helens
Alder Hey	LCH	Internal Provision	Knowsley, Liverpool and South Sefton	Liverpool
Wirral University Teaching Hospital	Wirral community Health Service	Cheshire & Wirral Partnership Mental Health Trust	Wirral CCG	Wirral

In any mass casualty incident those accident and emergency units nearest to the scene of the incident will play a major role in the treatment of those who are injured, especially those who are seriously injured. However the development of Trauma Networks across the NHS means that is it likely, quite quickly, that any response to a mass casualty incident in Merseyside will involve a NHS response incorporating the North West of England and beyond, especially for P1 and P2 patients.

13.4 Trauma Cell and Networks

North West Ambulance Service (NWAS) Trauma Cell

The NWAS Trauma Cell is a clinician staffed resource that coordinates Major Trauma Activity for the North West 24 hours a day, 7 days a week. It is staffed by an Advanced Paramedic and an Emergency Medical Dispatcher. Incidents identified as having the potential for a major trauma are tagged by trauma cell staff who then provide direct clinician-led advice to crews on scene regarding clinical treatment and transport options.

The Trauma Cell Advanced Paramedics have direct access to communicate with the regional Trauma Centres and Trauma Units to ensure the best treatment for major trauma patients in the region.

In the event of a major incident, the role of the Trauma Cell will be necessarily dynamic depending on the type and location of the incident, the nature of the severity of injuries and the numbers of patients involved.

The Trauma Cell will have a dual role within the major incident, not only as a resource for Strategic Commanders to ensure effective treatment of the injured but also for monitoring major trauma activity across North West Ambulance Service (NWAS) as part of maintaining normal levels of service for unaffected areas.

The use of an Advanced Clinician to assist with the decision making will ensure the best treatment for patients with major trauma as a result of a major incident.

Major Trauma Centres

Increasingly any response to a major incident – including a mass casualty incident - will involve the use of a Major Trauma Centres by the NHS. Hospitals in Merseyside designated as Major Trauma Centres are listed below.

In the North West of England a Major Trauma Centre is not always a single designated hospital site, but can be groups of acute hospitals which have access to both:

- large accident and emergency facilities, and;
- a range of specialist health services to aid the treatment of those with serious injuries (e.g., neurosurgery for brain injuries).

This means that patients with certain types of injuries will either be:

- sent straight to a Major Trauma Centre for treatment, and;
- sent to a Local Trauma Unit (i.e., the local accident and emergency unit) to allow their condition to be stabilised prior to being transferred to a Major Trauma Centre;

Always contingent on the patient receiving the appropriate life-saving treatment delivered as soon as possible. NWAS play a key role, in accordance with agreed pathways of care, in determining where a patient is taken. This is something NWAS do day-in day-out and is not just restricted to a major incident response.

Across the North West of England the Major Trauma Centres are:

(a) Liverpool Collaborative Major Trauma Centre

Incorporating the following hospitals:

- Aintree University Hospital,
- The Walton Centre
- Royal Liverpool University Hospital
- Alder Hey Children's Hospital, Liverpool (Children's Centre);
- Royal Manchester Children's Hospital (Children's Centre).

(b) Manchester Collaborative Major Trauma Centre

Incorporating the following hospitals:

- Salford Royal Hospital
- Manchester Royal Infirmary,
- University Hospital South Manchester

A map showing all the Major Trauma Centres in England is available at: http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Documents/2012/map-of-major-trauma-centres-2012.pdf

(c) Burns

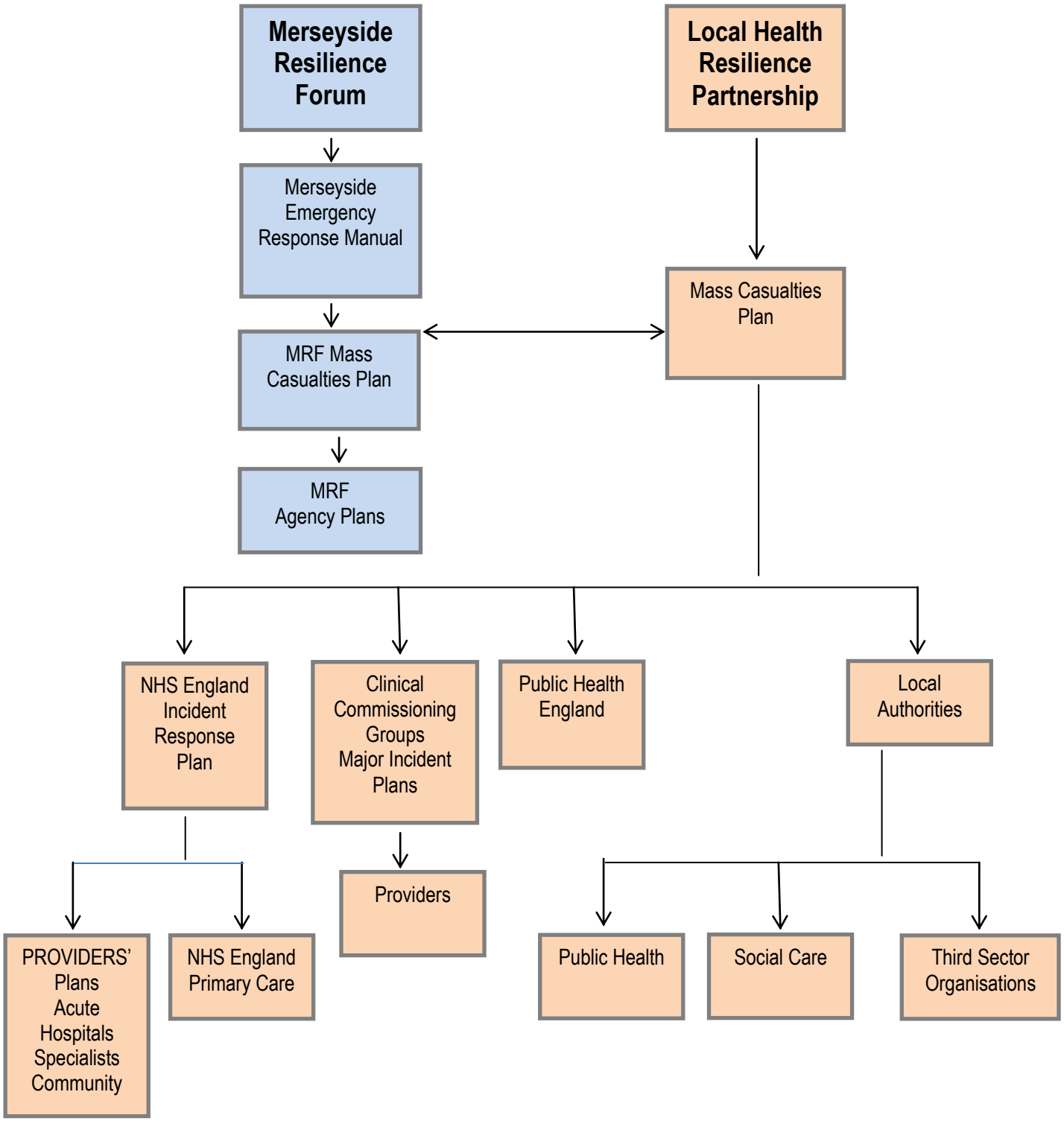
For some specialised services, such as burns, casualties may have to be referred to specialist hospitals outside of these trauma centres. In the North West the adult's burns service is provided at St Helens and Knowsley (Whiston) Hospital and paediatric burns at Alder Hey Children's Hospital with outreach support from St Helens and Knowsley (Whiston) Hospital.

Separate burns service plans exist within the NHS.

(d) Paediatric Services

Paediatrics specialist healthcare services for children and young people throughout the North West and nationally, are provided at Alder Hey Children's Hospital and Royal Manchester Children's Hospital.

14. MRF/LHRP STRUCTURE OF PLANS



ALERT AND ACTIVATION

15. DEFINITION OF MASS CASUALTY INCIDENT

A mass casualty incident is defined as 'a disastrous or simultaneous event(s) or other circumstances where the normal major incident response of Category 1 Responders 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.

16. ACTIVATION

This plan relates to a major incident of extremely serious proportions involving potentially large numbers of casualties that are beyond the capacity created by the local implementation of major incident plans.

Activation of this plan will occur when a mass casualty-producing incident requires Merseyside response capabilities. Depending upon the nature of the incident, two scenarios are likely that may trigger the activation of this plan

(1) in response to an incident that occurs locally in Merseyside that leads to demand on Merseyside response resources which may gradually increase and it may well be that local resources are quickly overwhelmed, and;

(2) in response to a request from another area for mutual aid.

It is most likely that a request to activate this plan will be made by:

(a) a Senior Police Officer either:
- responding to a mass casualty incident, or
- based on intelligence of a possible mass casualty incident;

(b) a Senior Ambulance Officer from NWAS in consultation with the NHS Gold Commander;

(c) Ambulance Control, acting on advice from -
- its officers at the scene of an incident, or
- receiving hospitals;

(d) the Merseyside NHS Strategic Commander (2nd on call), acting on advice from -
- NWAS Regional Health Control Desk (03451130099);

- receiving hospitals in Merseyside;
- a request for mutual aid from another area of the NHS (made through NHS command and control processes), or;
- a Local Authority DPH/ Consultant in Health from PHE as a result of a public health emergency.

In accordance with MERM, a request to activate this plan will be subject to a Dynamic Risk Assessment and should lead to the formal declaration of either:

- a "**major incident declared**, or;
- a "**major incident – standby**"

NHS provider organisations in Merseyside and NWAS have established procedures designed to handle a certain level of increased patient activity by transferring less critical patients to other treatment facilities such as Minor Injury Units and Walk-in Centres, cancelling elective procedures, and expanding surge capacity.

Incidents that exceed the resources of Merseyside will result in NHS England, through its Area Teams and Regional structures, in co-ordinating the deploying of regional / national NHS assets.

17. ESCALATION LEVELS

As an incident evolves it may be described, in terms of its level, as one to four as identified in the table below.

Alert	Activity	Action	NHS England Incident Levels	
Alert	Dynamic Risk Assessment	Declaration of incident level	1	A health related incident that can be responded to and managed by local health provider organisations that requires co-ordination by the local CCG.
			2	A health related incident that requires the response of a number of health provider organisations across an NHS England area team boundary and will require an NHS England area team to co-ordinate the NHS local support.
			3	A health related incident, that requires the response of a number of health provider organisations across and NHS England area teams across an NHS England region and requires NHS England Regional co-ordination to meet the demands of the incident.
			4	A health related incident that requires NHS England National co-ordination to support the NHS and NHS England response.

18. ROLE PROFILES

18.1 NHS Tactical Commander (1st on Call)

The role of the NHS Tactical Commander (1st on call) is to:

- Act as the first point of contact;
- Assess information received;
- Support and advise the NHS Strategic Commander (2nd on Call);
- Assist with inter-agency communication, and;
- Coordinate communication with external Trusts.

18.2 NHS Strategic Commander (2nd on Call)

The role of the NHS Strategic Commander is to:

- Direct all actions including escalation, and;
- Coordinate the wider NHS response;

19. AREA TEAM ICC

The Area Team ICC is the Strategic Command and Control Centre for the NHS emergency responders on Merseyside (including Wirral). It will be staffed and managed by NHS England Team and may be supported by liaison officers from all agencies represented at the LHRP.

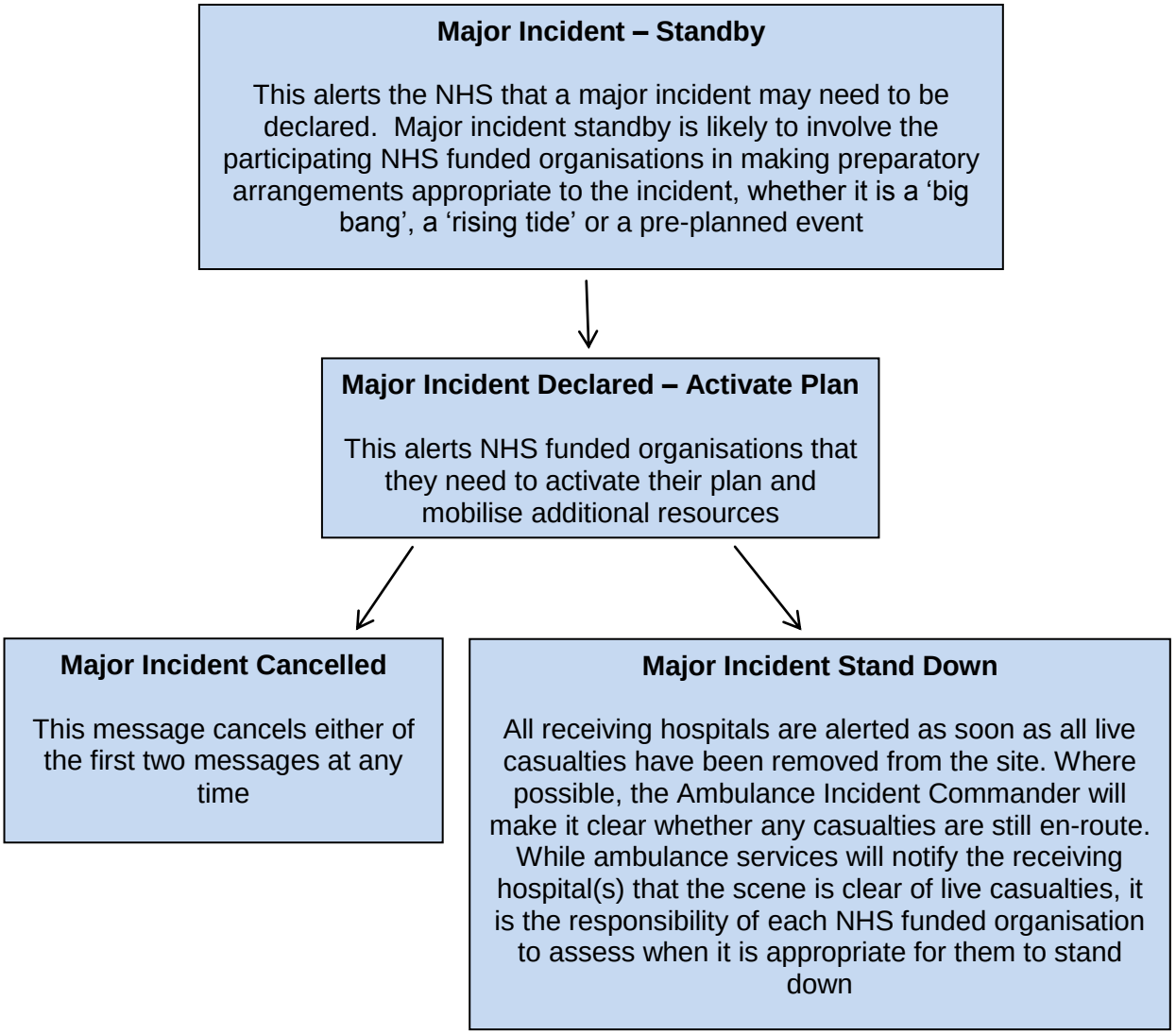
In the event of a mass casualties' incident, consideration should be given as early as possible to the activation of the ICC.

The ICC is located at:

Regatta Place (2nd Floor)
Brunswick Business Park
Summers Road
Liverpool
L3 4BL

20. STANDARD MESSAGES USED BY NHS ORGANISATIONS

To avoid confusion about when to implement plans, it is essential to use these standard messages in relation to both significant and major incidents:



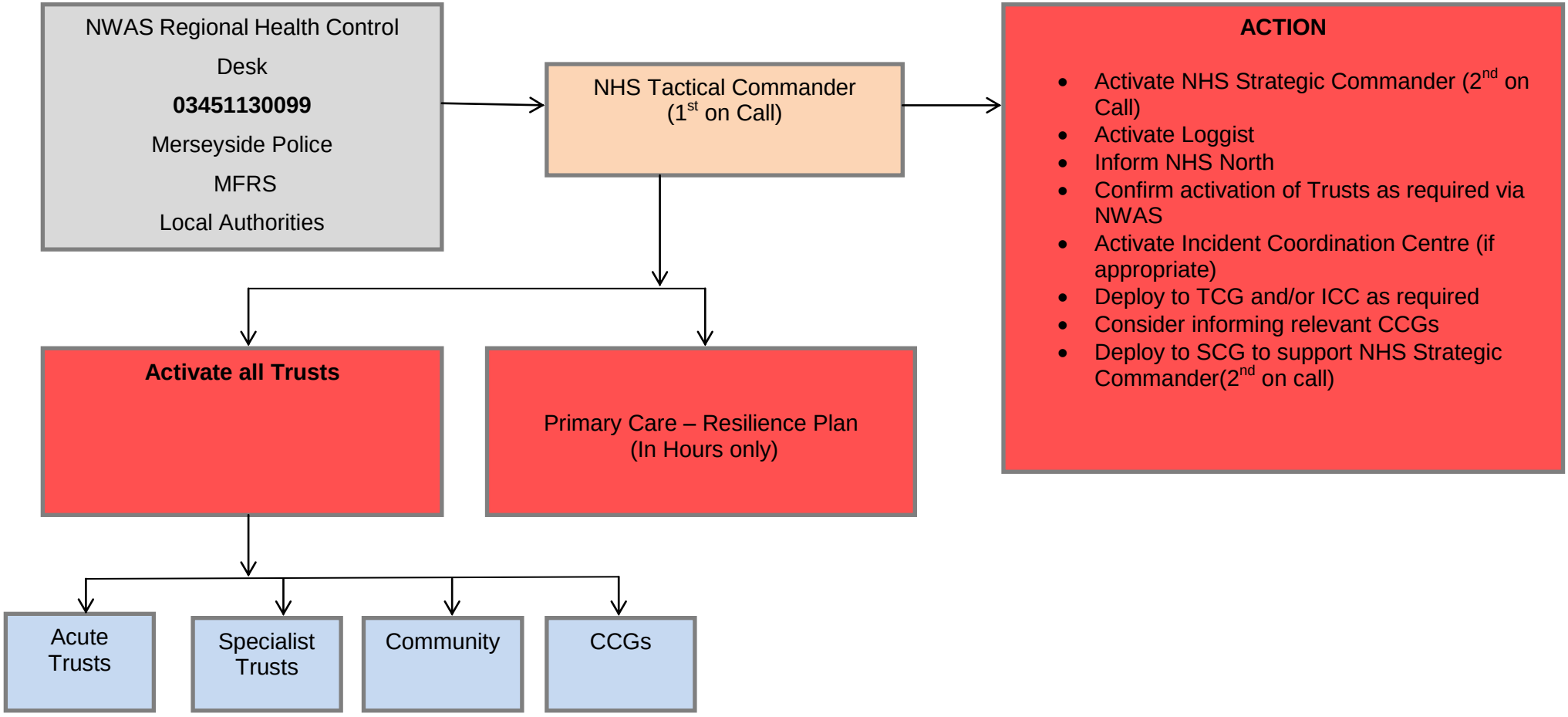
Activation – Standard Format (METHANE)

The following mnemonic should be used when passing information, in the initial stages, between emergency responders and Control Rooms to enable the establishment of shared situational awareness:

- **M**ajor incident declared?
- **E**xact location;
- **T**ype of incident e.g. explosion, building collapse;
- **H**azards present, potential or suspected;
- **A**ccess – routes that are safe to use;
- **N**umber, type, severity of casualties, and;
- **E**mergency services now present and those required.

21. NHS ACTIVATION – 24/7

Major Incident (Local Emergency) and Direct Commissioning Issues Out of Hours Escalation



RESPONSE

22. LEVELS OF COMMAND

All NHS organisations and those providing NHS funded care are required to have suitable plans in place to respond effectively to significant incidents, emergencies and periods of extreme pressure. These plans include the ability to apply a robust command and control structure which will provide strong leadership and management for both internal and external incidents.

Each organisations command and control structure must include the strategic, tactical and operational functions and should provide cover 24 hours a day, 365 days a year.

NHS organisations are responsible for providing assurance to the Area Team that its plans have been tested and exercised in line with national guidance and that it has sufficient trained staff to cover the various roles in its plan during a prolonged incident.

22.1 Strategic Command

Responsible for determining the overall management, policy and strategy for the mass casualties incident, whilst maintaining normal services at an appropriate level, and identifying the longer term implications and plan for the return to normality.

22.2 Tactical Command

Responsible for managing the mass casualties incident on behalf of their organisation involving making tactical decisions, determining operational priorities, allocating staff and physical resources and developing a tactical plan to implement the agreed strategy.

22.3 Operational Command

Responsible for providing the immediate 'hands on' response to the mass casualties incident, carrying out specific operational tasks either at the scene or at a supporting location such as a hospital or rest centre.

22.4 Subsidiarity

A guiding principle of emergency response is that of subsidiarity. This means that decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level.

This means that for any incident the appropriate response tiers of operational, tactical and strategic should be tailored to the needs of that incident and implemented in 'bottom-up order'.

23. COMMAND AND CONTROL OF THE NHS

The NHS response to a mass casualty incident will be co-ordinated in Merseyside by NHS England's Area Team.

The NHS Strategic Commander (2nd on call) at the SCG will coordinate any multi-agency requests

from health and present these to partner agencies.

If appropriate, at the request of the NHS Strategic Commander (2nd on call), NHS England (North) will co-ordinate the deployment of medical teams to assist in providing medical care in the affected areas from resources from across the North of England.

Merseyside has surge management plans in place and each NHS acute trust has major incident plans to respond to a mass casualty incident.

NHS England North's RICC will consider with the DoH Regulations to allow medical students, pharmacy students, Emergency Medical Technician students, paramedic students and nursing students - on a case-by-case basis - to practice prior to the completion of their licensing requirements. Where appropriate, Patient Group Directives will be developed to enable effective patient care to be established.

If necessary, the RICC will request support from the DoH. This support will be co-ordinated through the NHS England's National EPRR team.

24. NHS ORGANISATIONS' RESPONSE ROLES

When a major incident has been declared, involving mass casualties, the NHS agencies response roles shown below, will be actioned.

24.1 NHS England Merseyside Area Team

- Through the NHS Strategic Commander (2nd on call) assuming the command and control of all NHS resources across Merseyside;
- through the NHS Strategic Commander (2nd on call), attending the SCG, if established, to represent local NHS organisations;
- through the NHS Tactical Commander (1st on call) , attending the TCG, if established, to represent local NHS organisations;
- implementing Merseyside Area Team's internal Incident Response Plan and opening Merseyside Area Team ICC;
- ensuring NHS representation at the various groups convened;
- notifying and alerting all local NHS organisations and ensure NHS command and control mechanisms are established and implement this plan (as necessary);
- instruct Trusts to lockdown facilities;
- considering local NHS response plans and working with all NHS providers to create additional acute hospital capacity / staff Emergency Treatment Centres (ETCs), (as appropriate);
- liaising with NWAS to identify Receiving and Supporting Trusts;
- as necessary, mobilising NHS support for PHE Centre for Cheshire and Merseyside activities for disease surveillance and epidemiology teams;

- request the deployment of voluntary agencies and faith sector representatives to key locations via local authorities as appropriate;
- co-ordinating NHS support for the activation of emergency public health measures (where appropriate) under the guidance of the for PHE Centre for Cheshire and Merseyside, and;
- liaising with NHS England (North) - Regional Incident Co-ordination Centre (RICC) - in respect of providing briefing and requesting /organising mutual aid from the wider NHS.

24.2 NHS Acute Providers

- Implementing necessary major response plans if designated as a Receiving Hospital;
- consider implementing necessary major response plans if not designated as a Receiving Hospital;
- establishing control rooms and co-ordinate activities through the NHS Strategic Commander (2nd on call);
- liaising with the NHS Strategic Commander (2nd on call) in respect of the overall NHS response and providing briefings;
- providing mutual aid and support to NWAS / those acute hospitals who have been designated as Receiving Hospitals;
- in light of the situation and the advice from senior clinical leads, providing the best care possible, under the circumstances, within the healthcare capacity available, and;
- considering the temporary re-alignment of treatment protocols to reprioritise patient care and considering the following:
    - Identifying patients suitable for rapid discharge under the Accelerated Hospital Discharge protocol (as and when health and social care capacity becomes available;
    - Rapid expansion of A&E capacity;
    - Ensuring capacity in receiving wards;
    - Supplementing available staff and equipment;
    - Ceasing all elective activity;
    - Alternative use of specialist/day care beds;
    - Expanding theatre and ICU capacity in line with local plans;
    - Cancellation of outpatient services, and;
    - With due ethical consultation implement patient triage along the principles of "hospital treatment for those who will most benefit from it", and deploying, when requested and if not a Receiving Hospital, staff to support MERIT teams, other NHS Acute Providers and ETC.

24.3 Other NHS Providers and Specialist Services

- Implementing major response plans as necessary;
- establishing control rooms and co-ordinate activities through the NHS Strategic Commander (2nd on call);
- liaising with the NHS Strategic Commander (2nd on call) in respect of the overall NHS response

and providing briefings;

- providing mutual aid and support to NWAS / those acute hospitals who have been designated as Receiving Hospitals;
- considering the temporary re-alignment of treatment protocols to reprioritise patient care consider implementing Accelerated Hospital Discharge protocol and the cancellation of non-critical service;
- in light of the situation and the advice from senior clinical leads, providing the best care possible, under the circumstances, within the healthcare capacity available;
- opening, if requested, an ETC at their premises, and;
- deploying when requested, staff to support NHS Acute Providers and ETCs.

24.4 CCGs

- Implementing major response plans as necessary;
- establishing control rooms and co-ordinate activities through the NHS Strategic Commander (2nd on call);
- liaising with the NHS Strategic Commander (2nd on call) in respect of the overall NHS response and providing briefings;
- assisting with the management of pressures upon local NHS providers in line with their local health economy's escalation plans;
- providing mutual aid and support to NWAS / those acute hospitals which have been designated as Receiving Hospitals;
- deploying, when requested, staff to support ETCs, and;
- providing mutual aid to the Merseyside Area Team, when requested.

24.5 PHE Centre for Cheshire and Merseyside

- Providing public health support and advice to NHS organisations, particularly NHS England, CCGs and the local DPHs, and also other agencies involved in responding or managing the emergency at a Merseyside-wide level;
- providing impartial and authoritative advice to health professionals, other agencies, particularly local authorities and the public in monitoring long term effects of an emergency;
- providing specialist advice at regional, national and international level, and
- providing specialist input to the SCG/TCG including activating a Scientific and Technical Advice Cell (STAC), if requested.

25. NWAS RESPONSE ROLE

The primary roles of NWAS in an emergency are -

- Save life, in conjunction with the other emergency services;
- establish a strategic, tactical and operational command structure;

- have ‘on call’ Ambulance Tactical Advisors with the expertise to provide advice on matters relating to the Major Incident Plan and the appropriate response by the Trust;
- allocate a Safety Officer who has responsibility to protect the health and safety of ambulance and NHS personnel on site;
- coordinate and manage the on-site NHS response;
- alert other emergency services;
- provide a nominated member of staff to communicate with receiving hospitals, to be known as Hospital Ambulance Liaison Officer (HALO);
- provide on-site ambulance communications and Communications Officers;
- ensure that a log of all NWAS actions and communications are kept;
- instigate the use of a CCS when required;
- instigate the use of recognised triage ‘sieve’ and ‘sort’ on all patients prior to evacuation from scene;
- arrange and maintain the required personnel to provide optimal levels of treatment of casualties at the site;
- arrange and maintain the most appropriate means of transporting the injured to the receiving hospitals;
- early recognition of potential major trauma incidents;
- ensure appropriate allocation of resources to major trauma incidents (such a medical responders, Advanced or Senior Paramedics, Heli-med or additional resources);
- tracking progress of resources during major trauma incidents and providing pre-hospital clinical decision support including designation of appropriate receiving units;
- manage forward transfers of patients from Trauma Units to Major Trauma Centres;
- have the facility to deploy and provide sufficient bulk equipment (including oxygen) to meet the requirements at site;
- provide clinical decontamination of casualties that includes dirty side triage and limited Hot Zone clinical intervention;
- support public mass decontamination by maintaining health presence at the mass decontamination units when activated by fire and rescue services;
- provide post incident welfare and debriefing for its entire staff involved in the incident;
- ensure that supporting agencies such as MERIT, Voluntary Aid Societies (VAS) and Community Responders receive adequate welfare and debriefs;
- to comply with LRF multi-agency plans for the management of mass fatalities (and Regional Mass Fatalities Plan). Ensure that ambulances are not deployed for the removal of the deceased, ambulance services can only be concerned with transport of live casualties;
- provide a plan that has the flexibility to enable an effective response to a multi-sited incident;
- inform wider health partners of a Major Incident, and;
- warning and informing of the public.

26. NORTH WEST AIR AMBULANCE SERVICE

North West Air Ambulance Service is a registered charity and consists of three aircraft based strategically across the NWAS footprint.

Helipads are located at a number of hospitals to enable air ambulance transfers of patients.

27. NHS CONFERENCE CALL ARRANGEMENTS

NHS organisations' emergency plans should include the NHS Merseyside Conference Call arrangements. The draft agenda for Conference Calls is included at Appendix 3 and the Roll Call participants list is included at Appendix 4.

28. HTCG

If the NHS Strategic Commander (2nd on call) decides that the response to an incident requires coordination at the tactical level across NHS organisations, a HTCG will be convened.

The main role of the HTCG is to oversee and support but not be directly involved in the operational response and includes:

- Responsibility for directly managing the Merseyside NHS organisations' response;
- the development of a tactical plan which will achieve the objectives set by strategic command;
- overseeing the NHS response at operational level and ensuring that the response is coordinated and effective;
- setting response priorities in line with strategic command, and;
- allocating resources and coordinating tasks.

The NHS Strategic Commander (2nd on call) will decide which NHS organisations need to be represented at the HTCG and its meeting location.

A draft agenda is included at Appendix 4.

29. HEALTH STRATEGIC COORDINATING GROUP (HSCG)

If the NHS Strategic Commander (2nd on call) decides that the response to an incident requires coordination at the strategic level across NHS organisations, a HSCG will be convened.

The main role of the HSCG is to exercise overall command of the response to an incident by delegating tactical decisions and avoiding direct involvement in managing the tactical or operational detail, and includes –

- Control of NHS resources;
- liaison with partners to develop the strategy and policies;
- allocation of funding;
- ensuring that NHS normal services are maintained at an appropriate level, so far as possible, and;
- consideration of the incidents wider context to establish its longer term and wider effects.

The NHS Strategic Commander (2nd on call) will decide which NHS organisations need to be represented at the HSCG and its meeting location.

A draft agenda is included at Appendix 5.

30. MULTI- AGENCY COMMAND AND CONTROL

If a significant incident is large or widespread, it may be necessary to coordinate the response of several organisations. This may be at tactical level or at both tactical and strategic level.

30.1 SCG

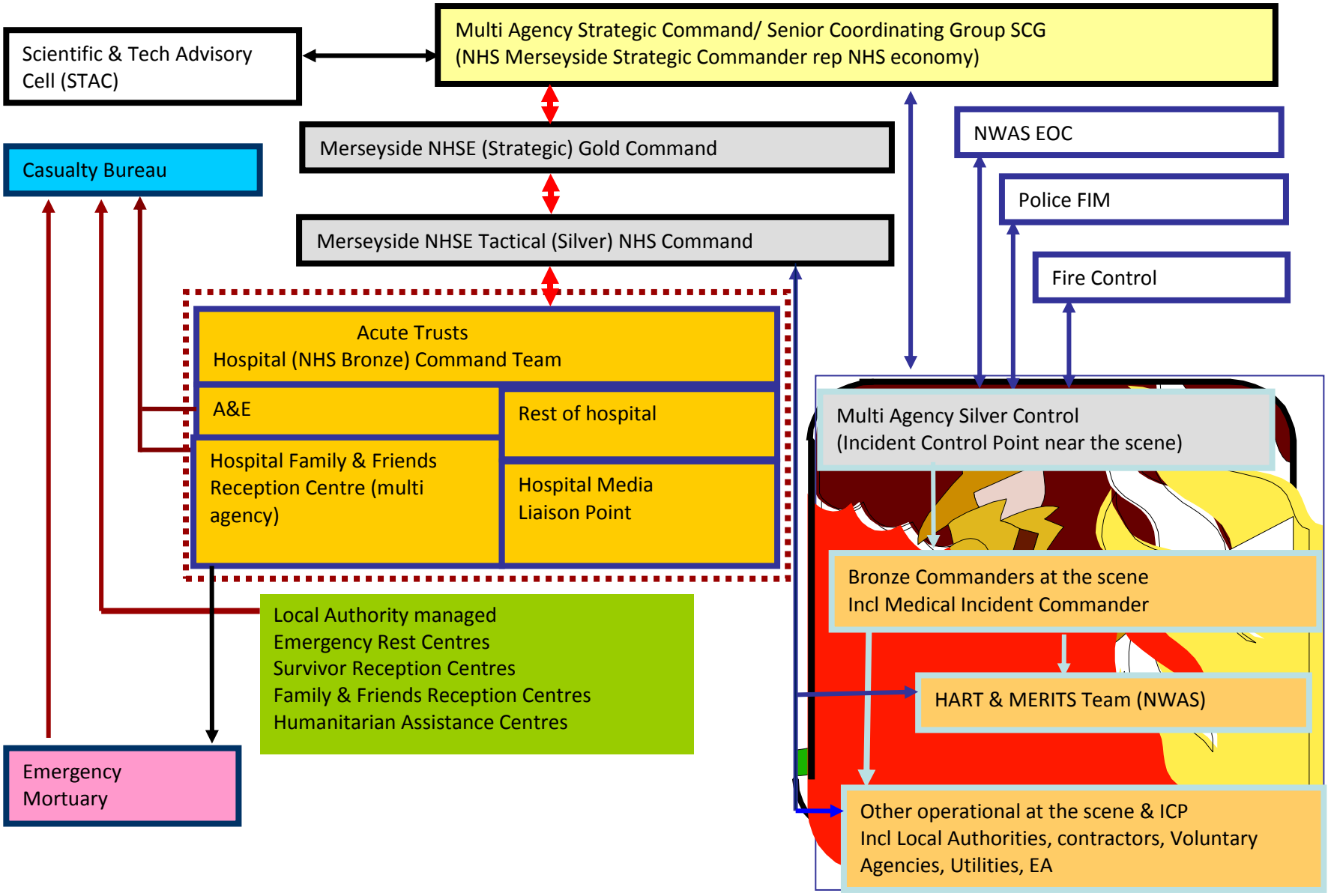
A SCG is usually called by the Police Gold Commander when an incident (such as mass casualties) requires coordination of response across agencies in keeping with the MRF's Plans.

MERM sets out the response arrangements of Category 1 and Category 2 Responders to an emergency or other incident that requires multi-agency coordination at any one or any combination of Operational, Tactical or Strategic levels.

30.2 TCG

A TCG is a multi-agency group of tactical commanders that meet to determine, coordinate and deliver the tactical response to an emergency, whilst liaising with 'on scene' responders or the SCG.

31. MAJOR INCIDENT COMMAND AND CONTROL STRUCTURE


Scientific & Tech Advisory Cell (STAC)
Multi Agency Strategic Command/ Senior Coordinating Group SCG
(NHS Merseyside Strategic Commander rep NHS economy)
Merseyside NHSE (Strategic) Gold Command
Merseyside NHSE Tactical (Silver) NHS Command
Casualty Bureau
NWAS EOC
Police FIM
Fire Control
Acute Trusts
Hospital (NHS Bronze) Command Team
A&E
Rest of hospital
Hospital Family & Friends Reception Centre (multi agency)
Hospital Media Liaison Point
Local Authority managed
Emergency Rest Centres
Survivor Reception Centres
Family & Friends Reception Centres
Humanitarian Assistance Centres
Emergency Mortuary
Multi Agency Silver Control
(Incident Control Point near the scene)
Bronze Commanders at the scene
Incl Medical Incident Commander
HART & MERITS Team (NWAS)
Other operational at the scene & ICP
Incl Local Authorities, contractors, Voluntary Agencies, Utilities, EA

KEY RESPONSE ISSUES

32. PRELIMINARY ASSESSMENT

The Merseyside first responders (i.e., police, fire and ambulance) will deploy to the scene as soon as possible and conduct their dynamic risk assessments.

Public health personnel, both locally and through the PHE will be accessed through the On Call Consultant in Health Protection from the PHE Centre for Cheshire and Merseyside to support the first responders.

33. URBAN SEARCH AND RESCUE (USAR)

Certain incidents may make search and rescue operations necessary. Search and rescue response will be led by MFRS who will set the priorities. MFRS will coordinate arrangements to provide additional search and rescue teams and equipment into any damage-affected areas using Fire Service USAR resources and supported by NWAS HART, where required.

33.1 Hazardous Area Response Team (HART)

NWAS, as part of the DoH national capability programme, has an established a HART function, which includes USAR skills.

Within the HART Programme there are currently three components: –

HART IRU (Incident Response Unit) - to provide a clinical response within the inner cordon of hazardous incidents (e.g. CBRN/HAZMAT)

HART USAR (Urban Search and Rescue) - to treat and rescue casualties from dangerous environments such as a collapsed building /structure or crashed vehicles

HART IWO (Inland Water Operations) - to undertake clinical interventions in areas of flood or fast flowing rivers

NWAS HART will provide direct links to the Merseyside NHS Strategic Commander (if necessary), through the Senior Ambulance Officer in attendance at the senior multi-agency Co-ordinating Group.

HART assets include-
Mass oxygen delivery system which enables the team to provide oxygen for 48 people simultaneously within the hot zone
Self-help first aid packs
Triage sieve bands
Mass casualty treatment pack

The National Capabilities Mass Casualty Vehicle (NCMCV) contents include:

- Mass oxygen delivery
- 80 adult and 20 paediatric bags (each bag will contain 3 P2 or 2 P1, their contents will have additional surgical items such as chest drain, tracheostomy and additional forms of limb immobilisation equipment
- 20 amputation kits
- Public use packs
- Anaesthetic drugs
- Analgesic therapies
- 9 pods that hold additional resilience for ophthalmic injuries, additional consumables, dressings saline, burns fluids (items generally found within a majors bay in A&E.

Each **Public Support Vehicle** contains over 1500 pieces of self-help equipment in 3 cages each cage containing:

- 500 dressings
- 500 foil blankets
- 500 face wipes
- 30 mega-mover carrying canvas stretchers

DoH Dressing Packs distributed throughout Merseyside at sites of mass gatherings contain:

- 96 small sterile dressings
- 96 medium sterile dressings
- 96 Large sterile dressings
- 96 extra-large sterile dressings
- 25extensive wound dressings
- 1 box of large sterile gloves
- 1 box of extra-large sterile gloves
- 5 paramedic shears
- 1 roll of cling film

33.2 Hazardous Materials (HAZMAT) Response

If the incident suggests there are hazardous materials involved, the initial HAZMAT response priorities will be set by local responders. The potential for large-scale hazardous materials release will result in the deployment of MFRS response assets to the damage-affected areas in order to assess the hazardous materials situation and coordinate technical assistance with support and advice from the PHE Centre for Cheshire and Merseyside and other interested bodies.

34. CASUALTY MANAGEMENT AT THE SCENE AND PRE-HOSPITAL CARE

NWAS will be the lead NHS agency with the responsibility for the triage and treatment of people at

the scene. NWAS have specific protocols and pathways for mass casualty-producing incidents which supplement their existing pre-hospital treatment protocols and will prioritise casualties requiring treatment / transport using the table shown below:

Priority	Category	Patient Condition
P1	Immediate	Casualties needing immediate life-threatening resuscitation and / or surgery
P2	Urgent	Stabilised casualties needing early intervention within 6 hours
P3	Delayed	Less serious cases that require treatment but not within a set time i.e., 'walking wounded
P4	Expectant	Casualties who cannot survive treatment or for whom the degree of intervention required means their treatment would seriously compromise the treatment to others
Dead	Dead	Dead

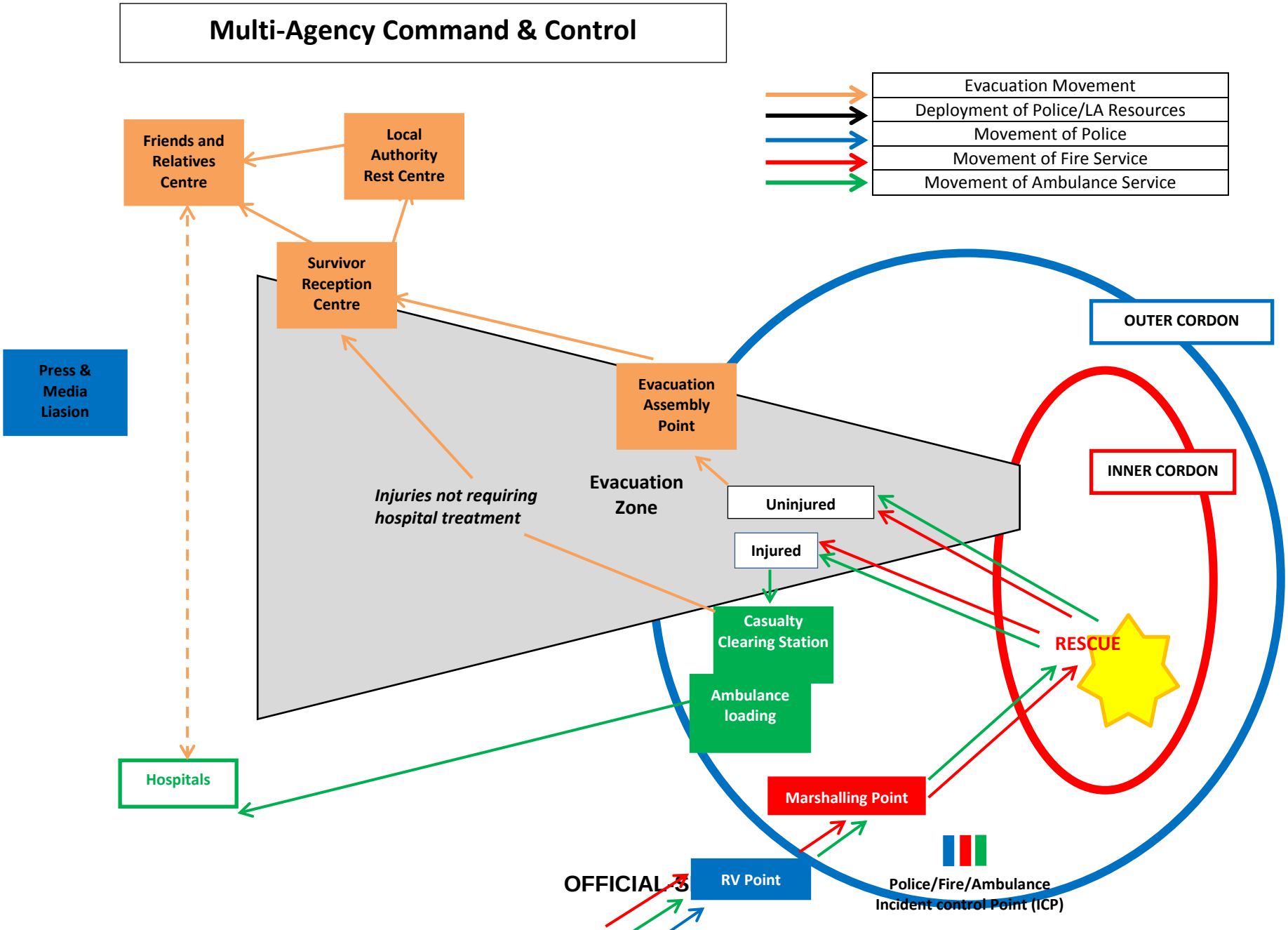
Subject to the time it takes to deploy resources and the nature of the mass casualty-producing incident NWAS will seek to:

- deploy a HART, who with the MFRS will seek to extract any casualties;
- deploy a Forward Medical Advisor, Casualty Clearing Medical Advisor and ambulance officer to lead their response and the triage and treatment of casualties;
- establish a facility near the scene to triage and treat (as is necessary) any casualties close to the scene of the incident. This will be the CCS and will be led by a Senior Ambulance Officer / Medical Incident Commander (Note: NWAS use the SMART triage system for identifying casualties);
- deploy a MERIT.

NOTE

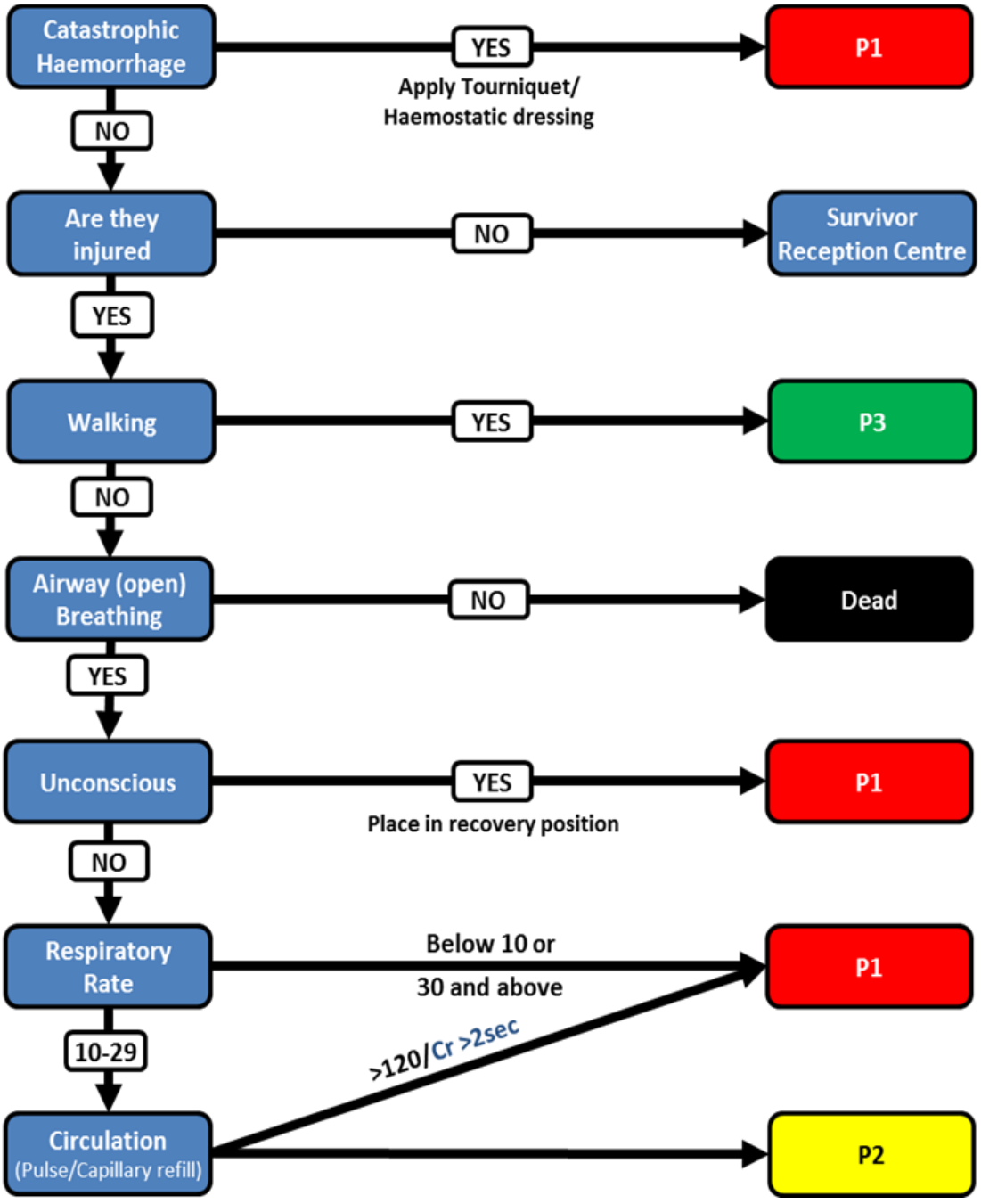
Non-receiving Acute Trusts may be required to provide additional medical resources to support/supplement MERIT (e.g. on site surgical/anaesthetic requirements).

35. INCIDENT DIAGRAM



36. CASUALTY COLLECTION POINT

Following Triage Sieve casualties will be evacuated in priority order to either a Casualty Collection Point (CCP) or directly to the Casualty Clearing Station (CCS) for treatment. This process is normally associated with a CBRNe, Hazmat scenario where decontamination is required or an 'active shooter' scenario where the warm zone is dynamic. However this can be utilised for any multi casualty incident.



Priority 1 and Priority 2 Casualties – will initially be managed by NWAS and transported to a Receiving Hospital as soon as is practicable / safe to do so.

Priority 3 Casualties – will most likely:

- be transported, signposted or will find their own way to NHS premises away from the scene of the incident;
- self-evacuate and seek treatment at one of the major Receiving Hospitals (which may not have the capacity to treat P3 casualties in the immediate aftermath of an incident;
- be provided with clear details of how to access any ETC that has been established in response to the incident, or;
- self-evacuate and seek treatment at a later time or at facilities nearer to where they live;

Priority 4 Casualties – will be provided with palliative care at the scene / CCS and will be continually assessed as resources and treatment options become available.

Casualties requiring an intervention will include:

- those seriously ill / injured as a result of the mass casualty-providing incident who will require immediate / urgent care;
- those affected by the incident who, although not obviously or immediately suffering, will require assessment, diagnosis and monitoring (in the short, medium and long term);
- those who are not ill or injured but require information, advice ad reassurance. Often referred to as 'worried well' this may affect people at the scene of the incident, their friends and families and people who believe they may be affected from elsewhere;
- those who fall ill (e.g., heart attack) totally unrelated to the incident, or;
- patients affected by the loss of a service due to the NHS response (e.g., dialysis patients, patients relying on community services).

36.1 NWAS Hospital Ambulance Liaison Officer (HALO) - Call sign 'Hospital Ambulance Liaison' (hospital name)

The Hospital Ambulance Liaison Officer (HALO) will attend designated receiving hospitals and will become the conduit between an incident site and the hospital emergency department.

The HALO will liaise with hospital medical and nursing staff regarding arrangements for reception/discharge of patients, the availability of beds and ensure that this information is made available to the NWAS ECC, RHCD, the AIC and the police.
HALO will not become involved in the treatment of casualties arriving at the emergency departments but will ensure a quick turn round of service vehicles at the hospital.

The latter is vital if ambulances are to be re-tasked.

36.2 Medical Advisor - Call sign 'Silver Medic'

The Medical Advisor will assume overall medical responsibility at the incident, Co-ordinating the actions of all medical personnel on scene, alongside the AIC. Both the AIC and the Medical Advisor will be located at the TCG alongside the other 'Silver' Commanders from the other agencies involved.

The above medical roles of Medical Advisor, Forward Medical Advisor and Casualty Clearing Medical Advisor will be structured using the following schematic.

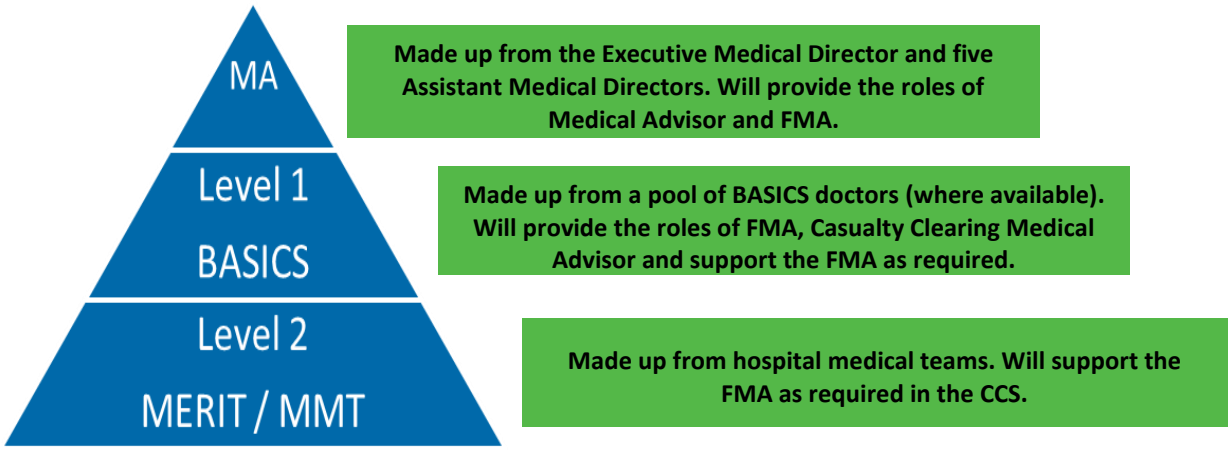


FIGURE 1 - MEDICAL TEAM COMMAND SCHEMATIC

36.3 Forward Medical Advisor - Call sign 'Bronze Medic'

The Forward Medical Advisor (FMA) where present, will manage the medical response at an operational level. Where the incident dictates, there may be more than one FMA, each with a remit of managing the medical response within a specific incident sector.
Where required, the FMA will assist the medical responders with the triage and treatment of casualties especially where advanced clinical interventions are required.

Where required, the FMA will assist the medical responders with the triage and treatment of casualties especially where advanced clinical interventions are required.

36.4 Casualty Clearing Medical Advisor (CCMA) - Call sign 'Casualty Clearing Medic'

The Casualty Clearing Medical Advisor is a newly acknowledged role which identifies a lead clinician who will support the Ambulance Casualty Clearing Officer. Their role will be overseeing

and directing the clinical treatment provided in the casualty clearing station. They will report casualty information to the FMA

37. RECEIVING HOSPITALS

37.1 Accelerated Hospital Discharge

Accelerated Hospital Discharge is the rapid discharge of medically fit patients from acute hospital beds into the community setting; it is a supporting mechanism that is designed to create surge capacity.

NWAS will transport critical and urgent cases to designated receiving hospitals. To cope with this mass influx of patients Receiving Hospitals may initiate Accelerated Hospital Discharge in co-ordination with their local health and social care partners. This procedure is designed to cancel all non-essential operations and discharge / redirect non-essential patients in order to free up beds.

Close working in relation to accelerated discharge between local hospitals, local NHS community providers and local authority social care providers is essential and is normally part of local health economy escalation plans (although not normally addressing a mass casualty incident).

37.2 Cancellation of Outpatient Services –

As part of their response receiving hospital are likely cancel outpatient appointments where this is clinically possible. A proportion of patients at outpatient clinic rely on others to bring them to appointments, they may need transport to leave the hospital premises.

38. EMERGENCY TREATMENT CENTRES (ETCs)

Although every effort will be made to ensure that all those who need treatment will be treated at a Receiving Hospital, the scale of a mass casualty incident means that this may not be possible for those casualties with minor injuries (i.e., P3 casualties).

The locations of ETCs will be decided dynamically on the day as joint decision with the multi-agency TCG.

The NHS England Area Team will seek to deploy medical support to deal with the minor injuries to any ETC, however the staffing of ETCs may need to be addressed as part of the overall strategic management to the mass casualty-producing incident by the senior multi-agency Co-ordinating Group.

Working with local NHS providers, the NHS Strategic Commander (2nd on call) will first seek to staff any ETCs from NHS staffing resources, looking primarily to:

- minor injury staff / GP Out of Hours Staff (due to their experience of working with P3 casualties);
- clinical and administrative staff from community and mental health providers or;
- GP and nursing staff from primary care.

An increased demand on NHS resources may develop as a result of the overall incident response which may mean that non-NHS staffing for ETCs may be required and alternate staffing for these centres may be needed since NHS staff may be otherwise tasked. This would involve clinically-trained staff from voluntary and other local agencies and administrative staff from local agencies.

The NHS Strategic Commander (2nd on call) will also contact NHS England (North) to mobilise mutual aid resources from NHS organisations not affected by the incident to support the operation of any ETC.

39. TRANSPORT ARRANGEMENTS

The nature of the mass casualty-producing incident may mean that the NHS and other agencies needs support to provide transport.

NHS agencies will support the transport of:

- P3' casualties to Receiving Hospitals / treatment facilities;
- patients discharged from Receiving Hospitals under Accelerated Discharge Arrangements, and;
- patients who've had their outpatient clinic cancelled.

Non-NHS agencies will support the transport of:

- survivors to Rest Centres and Survivor Reception Centres;
- survivors from Rest Centres / Survivor Reception Centres to local transport hubs, and;
- friends and families from transport hubs to Friends and Families Reception Centres.

Arrangements may include the following options to support NWAS Patient Transport Service (PTS) and voluntary agencies transport -

Taxis - assuming that telephones are operational, those affected / patients discharged may be able to call for a taxi.

Partner agency transport - given that public transport may be redirected for the Mass Evacuation, it may be necessary to collect survivors / casualties with minor injuries / discharged patients. Consideration will need with partner agencies, to a variety of transport options that may be available (eg. Mersey travel).

Voluntary Sector – co-ordinated by NWAS when it relates to the movement of casualties with minor injuries.

Additional traffic may have an impact on access and egress at Trust's and may need specific consideration.

40. HUMANITARIAN ASSISTANCE (EVACUATION AND SHELTER)

Depending on the nature of the mass casualty incident, two strategies in respect of evacuation and shelter may be needed, the initial response and a longer-term response. Evacuation and shelter encompasses:

- sheltering (existing or constructed facilities);
- feeding (fixed sites, mobile feeding units);
- bulk distribution of food and supplies;
- first aid at mass care facilities and designated sites, and;
- welfare support.

Local Authorities are responsible for managing such shelters and the MRF has a Mass Evacuation and Shelter Plan which contains arrangements for the coordinated multi-agency response to a mass evacuation and shelter emergency.

In addition voluntary agencies - including the British Red Cross, Royal Voluntary Service and the Salvation Army - can provide feeding capability through their own resources.

The MRF UNITY Plan provides information on the capabilities of voluntary agencies in Merseyside who provide support in major humanitarian situations.

Humanitarian assistance comprises of the following aspects:

The management of displaced persons – in the event of a significant number of people being displaced or evacuated as a result of the incident it may be necessary to open a ***Rest Centre*** to provide temporary accommodation. Each Local Authority has an Emergency Rest Centre Plan which has identified suitable premises for use as rest centre. Where necessary, overnight accommodation will be arranged through the Local Authority;

The management of survivors – in the initial response to an emergency the focus of the emergency services will be on saving life; however the needs of survivors should be considered a priority at an early stage and will be an important part of identifying casualties and witnesses. To ensure the safety and needs of the survivors (who do not require acute hospital treatment) for short-term shelter, first aid, information and support a **Survivor Reception Centre** may be opened by the Local Authority. All survivors would be treated as potential casualties and undergo some

form of 'casualty clearance' or 'triage' process by the NHS responders before being transferred to a Survivor Reception Centre;

The management of family and friends - it is a feature of major incidents that many people will travel to the scene or to meeting points if they believe their friends or relatives may have been involved in the emergency. Local Authorities, in liaison with Merseyside Police , will establish **Family and Friends Reception Centre(s*)*** at suitable location(s) to help reunite families and friends with survivors and to provide a safe and secure place to register and interview families and friends who believe they may be bereaved. Family and Friends Reception Centres will work closely with multi-agency **Family Support Team** at the Receiving Hospitals where casualties from an incident are taken to support family and friends who arrive enquiring about loved ones.

Note – although one agency may be charged with establishing any of the facilities / teams outlined in this section, they will require support from multi-agency partners in order to operate effectively and will co-ordinate their activities, through the lead agency, in accordance with the strategy established and directions issued by the senior multi-agency Co-ordinating Group operational in Merseyside.

41. PUBLIC SAFETY

Merseyside Police and MFRS will ensure public safety establishing cordons to

- to guard the scene;
- to protect the public;
- to control the sightseers;
- to prevent unauthorised interference with evidence or property, and;
- to facilitate the operations of the emergency services.

Merseyside Police will also be asked to establish and maintain identified routes for emergency services and other essential vehicles (Blue Routes).

42. MASS FATALITIES

It is likely that any mass casualty-producing incident will also produce a significant number of fatalities. Those fatalities may be:

- immediate – occurring at the scene;
- early – mainly occurring in healthcare premises or ambulances in patients who were initially identified as severely affected casualties, or;
- late – deaths occurring from the long term consequences of the incident, often after a period of stable health.

Subject to the extent of the incident, the number of fatalities and consultation with HM Coroner the fatalities may be managed as followed:

- Immediate fatalities (who die at the scene) - predominantly the responsibility of the HM Coroner working in conjunction with Local Authorities. If the number of fatalities is significant, the MRF Mass Fatalities Plan may be activated which involves the opening of Emergency Mortuary facilities;
- early casualties (who die in NHS facilities) - predominantly the responsibility of the NHS which has mortuary capacity at its major hospital sites, or;
- Late deaths - will be managed in the same way as deaths from unrelated health conditions.

43. PSYCHO-SOCIAL SUPPORT FOR RESPONDERS

Local authorities have Humanitarian Assistance Centre Plans which outline how local authorities will co-ordinate the provision of psycho-social support to those affected by the mass casualty-producing incident in conjunction with NHS mental health service providers.

Every responding agency has an obligation to provide psycho-social support to their own staff as well and should ensure their responding staff are made aware of these services both during and following the incident response.

Given the potential nature of the effects of a mass casualty incident, it may be necessary for:

- responding agencies to consider pooling the psycho-social support to responders, and;
- those responding agencies that cannot access sufficient psycho-social support to their responders to be allowed access to another agencies support.

44. THE JOINT DECISION MODEL

The JESIP Joint Decision Model should be used as a framework for decision making throughout the course of the emergency. The model is cyclical where each step logically follows another and allows for continued reassessment of the emergency enabling previous steps to be revisited.

Working Together – Saving Lives, Reducing Harm

Joint decisions must be made with reference to the overarching or primary aim of any response to an emergency: to save lives and reduce harm. This is achieved through a co-ordinated, multiagency response. Decision makers should have this uppermost in their minds throughout the decision making process.

Gather and Share Information and Intelligence

Situational awareness is about having appropriate answers to the following questions: what is happening, what are the impacts, what are the risks, what might happen and what is being done about it? In the context of the JDM, shared situational awareness becomes critically important. Shared situational awareness is achieved by sharing information and understanding between the organisations involved, to build a stronger, multi-dimensional awareness of events, their implications, associated risks and potential outcomes.

For major and complex emergencies, whether a *rapid onset* or a *rising tide* event, it is a simple fact that no one service can initially appreciate all relevant dimensions of an emergency. This deeper and wider understanding will only come from meaningful communication between the emergency services and other emergency responders. This should be built upon agreed procedures to share the required information and a commitment to use commonly understood terminology rather than service specific terminology or jargon where this may impede understanding. In simple terms, commanders cannot assume other emergency service personnel see things or say things in

the same way, and a sustained effort is required to reach a common view and understanding of events, risks and their implications.

Decision making in the context of an emergency, including decisions involving the sharing of information, does not remove the statutory obligations of agencies or individuals, but it is recognised that such decisions are made against an overriding priority to save life and reduce harm.

The sharing of personal data and sensitive personal data (including police intelligence) requires further consideration before sharing across agencies and the JDM can be used as a tool to guide decision making on what to release and to whom. In particular, in considering the legal and policy implications, the following are relevant:

- A legal framework to share information is required – in an 'emergency' situation this will generally come from Common Law (save life/property), the Crime and Disorder Act 1998 or the Civil Contingencies Act 2004;
- Formal Information Sharing Agreements (ISAs) may exist between some or all responding agencies but such existence does not prohibit sharing of information outside of these ISAs;
- There should be a specific purpose for sharing information;
- Information shared needs to be proportionate to the purpose and no more than necessary;
- The need to inform the recipient if any of the information is potentially unreliable or inaccurate;
- The need to ensure that the information is shared safely and securely – it must comply with the Government Protective Marking Scheme (GPMS – replaced by the Classifications Policy in 2014) if appropriate, and;
- What information is shared, when, with whom and why, should be recorded.

Jointly Assess Risks, Develop a Working Strategy

Understanding risk is central to emergency response. The Civil Contingencies Act places a requirement on all Category 1 responders to have an accurate and *shared* understanding of the risks which would or may affect the geographical area for which they are responsible. A key task for commanders is to build and maintain a common understanding of the full range of risks and the way that those risks may be increased, reduced or controlled by decisions made and subsequent actions taken. In a major or complex emergency the blue light services will have unique insights into those risks and by sharing that knowledge; a common understanding can be established.

The joint assessment of risk is the process by which commanders' work towards a common understanding of threats, hazards and the likelihood of them being realised, in order to inform decisions on deployments and the risk control measures that are required. Risk mitigation

measures to be employed by individual services also need to be understood by the other responding organisations in order to ensure any potential for unintended consequences are identified in advance of activity commencing. A joint assessment of the prevailing risks also limits the likelihood of any service following a course of action in which the other services are unable to participate. This, therefore, increases the operational effectiveness and efficiency of the response as well as the probability of a successful resolution of the incident.

It is rare for a complete or perfect picture to exist and therefore a working strategy, for a rapid onset emergency, should be based on the information available at the time. The following should be taken into account when developing a working strategy:

- **What** are the aims and objectives to be achieved?
- **Who** by – Police, Fire, Ambulance and partner organisations?
- **When** – timescales, deadlines and milestones?
- **Where** – what locations?
- **Why** – what is the rationale? Is this consistent with the overall strategic aims and objectives?
- **How** are these tasks going to be achieved?

In order to deliver an effective integrated multi-agency operational response plan, the following key steps must be undertaken:

Identification of hazards – this will begin from the initial call received by a Control Room and will continue as first responders arrive on scene. Information gathered by individual agencies must be disseminated to all first responders and Control Rooms effectively. The use of the mnemonic **METHANE** will assist in a common approach.

Dynamic Risk Assessment – undertaken by individual agencies, reflecting the tasks / objectives to be achieved, the hazards that have been identified and the likelihood of harm from those hazards.

Identification of the tasks - each individual agency should identify and consider the specific tasks to be achieved according to its own role and responsibilities.

Apply control measures – each agency should consider and apply appropriate control measures to ensure any risk is as low as reasonably practicable.

Integrated multi-agency operational response plan – the development of this plan should consider the outcomes of the hazard assessment and service risk assessments, within the context of the agreed priorities for the incident.

Recording of decision– the outcomes of the joint assessment of risk should be recorded, together with the identified priorities and the agreed multi-agency response plan, when resources permit. It is acknowledged that in the early stages of the incident this may not be possible, but it should be noted that post-incident scrutiny inevitably focuses on the earliest decision making.

Consider Powers, Policies and Procedures

Decision making in an emergency will be focussed on how to achieve the desired end state and there will always be various constraints and considerations that will shape how this is achieved. Powers, policies and procedures relate to any relevant laws, operating procedures or policies that may impact on the desired response plan and the capabilities that are available to be deployed. They may impact on how individual services will need to operate and co-operate in order to achieve the agreed aims and objectives. In the context of a joint response, a common understanding of any relevant powers, policies, capabilities and procedures is essential in order that the activities of one service compliment and do not compromise, the approach of the other services.

Identify Options and Contingencies

There will almost always be more than one option to achieve the desired end state and it is good practice that a range of options are identified and rigorously evaluated. Any potential option or course of action should be evaluated with respect to:

- **Suitability** – does it fit with the strategic direction?
- **Feasibility** – in resource terms can it be done?
- **Acceptability** – is it legal, morally defensible and justifiable?

An option may include deploying resources, briefing the public (mainstream and social media) or developing a contingency or emergency plan. Whichever options are chosen, it is essential that commanders are clear what they are required to carry out and there should be clearly agreed procedures for communicating any decision to defer, abort or initiate a specific tactic.

Contingencies relate to events that may occur and the arrangements that are put in place to respond to them should they occur. For example, strong evidence may suggest that an emergency is being successfully managed and the impacts safely controlled, but there remains a likelihood that the situation could deteriorate with significant impacts. Simply hoping for the best is not a defensible option and a contingency in this case may be to define measures to adjust the response should the situation deteriorate.

Take Action and Review What Happened

Building situational awareness, setting direction and evaluating options all lead to taking the actions that are judged to be the most effective and efficient in resolving an emergency and returning to a new normality. As the JDM is a continuous loop, it is essential that the results of those actions are fed back into the first box – Gather and share information and intelligence – which establishes shared situational awareness. This will, in turn, shape any revision to the direction and risk assessment and the cycle continues.

45. COMMUNICATION AND PUBLIC INFORMATION

45.1 Multi-agency

Responders' duties to communicate with the public under the CCA are based on the belief that a well- informed public is better able to respond to an emergency and to minimise the impact of the emergency on the community and NHS services.

The overall aim for communications in an emergency is to provide effective, accurate and timely communications to the public, staff and other agencies.

The SCG will establish a Communications Cell in the event of a major incident. This will comprise media specialists from Category 1 and Category 2 Responders with external media partnerships invited when appropriate.

Further detail is available in the MRF Merseyside Media Protocol during an Emergency and the MRF Merseyside Warning and Informing Plan.

The SCG Communications Cell will liaise with the LHRP agencies' media arrangements described below.

45.2 NWAS

During a mass casualties incident, NWAS will assist with media enquiries and provide advice to the Ambulance Incident Commander and if appropriate the NWAS Gold Commander. NWAS will also arrange operational interviews with the media if necessary in consultation with the police who will be co-ordinating the media response..

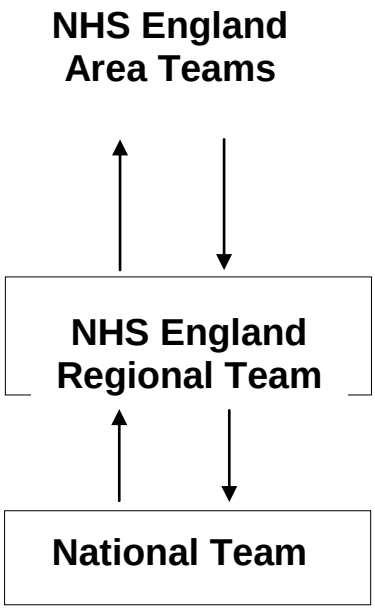
During the response and recovery phases, NWAS will liaise with other agencies in regard to setting up press conferences and joint press statements.

45.3 North Midlands and East Communications Service (NME)

The NME provides a 24 hour media service through its media hub to work with NHS Agencies during the response to mass casualties incidents.

The following describes the new NHS Structures and areas of responsibility for external communication:

New structures	Responsibilities
CCGs	• Communication with local providers in their area and other local commissioners (local authorities) • Communication with patients the public and local stakeholders • Messages about accessing services, changes to services and local NHS response to pressures, self-care and so on • Informing the Area Team of any significant issues
	• Co-ordinating communications across a number of CCGs in support of Command and Control structures • Providing responses and statements on behalf of NHS England area team where appropriate • Cascading communications from the regional office and national teams • Supporting regional and national communication activity



- Decisions on communications at a strategic level for the Northern region
- Providing communications, responses and statements on behalf of NHS England at a regional level where appropriate

- Decisions on communications at a strategic level for NHS England
- Providing communications, responses and statements on behalf of NHS England at a national level where appropriate e.g. the Winter Health Check

45.4 Communications – Agencies' Roles

The priority for communications is to ensure confidence amongst the public, patients, staff and stakeholders that the NHS can manage fluctuations in pressures. The table below sets out the roles of different partners in managing communications to reflect different levels of pressure within the NHS system.

Escalation Levels (see Para. 23)	Organisations				
	NME	**NHS England Area Team**	**CCGs**	**PHE**	**LA / DPH**
Level 1	NME Comms will liaise with lead CCG to ensure team receive a copy of briefings and has opportunity to comment.	Liaise directly with CCG communications teams as appropriate.	Local CCG will manage communications	Liaise directly with CCG Communications Teams as appropriate.	Liaise directly with CCG/CSU Communications Teams as appropriate
Levels 2, 3 and 4	Work with NHS Tactical Commander (1st on call) and NHS Strategic Commander (2nd on call) to manage communications for NHS England including advice, agreeing key messages, briefings and press statements. Input to a multi-agency communications cell if established. Coordination of communications across NHS partners through the NHS Communications Cell. Coordinating internal communications across NHS England and across NHS partners through working with local NHS communications teams. Briefing the Head of Communications for the NHS England (North).	Liaise with NME on the communication issues within their remit. Ensure communications issues are considered at any meetings of HTCG/HSCG. Represent NHS agencies at the SCG/TCG and contribute to the multi-agency communications process.	Liaise with NHS England Area Team.	Liaise with NHS England Area Team. Attend SCG/TCG meetings and contribute to the multi-agency communications process.	Liaise with NHS England Area Team. Attend SCG/TCG meetings and contribute to the multi-agency communications process.

45.5 Hospital Communications

Factual details of the response to a mass casualties incident by LHRP agencies will be made available to the media, including which hospitals have received casualties, how many, what kind of injuries are involved and how the incident is being managed.

It is important that hospitals who deal with the media during an incident restrict any information to their individual operational arrangements only.

46. COMMUNICATING PATIENT IDENTIFICATION

LHRP agencies in possession of patient information should follow the requirements of the Data Protection Act 1998 and the following general principles for the safe handling of personal, identifiable patient information established by the Caldicott Committee review of 1997 –

Justify the purpose(s) of using confidential information;
Do not use patient-identifiable information unless absolutely necessary;
Use the minimum necessary patient- identifiable that is required;
Access to patient-identifiable information should be on a strict need-to-know basis;
Everyone with access to patient-identifiable information should be aware of their responsibilities, and;
Understand and comply with the law.

The Act and the Caldicott principles cover information held in whatever format whether electronic, paper, verbal or visual.

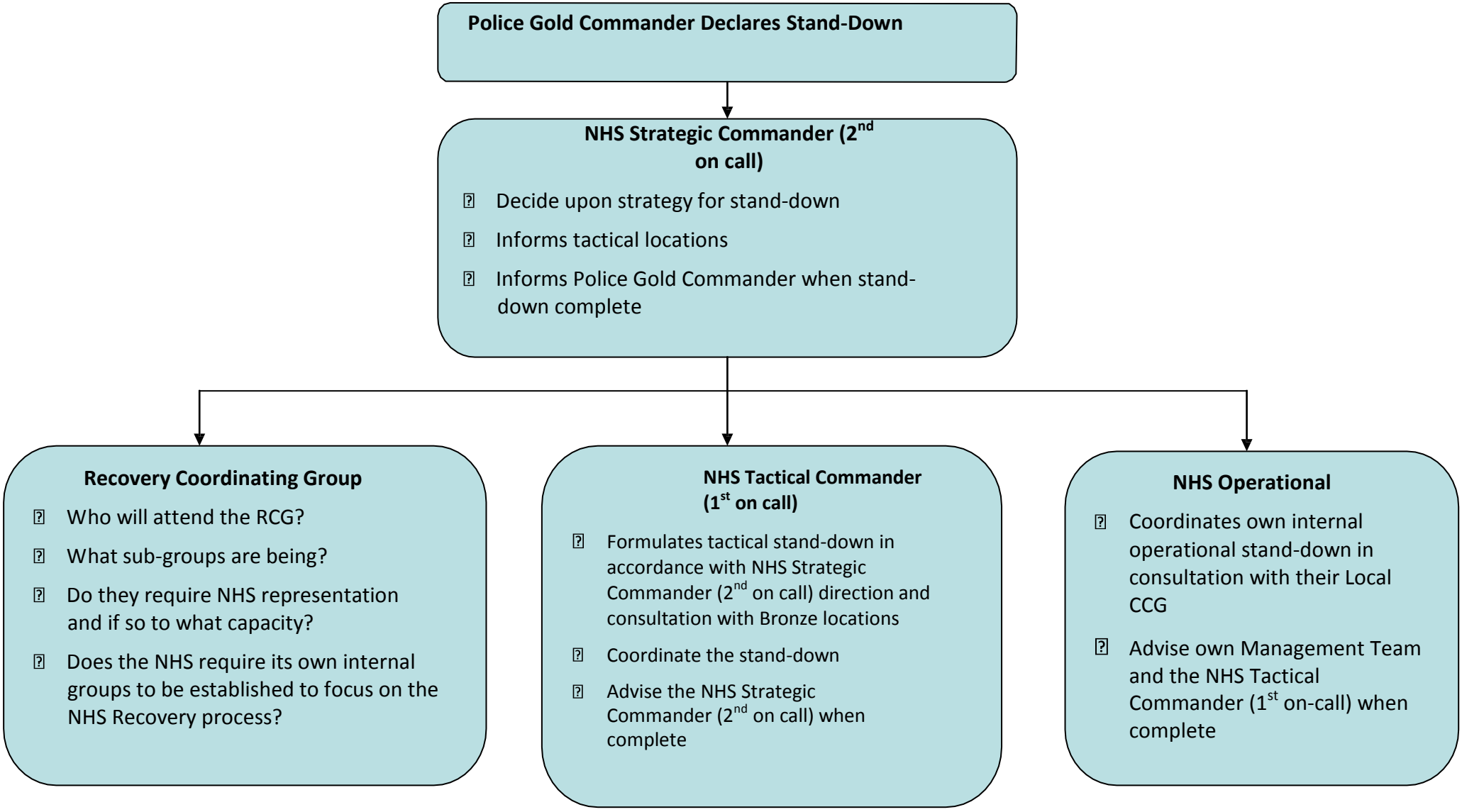
47. STAND DOWN

Dependent upon who is leading the healthcare response, the NHS Tactical Commander (1st on call) or the NHS Strategic Commander (2nd on call) will decide when a local/significant emergency stand down should be declared, which may be long after the response to a mass casualties incident is over.

This could be either a full or partial stand down with on-going monitoring.

When an incident is closed, NWAS will be responsible for notifying closure to all NHS organisations.

48. STAND DOWN CASCADE AND ACTIONS NOTE:



RECOVERY AND BUSINESS CONTINUITY

49. RECOVERY

49.1 Multi-agency Recovery Process

The recovery process should begin at the earliest possible stage in the response to an incident.

The SCG or TCG will give early consideration to recovery and a discussion will be held at the first meeting of the coordinating group.

Where a mass casualties incident has resulted in the establishment of a SCG, the recovery process will become an integral function of that group.

In this event, the MRF 'Recovering from Emergencies Plan' will be implemented.

49.2 NHS Recovery Process

NHS Merseyside organisations will automatically move into the recovery mode and will remain so until the NHS Strategic Commander (2nd on call) declares otherwise.

Recovery may involve –

- Ensuring that the NHS Organisations are assisted in the return to normality;
- Dealing with the long term physical and mental health problems associated with the incident ;
- Ensuring that any commitments made in relation to the waiving of targets are honoured, and;
- Brokering financial solutions following commitments made during the peak of the incident.

The recovery process will be supported by the Merseyside Area Team which will lead on the monitoring of other aspects of acute and elective healthcare.

During the recovery phase, a report on the emergency will be produced including the lessons learnt. The report will be submitted to the Area Management Team of NHS England (Merseyside) in consultation with the LHRP and may be shared with NHS organisations as appropriate.

An Action Plan will be produced to address any improvements that are required, and the implementation of the plan will be overseen by the Director of Operations and Delivery NHS England (Merseyside).

Mass casualties following major incidents are often characterised by a quantity, severity and diversity of injuries and other patients that can rapidly overwhelm the ability of medical resources to deliver comprehensive and definitive medical care.

The management of mass casualty incidents does not stop once the final casualties have been treated; the social and medical ramifications of such an event can linger on for many years and needs to be borne in mind in the planning process.

The recovery phase for some NHS organisations may be prolonged and the return to normality difficult to define. Some areas may be able to start the recovery process whilst others are still responding to the incident. Other areas response may need to be sustained.

Whilst some patients are able to be cared for by primary care, the ability of the health and social care services to return to normality will be placed under huge pressure. The impact could cause widespread disruption across the whole of the health and social care system.

Impact assessments to determine the prioritisation and reintroduction of quality assurance, performance frameworks and targets will need to be considered. There may have to be a gradual resumption to restore services to pre-incident standards.

In the recovery phase there could be a backlog of work to clear before services are operating normally. Staff may be tired, bereaved, in need of support or have leave to take. These issues could impact on the service recovery and will need to be taken into account.
The impact on patient services will need to be closely monitored.

Psychosocial support covers the emotional and social support and other care that particular patients and their families may require as a result of injuries. Mental healthcare refers to psychiatric, psychological and specialised assessments and interventions that patients may require as a consequence of their injuries, care and treatment and any pre-existing mental health needs.

The intention is to deliver responses to patients and families of patients and the deceased needs for specialised social, mental health and psychological care.

49.3 Role of NHS England (Merseyside)

NHS England (Merseyside will provide a coordination function on behalf of all NHS Trusts and liaise with NHS England North during the recovery phase. The NHS Strategic Commander (2nd on call) will undertake a coordination function between NHS organisations, the Merseyside Recovery Coordinating Group (RCG) and associated sub groups.

NHS England (Merseyside) in conjunction with CCGs, as appropriate will coordinate the recovery work streams. CCGs have a responsibility within their commissioning areas to coordinate recovery work streams and work effectively with health and social care partners.

49.4 NHS Roles and Responsibilities

During the recovery process, the NHS is responsible for –

- Coordinating the primary care, community and mental health role;
- Providing health care and advice to evacuees, survivors and relatives including replacement medication;
- Establishing with local authority facilities for mass distribution of counter measures (e.g. vaccinations and antibiotics);
- Providing support, advice and leadership to the local community on health aspects of an incident;
- Supporting screening, epidemiology and long-term assessment and management of the health effects of an incident, and
- Maintaining liaison with and coordinating the response with, the NHS England North.

50. STAFF WELFARE

NHS organisations should ensure staff welfare issues are addressed. Incident Commanders must be aware of the potential for stress and/or fatigue to impact upon individual performance and decision making. They must ensure that they are cognisant of their own and their teams' levels of stress and fatigue and that effective arrangements are in place to minimise the potential impact such as rest-breaks and shift systems for protracted incidents.

51. DEBRIEFS AND REPORTS

A 'hot debrief' will be held within 24 hours of the close of the incident.

A full debrief will be held within 14 working days of the incident.

The initial incident report will be produced by NHS England (Merseyside) Head of EPRR, if available.

52. MULTI-AGENCY DEBRIEF

In mass casualties incidents a multi-agency debrief meeting will be convened.

A multi-agency debrief will be conducted under the direction of the MRF where lessons learnt will be incorporated into multi-agency and single agency plans.

53. BUSINESS CONTINUITY MANAGEMENT

Those NHS organisations identified under the CCA 2004 as Category 1 Responders have a legal duty to develop robust business continuity management arrangements which will help them to maintain their critical functions during an emergency and to resume normal services as soon as practicable.. This would include an emergency as a result of a mass casualties incident.

Each NHS organisation is responsible for ensuring it meets the legal requirements of the CCA and the NHS core standards for business continuity, which extends to services provided through partnerships and other forms of contractual arrangements.

Other NHS funded care providers not covered by the requirements of the CCA are expected to adopt business continuity management as good practice.

APPENDIX 1

LHRP AGENCIES ROLES – GENERAL

NHS England (Merseyside) Area Team

The primary roles of NHS England (Merseyside) Area Team in an emergency are -

- Activate the Area Team Incident Response Plan;
- Assess the initial information received in respect of a potential/actual local significant emergency (major incident) and determine the appropriate initial course of actions to be taken;
- Attend the TCG and/or SCG, if established, and where appropriate;
- Activate the Incident Coordination centre (ICC) to support the NHS Tactical Commander(1st on call)/ NHS Strategic Commander (2nd on call), as appropriate;
- Coordinate the wider NHS response, as appropriate;
- Direct all subsequent actions including stand-down decisions, and;
- Provide appropriate representation to facilitate recovery, as appropriate.

Primary Care Services

NHS England (Merseyside) Area Team is also responsible for:

- Commissioning a range of primary care services including general practitioners, pharmacists, dentists and optometrists at a local level, and;
- Commissioning specialist services such as Liverpool Heart and Chest Hospital locally and provide a link to other specialist area, commissioned regionally such as offender health and military veteran services.

Some of the services identified could be utilised either as part of an initial response to a local or significant emergency or during the recovery phase.

NHS England Regional Team

NHS England Regional Team provides a 24/7 point of contact for local Area Teams to seek advice, support or briefing for significant operational challenges that have or have the potential to impact on patient care across a wide area.

NHS England North is responsible for receiving and processing any notification from NHS England Corporate Team of impending incidents that have the potential to impact on the delivery of patient care across the North. This includes providing a risk assessment of potential impacts to health care across the region from the incidents that have a national footprint.

NHS England Corporate Team

The NHS England Corporate Team links with regional offices as required to either, mobilise the local Area Team, or support one or more regional office during periods of national emergencies.

Acute Trusts and Foundation Trusts

In the event of an emergency resulting in a large number of casualties, the ambulance service will designate receiving hospital(s) from one of these organisations. Hospitals with major accident and emergency units and specialist treatment centres (i.e. burns units) are usually selected.

Aintree Hospital, the Royal Liverpool Hospital and the Walton Centre for Neurology form the Trauma Collaborative for Merseyside and as such, act usually as the first receiving Trusts of any trauma type injuries. This is coordinated by the NWAS Trauma Cell.

Community Health Services

Community Health Services cover a range of health professions, including community nurses, health visitors and mental health services and have an important role in delivering a local, community based health response in emergencies. Some of these services could be used either as part of an initial response to a local or significant emergency or during the recovery phase.

Primary Care and community health providers are not listed in the CCA. However, the DoH and NHS CB guidance expects them to plan for and respond to incidents in the same way as Category 1 Responders in a manner which is proportionate to the scale and services provided.

The primary roles of Community Health Services in an emergency are:

- The follow-up to injuries incurred at the emergency;
- Post-traumatic stress caused by the emergency;
- Long term health monitoring/ surveillance;
- Support early discharges and admission avoidance schemes to create surge capacity in the acute hospitals, and;
- Support to local authority rest centres and support to vulnerable patients.

Primary Care Services

The principal roles of primary care services in an emergency are;

- The follow-up to injuries incurred at the incident;
- Post-traumatic stress caused by the event;
- Referral to psychological care services re. mental health issues caused by the event;
- Long term health monitoring/surveillance, dependent upon the nature of the incident, and;

- Support early discharge and admission avoidance schemes to create surge capacity in the acute hospitals.

The Area Team will decide if Clinical Commissioning Group (CCG) engagement and involvement is appropriate and will coordinate where necessary.

Public Health England (PHE)

The primary roles of PHE in an emergency are:

- Provide public health leadership and coordinate the public health elements of the emergency;
- Identify and respond to health hazards and emergencies which cause harm to public health;
- Contribute to multi-agency messaging including leadership of public health advice;
- Provide specialist data information and advice to partners at all levels to help inform their decision making, and;
- Long term health monitoring/surveillance, where applicable.

Port Health Authority

The primary roles of the Port Health Authority in an emergency are:

- The control of infectious disease, environmental protection, imported food control and hygiene on vessels, and;
- To work closely with the Public Health England, Food Standards Agency, Maritime and Coastguard Agency, Department of the Environment and Food and Rural Affairs.

Local Authority Public Health Function

For Public Health, led by the Director of Public Health (DPH) who has the oversight role for population health in their Local Authority Area:

- The Local Authority will ensure plans are in place to protect the health of their geographical population from threats ranging from relatively minor outbreaks to full-scale emergencies;
- A lead DPH from a local authority within the MRF area will act as co-chair at the LHRP during emergency planning and will coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the MRF area. PHE will provide the specialist health protection expertise and advice;
- The Local Authority will respond to emergencies involving a risk to public health in collaboration with NHS England and PHE. The DPH will lead the Local Authority response to incidents that present a threat to the public's health;
- The Local Authority will provide information and advice to relevant organisations to ensure all parties discharge their roles effectively for the protection of local people and will ensure effective communication with local communities on health issues, and;

- If the Local Authority becomes aware of an emergency situation, it will notify other partners in the local health system at the outset to ensure appropriate engagement in delivering any response required.

Clinical Commissioning Groups (CCGs)

The primary roles of the CCGs in an emergency are:

- To support NHS England as required in the event of a Major Emergency;
- To provide links with their commissioned services and act as a conduit when required between NHS England and the provider services;
- To continually assess the continuity of patient care in their commissioned services during a Major Incident, and;
- To provide other support as necessary to support the Major Incident response.

NWAS

The primary roles of NWAS in an emergency are:

- Notifying Merseyside Area Team, local Acute Hospitals and PHE Centre for Merseyside of the declaration of the 'major incident' / 'major incident standby';
- Liaising with the NHS Strategic Commander (2nd on call) in respect of the overall NHS response and providing briefings;
- Activating its own Major Incident Plan and ensuring the establishment of its own command and control arrangements;
- Deploying an appropriate senior officer to the SCG/TCG, if established;
- Deploying an Ambulance Officer / Manager to the A&E department of the Receiving Hospitals as a Liaison Officer;
- Deploying Ambulance Officer / Manager to the Hospital Incident Control Centre to assist the hospital team in managing bed capacity including patient transfer / discharge;
- Deploying an Ambulance Officer Incident Commander (tactical) and Medical Advisor to the TCG;
- If appropriate, making arrangements for the establishment of a Casualty Clearing Station (CCS) to triage and treat patient as necessary, including activation of any Major Emergency Response Incident Team (MERIT) (as necessary);
- Deploying, if necessary, a Hazardous Area Response Team (HART), and;
- Arranging for the transport of casualties to the appropriate treatment facility.

CATEGORY 1 RESPONDERS

The roles and responsibilities of the following Category 1 Responders are described in the MERM:

- Merseyside Police
- British Transport Police
- Port of Liverpool Police

- Mersey Tunnels Police
- Merseyside Fire and Rescue Service (MFRS)
- NWAS
- NHS England (Merseyside Area Team)
- Acute Trusts and Foundation Trusts
- Community Care Services
- Public Health England
- Port Health Authority
- Maritime and Coastguard Agency
- Merseyside Local Authorities
- Environment Agency

CATEGORY 2 RESPONDERS

The roles and responsibilities of the following Category 2 Responders described in MERM:

- SP Energy Networks
- United Utilities
- National Grid
- British Telecom
- Mersey rail Electrics
- Network Rail
- Liverpool John Lennon Airport
- Mersey travel
- Highways Agency
- Clinical Commissioning Groups
- Health and Safety Executive

OTHER SUPPORT AGENCIES

The following agencies have specific roles in the response to incidents, described in the MERM:

- DCLG Resilience and Emergencies Division
- Armed Forces
- Search and Rescue
- Coroner

THIRD SECTOR ORGANISATIONS/GROUPS

The Third Sector can provide an extensive and diverse range of operational and support skills and services to statutory responders, described in the MERM as follows:

- British Red Cross
- RAYNET
- Salvation Army
- Rotary International
- Royal Voluntary Service
- Maritime Volunteer Service (Mersey Valley Region)
- Merseyside Jewish Community Care
- Churches Together in the Merseyside Region
- St John Ambulance
- RSPCA
- Animal Health and Veterinary Laboratories Agency
- Independent Health Organisations
- Air Accident Investigation Branch
- Rail Accident Investigation Branch
- Marine Accident Investigation Branch

APPENDIX 2

NATIONAL GUIDANCE AND LEGISLATION

Civil Contingencies Act 2004

Health and Social Care Act 2012

NHS England Emergency Preparedness Framework 2013

Department of Health Mass Casualties Incidents – A Framework for Planning 2007

Civil Contingencies Secretariat – Identifying People who are Vulnerable in a Crisis 2008

HM Government – Emergency Response and Recovery 2013

Coroner's Inquests into the London Bombings of 7 July 2005

The 9/11 Commission Report

OTHER ASSOCIATED MRF MULTI AGENCY EMERGENCY PLANS

MRF Mass Fatalities Plan – Arrangements in Merseyside to respond to mass fatality incidents that require multi-agency co-ordination on a local basis

MRF Humanitarian Assistance Concept of Operations – Options available to facilitate humanitarian elements during an emergency

MRF Extra Deaths Plan – Multi agency arrangements to manage excess deaths caused by a rising tide type of event i.e. disease, weather

MRF Merseyside Media Protocol During an Emergency – Framework to supply the flow of co-ordinated information to all media organisations

MRF Merseyside Maritime Rescue Plan – Co-ordinated multi-agency response and post incident recovery to a shipping, aircraft crash offshore, cliff and mud, wind farm, offshore oil or gas installation incidents

MRF UNITY Plan & Merseyside Voluntary Agencies, Faith Groups – Information on the capabilities of voluntary agencies in Merseyside who provide support in major humanitarian situations

MRF Recovering from Emergencies – All aspects of the recovery phase following an emergency

MRF Merseyside Warning & Informing Plan - How Category 1 and Category 2 responders and stakeholders will work together to maintain arrangements to warn and inform the public – before, during and after emergencies – and identifies the capabilities which may be deployed to disseminate relevant information

MRF Mass Evacuation and Shelter Plan – Arrangements for the co-ordinated multi-agency response to a mass evacuation and shelter emergency within Merseyside

MRF Merseyside Resilient Telecommunications Plan – outline the telecommunication arrangements in place to ensure continued communication between responders during an emergency

MRF CBRN Site Specific Plan – The purpose of this plan is to facilitate the delivery of a multi-agency response to a CBRN incident in Liverpool City Centre

MRF Guidance on Multi Agency Response to a CBRN Incident - Provides a strategic framework for a co-ordinated and integrated multi-agency response to a CBRN incident in Merseyside and an outline of the activation process that will trigger the multi-agency response to a CBRN incident.

LHRP DOCUMENTS

Merseyside LHRP Terms of Reference

Merseyside LHRP Model Concept of Operations

APPENDIX 3

NHS CONFERENCE CALL - SUGGESTED AGENDA

1. Current situation e.g.:

    - Incident Overview;
    - Command and Control Structure in Place (Healthcare or multi-agency);
    - Response Overview, and;
    - Weather.

2. Aim (Strategic/Tactical) e.g. **to support the emergency services in the response to the incident whilst maintaining critical health care services**

3. Objective(s) e.g.:

    - To Save Life;
    - To Prevent the Situation from Becoming Worse;
    - To Maintain NHS Critical Services and Patient Care, and;
    - To Begin Recovery Form the Incident as soon as Possible.

4. Critical Issues Requiring Immediate Attention

5. Impact on the NHS (Health Economy or by Provider)

6. Actions Taken So Far

7. Further Actions Required

8. Additional Resources/Support Required (Locally/Regionally)

9. Authorisation of expenditure

10. Communications e.g.:
    - Daily reporting;
    - Internal Staff Engagement and Briefings;
    - Media Engagement, and;
    - Public Enquiries.

11. Horizon scanning

12. AOB

13. Date and Time of Next Meeting

APPENDIX 4

TELECONFERENCE ROLL CALL

Organisation Name	Representative
Community Trusts	
Liverpool Community Health	
Bridgewater Community Trust	
Specialist Trusts	
Liverpool Women's Hospital	
Liverpool Heart and Chest Hospital	
Alder Hey Hospital	
Walton Centre	
Acute Trusts	
Warrington	
Royal Liverpool Hospital	
St Helens & Knowsley Hospitals	
Southport and Ormskirk Hospital	
Aintree Hospital	
Mental Health Trusts	
5 Boroughs Partnership	
Mersey Care	
Clinical Commissioning Groups	
Liverpool	
South Sefton	
Southport and Formby	
Knowsley	
St Helens	
Halton	

Organisation Name	Rep
Local Authorities	
Liverpool	
Sefton	
Knowsley	
St Helens	
North West Ambulance Service	
NME Communications	
Other Organisations	

APPENDIX 5

HSCG/HTCG MEETING – STANDING AGENDA

Preliminaries:

Pre notified seating plan by organisation & name plates for attendees in place
Item Lead

1. Introductions (by exception and only where deemed necessary) Chair

2. Declaration of items for urgent attention Chair

3. Confirmation of decisions on urgent items Chair
   Adjourn as Necessary to Action Urgent Issues

4. Situational briefing (including any clarifications or recent updates from Chief of Staff/ Information Manager/Attendees by exception only

5. Review and agree strategy and priorities Chair

6. Review outstanding actions and their effect Chair

   - Determine new strategic actions required
   - Allocate responsibility for agreed actions

7. Confirm date and time of next meeting (alongside an established meeting rhythm) Chair

8. Post Meeting: Distribute record of decisions, ensure decision log is updated & complete Sec/Chair