SUFFOLK
MASS CASUALTY PLAN

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FREEDOM OF INFORMATION

The contents of this plan are assumed to be accessible to the public and to staff, unless an exemption under the Freedom of Information Act 2000 has been identified during the drafting process.

Please indicate opposite any exemptions you are claiming. Remember that some exemptions can be overridden if it is in the public interest to disclose – as decided by the FOI multi-disciplinary team. Exemptions normally apply for a limited time and the information may be released once the exemption lapses. 	<u>This plan contains information;</u>	Please insert an "x" if relevant
	That is **personal data**	
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Remember to destroy all unnecessary drafts and unneeded correspondence, once the final version of this plan is agreed

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DISTRIBUTION

East of England Ambulance Service

NHS England

Ipswich & East Suffolk CCG

West Suffolk CCG

Gt. Yarmouth & Waveney CCG

Ipswich Hospital NHS Trust

West Suffolk NHS Foundation Trust

Suffolk Community Healthcare

Norfolk & Suffolk NHS Foundation Trust

East Coast Community Healthcare

Public Health England

Suffolk Constabulary - Contingency Planning

Suffolk Fire & Rescue Service - Resilience Team

Suffolk Local Authorities - via JEPU

Norfolk LRF

Essex LRF

Cambridgeshire LRF

USAFE (UK) - RAF Mildenhall

7 (East) Brigade - JRLO

RAFRLO - East of England

DCLG – RED

Glossary of Terms

A&E / ED	ACCIDENT AND EMERGENCY / EMERGENCY DEPARTMENT
CCG	CLINICAL COMMISSIONING GROUP
DH	DEPARTMENT OF HEALTH
DPH	DIRECTOR OF PUBLIC HEALTH
EEAST	EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST
HALO	HOSPITAL AMBULANCE LIAISON OFFICER
HART	HAZARDOUS AREA RESPONSE TEAM
HAZMAT	HAZARDOUS MATERIALS
ICC	INCIDENT CONTROL CENTRE (NHS)
IDPT	INTEGRATED DISCHARGE PLANNING TEAM
IMT	INCIDENT MANAGEMENT TEAM (NHS)
JRLO	JOINT REGIONAL LIAISON OFFICER
MACA	MILITARY AID TO CIVIL AUTHORITIES
MA	MEDICAL ADVISOR
MIU	MINOR INJURIES UNIT
NARU	NATIONAL AMBULANCE RESILIENCE UNIT
PASs	PRIVATE AMBULANCE SERVICE
PbR	PAYMENT BY RESULTS (GUIDANCE)
OOH	OUT OF HOURS
RWG	RECOVERY WORKING GROUP
SCG	STRATEGIC CO-ORDINATING GROUP
STAC	SCIENCE AND TECHNICAL ADVICE CELL
TCG	TACTICAL CO-ORDINATING GROUP
TPOS	TEMPORARY PLACE OF SAFETY

Cabinet Office Lexicon of UK Civil Protection Terminology

http://www.cabinetoffice.gov.uk/cplexicon

FOREWORD

This plan was originally produced by the Norfolk Local Health Resilience Partnership Working Group and has been adapted by the Suffolk Local Health Resilience Partnership for Suffolk Resilience Forum use.

References:
Department of Health - Mass Casualties Incidents - A Framework for Planning - March 2007
Home Office Guidance - Responding to a Marauding Terrorist Firearms Attack - Dec. 2011

If necessary, the Suffolk Resilience Forum Mass Fatalities Plan should be consider in conjunction with this plan.

AMENDMENT RECORD

Amd no.	Date	Carried out by	Amendments made

1. INTRODUCTION

1.1 Major Incidents that produce large numbers of casualties require extra resources. Events such as the London bombings in July 2005 produced a large number of casualties, many of which did not need critical care to survive.

1.2 The Department of Health Guidance document 'Mass Casualties Incidents – a Framework for Planning' defines a Mass Casualty incident as:

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

1.3 For the purposes of this plan, a casualty is defined as:

> 'A person who is affected by a mass casualty incident that has caused them injury or resulted in them requiring other assistance'

1.4 In general, actions required in a mass casualty event do not require specific legal powers. If legislative provision is required, it may be covered under the following;

- Civil Contingencies Act 2004
- Public Health Act 1984
- Health & Social Care Act 2013

Powers under this legislation include the ability to declare a Public Health Emergency and issue Public Health Orders, including ordering quarantine, isolation, school closings and cancellation of public gatherings in order to protect the public from disease or other public health threats.

2. AIM

To provide details of multi-agency contingency arrangements for a mass casualty incident within Suffolk where casualty numbers exceed the capacity of normal Major Incident plans.

3. OBJECTIVES

The purpose of this plan is to:

- Outline the circumstances under which the plan will be activated.
- Describe the command, control and co-ordination arrangements.
- Describe organisational roles and responsibilities.
- Outline measures to increase capacity to treat injured persons.
- Provide guidance on the triage of multiple major trauma injuries.

4. RISK

4.1 Natural and man-made events have the potential to generate large numbers of casualties amongst the population. Although the probability of such events may be considered low, their impact would be significant.

4.2 The national Strategic Defence and Security Review identified the following as being top tier risks faced by the UK:

- International terrorism affecting the UK or its interests, including chemical, biological, radiological or nuclear attack by terrorists.
- A major accident or natural hazard which requires a national response, such as severe flooding affecting 3 or more regions of the UK or an influenza pandemic.

4.3 There are specific concerns regarding a 'Marauding Terrorist Firearms Attack (MTFA)', or 'Mumbai style' attack. In the event of this type of attack casualties are likely to suffer blast injuries, major trauma, penetrating injuries and burns of types rarely seen in everyday practice.

5 PLAN ACTIVATION

Activation of this plan will occur when it is believed that a mass casualty incident exceeds local response capabilities. Depending upon the nature of the incident,

demand on response resources may gradually increase and it may well be that local resources are quickly overwhelmed.

The Ambulance Service will be the agency which is responsible for declaring a mass casualty incident. In the event that such an incident is declared, the Ambulance Emergency Operations Centre will notify the on-call manager or Director of NHS England Midlands & East – East. The Ambulance Service will also request the Police to convene a Strategic Coordinating Group (SCG) or, if a SCG is already convened, advise that the Mass Casualty Plan is being activated.

If a mass casualty incident is declared in another part of the region or country, agencies may be required to provide mutual aid.

Due to the scale of the incident, a Strategic Coordinating Group will be convened. Early notification of partner agencies will assist with speedy attendance and provision of resources. Notification should be via the contacts in the SRF Alerting Directory.

6. WARNING AND INFORMING

Mass casualty event public information will be disseminated in accordance with provisions contained within the SRF Communications Plan.

The public will be made aware of potential adverse affects and of actions recommended to safeguard lives and property. Information regarding prudent protective actions will be conveyed to the public as time allows during a real event and will continue into the recovery stage.

The public should also be advised of any reduction in routine medical services as a result of a mass casualty incident, either because they are directly affected or because response priorities base diverted resources elsewhere.

Local information of greatest public interest during and immediately following a mass casualty incident may include, but may not be limited to:

- quarantine and isolation issues;
- medical-care issues including listings of available functional hospitals and health-care facilities;
- family assistance services;

- traffic management; transportation issues including road closures;
- shelter locations;
- bridge closures;
- search and rescue issues;
- power outages.

7. EMERGENCY RESPONSE

7.1 Generic Concept of Operations

In the early stages of any mass casualty incident, all organisations are expected to manage their individual responses in accordance with their own major incident plans.

Multi-agency response activities will be co-ordinated by the Strategic Coordination Group at the Suffolk Strategic Co-ordination Centre. NHS England Midland & East - East will establish their Incident Management Team (IMT) at the Incident Control Centre (ICC) at Fulbourn, Cambridgeshire. This IMT will coordinate the NHS/Health response to the incident, unless a 'lead' Clinical Commissioning Croup (CCG) is designated to coordinate instead.

7.2 Treatment of Casualties

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. There will be a need to arrange for:

- Those seriously ill or injured as a direct result of the incident, who require immediate treatment and care, to be admitted to an acute hospital.
- Those affected by the incident who, although not obviously or immediately suffering from serious illness or injury, need assessment and diagnosis, advice or treatment and may need subsequent monitoring and on-going support that can often be better provided in a non-acute or primary care setting.
- Those people who are neither ill nor injured but require information, advice and reassurance (the 'worried well').
- Continued services for those who fall acutely ill (i.e. 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 responses.

Response to a mass casualty incident involves triage, transport and treatment of patients, and logistics support. Four approaches will be used to support the response to a mass casualty incident.

Expansion of the capacities in medical treatment facilities to accept critical patients.
Transportation of casualties to unaffected areas.
Reception of deployable medical assets in the affected area and establishment of on-site and off-site treatment facilities.
Effective information management between responders.

These approaches are not listed in the order they would necessarily occur and may be used simultaneously.

Responders should make use of the Triage Sieve, as outlined in the National Ambulance Resilience Unit (NARU)Clinical Guidelines for use in Major Incidents – **Appendix A**

Local capacity building will be conducted by the relevant CCGs. Capacity at Minor Injury Units and Hospitals may be expanded by postponing/rescheduling elective surgical procedures, discharging non-critical patients, and diverting non-critical patients to other facilities. Capacity building within Primary Care Services will be conducted by NHS England.

Early involvement of the Local Authority [Community Services], initially directly and subsequently via the SCG, will assist to identify nursing & care home beds to assist the acute hospital discharge process.

Additional specialised transportation assets may be required to support the discharge/diversion or transfer of patients. The use of voluntary organisations should be considered. Casualties may be transported to other appropriate interim care providers that have not been affected by the mass casualty-producing event.

Deployable medical assets from within the region may be sent to the affected area. National assets, if available, will also be deployed. In any of these instances, the assets will be used to establish additional off-site treatment facilities to augment the arrangements that are already in place.

7.3 Communicable Disease Control

Public Health England will deploy for case and contact investigation in the case of certain communicable diseases. Regional-level Epidemiology and Surveillance staff will support CCGs and/or NHS England's Incident Control Team(s).

7.4 Air Support

If roads are passable and ground transport assets are available, casualties will normally be evacuated via ground transportation. However, if there is a requirement for casualties to be transported by air, the East of England Ambulance Trust will co-ordinate these arrangements. Where multiple air assets are deployed, e.g. Air Ambulance/SAR/military, the Combined Tactical Air Cell (CTAC) will be activated to provide de-confliction support.

7.5 Science and Technical Advice Cell (STAC)

Advice of a scientific or technical nature including advice on public health, environmental issues or hazardous materials (HAZMAT)/Chemical, Biological, Radiological, Nuclear (CBRN) incidents may be sought via the Science and Technical Advice Cell (STAC).

7.6 Military Aid/Assistance

Military Aid to the Civil Authorities (MACA) can be sought to support the civil authorities when they have an urgent need for help to deal with an emergency arising from a natural disaster or a major incident, and is detailed in the SRF Generic Response Plan.

The Department of Health has made specific arrangements for the provision of trained clinicians to support in the treatment of high velocity blast and ballistic injuries. This provision is also supported under MACA.

7.7 Psycho-Social Effects

To mitigate the psycho-social effects of a mass casualty incident on those involved, counselling services may be made available by Norfolk and Suffolk NHS Foundation Trust (NSFT) and appropriate voluntary agencies (utilising available professionals, volunteer counsellors and religious organisations) coordinated by the Trust. This support will be made available at the recommendation of NSFT, or on request to the organisation and in accordance with current Department of Health guidance.

8 HEALTH SERVICE RESPONSE

8.1 Capacity and Staffing

By definition, a mass casualty incident is sudden, traumatic and unexpected. Reference to individual organisation escalation plans should be considered in the first instance, although these will quickly become exhausted.

NHS England, or the lead CCG (if designated), will co-ordinate capacity building with providers. Critical information on bed capacity and transportation assets will be reviewed on a dynamic basis at the relevant ICC.

8.2 Discharge and onward referral arrangements, secondary care

8.2.1 Options for onward referral

The standard options for discharge/referral from secondary care are:

- Discharge to a community bed (rehabilitation/transition/step-down).
- Discharge to a residential or nursing home (either independent sector or local authority).
- Discharge home under a domiciliary care package.
- Discharge home, self care/family care.

In mass casualty circumstances there may be additional options:

- Transfer to a Temporary Place of Safety (TPOS).
- Transfer to another secondary care facility.

The processes detailed below in paragraphs 8.2.2 to 8.6 apply to all of these discharge/transfer arrangements except transfer to a TPOS, where specific arrangements for emergency transfer apply.

8.2.2 Triage processes under mass casualty circumstances

Wherever possible, the standard discharge referral processes should be followed, namely the person transferred can only be referred on if the patient's circumstances have been verified by the relevant Discharge Planning Nurse, Discharge Planning Team, or Senior Manager on Call (OOH)

8.2.3 Criteria for triage on emergency transfer/referral:

- The patient must be medically fit.

- Triage should aim wherever possible to identify patients due for early discharge.

8.3 Where appropriate the early involvement of the Local Authority [Community Services], initially directly and subsequently in collaboration with the Tactical Co-ordinating Group (TCG), will assist to identify nursing & care home beds to assist the acute hospital discharge process. In such circumstances it is recognised that there may be a requirement for flexibility with regard to accepting referrals out of hours.

8.4 Acute hospitals have existing procedures to create capacity following a major incident and in such circumstances should activate these procedures.

8.5 Additional capacity may also be created from the establishment of off-scene treatment centres set up in local non-medical facilities. Premises identified for use as Humanitarian Assistance Centres could be considered for this purpose. An early decision at strategic level should be taken in order to allow time for premises' owners to be contacted and resources deployed. It must be stressed that these are non-medical facilities and will not have the range of facilities that modern health care settings rely on.

An Aide Memoire to assist in sourcing additional supplies at such locations is at **Appendix C**

An Aide Memoire to assist in sourcing additional staffing is at **Appendix D**

8.6 Pharmaceutical Issues

In the event of rapid unscheduled discharge from hospital, circumstances may prevent the necessary medication accompanying the patient in accordance with existing service level agreements. In such circumstances the hospital should contact the local pharmacy and arrange an emergency prescription, supplying details by fax if necessary.

The original prescription should then be sent to the pharmacy within 48 hours.

9. KEY ORGANISATIONAL ROLES & RESPONSIBILITIES

The generic roles and responsibilities of responding agencies are outlined in the SRF Generic Emergency Response Plan.

Outlined below are the additional organisational roles and responsibilities pertaining to a mass casualty incident.

9.1 East of England Ambulance Service NHS Trust (EEAST)

The role of the EEAST in a confirmed Mass Casualty incident will be an extension of their role within a major incident:

- Set priorities for lifesaving interventions to ensure the largest number of survivors by implementing revised on scene triage guidelines in liaison with the Medical Advisor.
- HAZMAT/CBRN incidents - deployment of specialist resources and national mutual aid for ambulance decontamination teams.
- Subject to a dynamic risk assessment, extract casualties from the scene so that further treatment can be effected.
- Capacity management, postponement/rescheduling of all routine work, suspension of all operational training and redeploy staff/managers. Consider transport provision for Acute/community hospital patient diversion/discharge/transfer either within or outside the region by use of A&E, Patient Transport Services, British Red Cross, St John Ambulance, Private ambulance etc.
- Deployment of Air Ambulance and extended skill medics.
- Arrange activation & transport for surgical/medical teams from units within or outside the region by means of national mutual aid agreements.
- Ambulance Incident Commander (Tactical Commander) to request activation of National Ambulance Coordination Centre (NACC) to coordinate national Ambulance mutual aid requests.
- Ambulance Incident Commander to consider provision of medical support to designated off scene treatment centres.
- Mobilise national equipment vehicle via Ambulance Emergency Operations Centre.
- Request deployment of specialist supplies via the NARU on call advisor

- Deploy managers to the appropriate A&E departments as Hospital Ambulance Liaison Officer (HALO)
- Where appropriate, deploy an appropriate manager to hospital control centres to assist in managing bed capacity including patient discharge/transfer

9.2 Suffolk Fire & Rescue Service (SFRS)

Suffolk Fire & Rescue Service is responsible for the co-ordination of necessary rescue measures and the provision of associated specialist equipment. This may also include:

- The provision of specialist capabilities for detection, identification and monitoring (DIM) of hazardous materials.
- Support to the Ambulance Service in the extraction and immediate life-saving interventions of casualties – if required and as far as it is within the expertise of SFRS personnel.
- Ensure reasonable steps are taken to prevent or limit serious harm to the environment.
- Support decontamination process for any contaminated fatalities in accordance with nationally agreed procedures.

9.3 Suffolk Constabulary

Consideration of:

- The establishment of cordons, rendezvous points and access routes for emergency services.
- Set up of Casualty Bureau including staff to assist in relation to:
  - Hospital Documentation Teams.
  - Survivor/Friends and Family/Humanitarian Assistance Centres.
  - Family Liaison (if appropriate).
- In the absence of a Casualty Bureau, contact ambulance control to ascertain details of receiving hospital, and contact those hospitals to obtain details of patients.

9.4 NHS England Midlands and East - East

- NHS England is required to take such steps as it considers appropriate for facilitating a response to an emergency. In order to comply with this

requirement they provide the ‘health’ representation at the Strategic Co-ordination Centre.

- On occasion where more than one SCG has been established NHS England may request that its functions are exercised by a ‘lead’ CCG.
- In order to effectively co-ordinate the health response to a major incident, the NHS England Gold Commander will be supported by the establishment of an Incident Management Team, operating from the ICC, which will liaise with healthcare organisations and other responders.
- Broker mutual aid between NHS organisations within the East Anglia area where necessary and escalate to NHS Midlands and East Region, where support/assistance is required from outside the area of responsibility

9.5 CCGs

- Make arrangements to create capacity to receive discharged patients from Acute Trusts in community hospitals/local authority settings/with private providers.
- Facilitate care of P2 (intermediate or urgent care needed) and (mainly) P3 (delayed care) patients in community settings.
- Provide support to the emergency responders and local A&E departments with clinical and nursing staff (if resources are available).
- Enhance provisions at Minor Illness, Injury and Treatment Centres away from acute hospitals.
- Ensure that a continuing health service is provided to those not directly affected by the incident.
- Advise health professionals, other agencies and the public in monitoring long term effects of an incident.
- Ensure effective Directory of Services is maintained for NHS111.
- Be prepared to activate Mutual Aid agreements.

9.6 Acute Trusts

- Maximise bed availability and rapidly free up capacity in conjunction with community and primary care partners.
- Identify ways to increase P1 (immediate care needed)**,** P2 (intermediate or urgent care needed) or P3 (delayed care) capacity after consultation with Ambulance Service to identify the primary need.
- Where appropriate, cease all elective activity.
- Consider reducing or cancelling outpatient activity and use outpatient areas for P3 casualties.
- Identify patients suitable for rapid discharge - utilise Integrated Discharge Planning Team.
- Supplement available equipment and consider the alternative use of specialist/day care beds.
- Provide clinical support to the ambulance service in the short and medium term management of P2 or P3 patients on scene**,** if not a receiving hospital or if appropriate staffing resources allow, via the deployment of pre hospital medical teams.
- Manage excess deaths in a hospital setting.

- Ensure critical services continue whilst accommodating increased numbers of casualties.
- Assist the recovery of NHS assets and services and aid the return to normality.
- Suspension of operational training and redeployment of staff/managers.

9.7 Community Healthcare Service Providers

- Reprioritise community based services to maximise capacity and capability including:
    - Creation of capacity in the community to enable acute hospitals to discharge patients to community hospitals or home.
    - Deferring non-urgent planned community activity.
- Expediting discharges from community beds.
- Suspension of operational training and redeployment of staff/managers.
- Ensuring that a continuing health service is provided to those not directly affected by the incident including non-incident minor injury.
- Support the treatment of any patients held at the incident scene for prolonged periods.

9.8 Norfolk and Suffolk NHS Foundation Trust

- Coordinate and enable the provision of psycho-social support when requested or recommended by the Trust.
- Assist with the provision of estates, staffing and transportation where requested and subject to operational requirements.

9.9 Public Health England & Local Authority, Public Health (Director of Public Health)

- Support the management of incident response through attendance at SCG.
- Provide specialist input to incident management teams including Science and Technical Advice Cell (STAC) if established.
- Provide public health advice and support to NHS England and CCGs in monitoring the long-term health effects of an incident.
- Suspension of operational training and redeployment of staff/managers.

9.9 NHS 111

- Provide telephone assessment service for symptomatic and worried well.

- Provide consistent information via non clinical staff to callers with related non symptomatic queries – Information database can be used to provide consistent information across the National Service.
- Provide access to a dedicated National Operations Centre 24hrs a day that can provide accurate data on calls received, symptoms assessed and outcomes of calls.

9.10 Local Authorities

- Assist to support the care of discharged patients from community hospitals into nursing home or care home settings.
- Provide facilities and resources to support the local Health Services where necessary, including facilitating the provision of premises used as off-scene treatment centres, e.g. premises designated as Rest Centres.
- Assist the Ambulance Service, wherever possible in the provision of additional transport.
- Assist the Police in collecting, receiving and reporting information about the status of victims and assist with family reunification.
- Activate the SRF Recovery Plan if requested by SCG.

9.11 Voluntary Agencies

Voluntary agencies may be able to support statutory authorities, through the provision of some of the following functions:

- Support local authorities in opening emergency shelters, providing administrative support, psychosocial support.
- Provide first aid at temporary treatment & emergency shelters.
- Support local authorities in providing food for the public, emergency workers, volunteers & patients at emergency and temporary treatment shelters.
- Assist with registration at emergency shelters and Humanitarian Assistance Centres.
- Assist with tracing, messaging & communications service and family reunification.
- Assist with transport of patients and support staff.
- Provide appropriate and culturally sensitive support to bereaved relatives.
- Support a telephone help line for information.
- Provide short-term assistance following hospital discharge.

- Provide access to mobility equipment for patients (wheelchairs, walking sticks, etc).
- Assist with providing longer term care and support for recovery.

10 Recovery

10.1 In line with the response to any major incident, the SCG will address the issue of recovery, and where appropriate request a Recovery Working Group (RWG). The intention being to consider, at an early stage, management of recovery related issues, such as resourcing and rebuilding affected communities in the aftermath of an incident which generates a mass casualties event.

10.2 The Recovery process will follow procedures laid out in the SRF Recovery Plan.

11 Finance

11.1 For agencies responding to a major incident, costs generally lie where they fall.

11.2 In order to accommodate large numbers of incoming casualties at acute hospitals, existing patients may be discharged or transferred to suitable alternative care locations. In such circumstances, the general funding principle will be:

- Patients who are signed off as medically and functionally fit [S.5 Community Care (Delayed Discharges etc.) Act 2003] – Local Authority
- Patients not so signed off – NHS

11.3 Readmissions

Specific contractual arrangements apply to the readmission of (non-elective) patients discharged from secondary care – see contract extract below:

> Non-elective readmissions following a non-elective admission within 30 days of discharge should deliver a 25% reduction in the readmission rate over the previous year (subject to exceptions defined by PbR Guidance. Readmissions above this level will not be funded. This will be applied at year end.

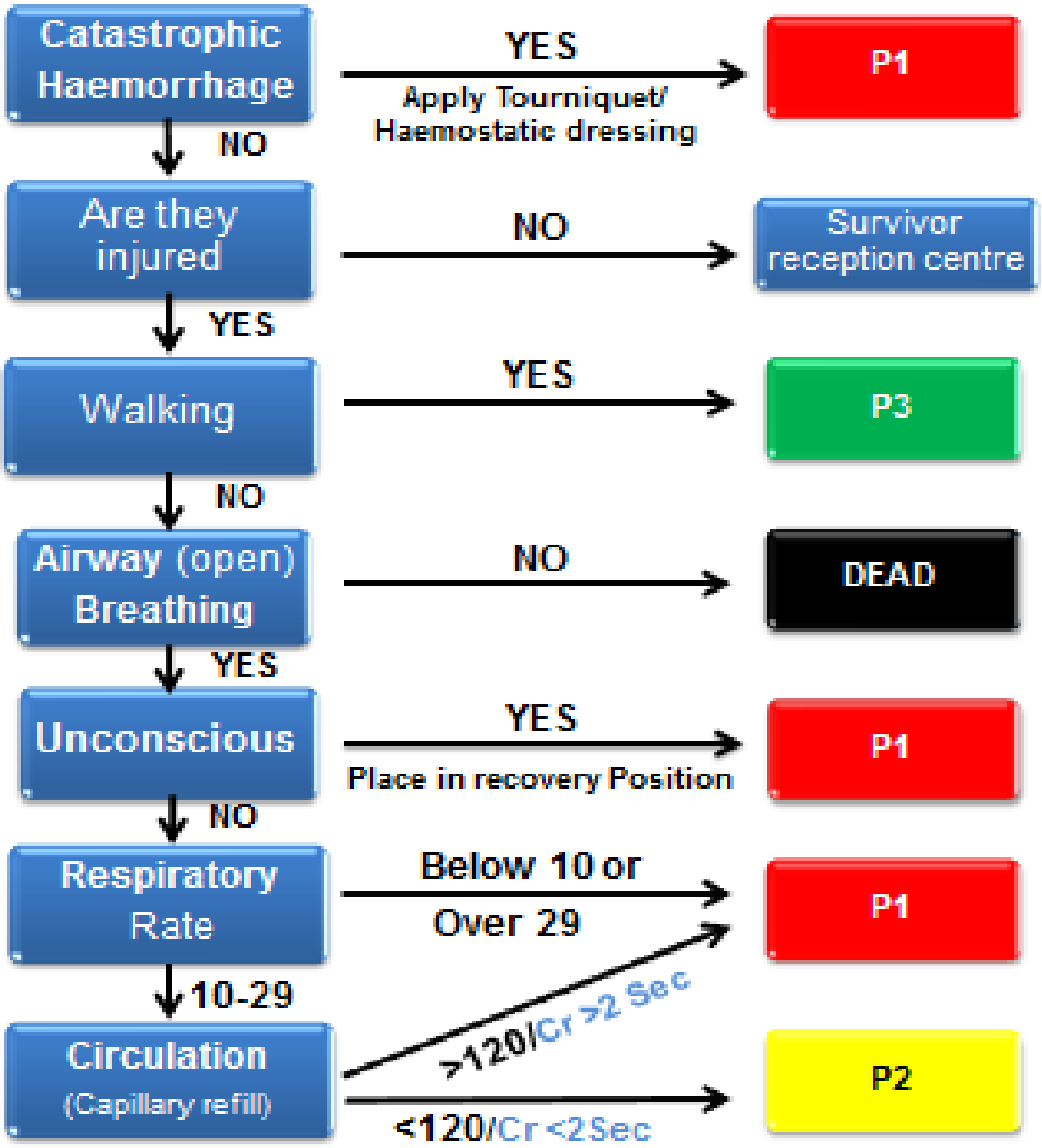
Where records indicate that such a readmission applies to a patient discharged early as a result of a mass casualty incident, allowance will be made contractually for these circumstances, as recognised in the contract.

11.4 Acute Hospitals – Service Level Agreement

Reference should be made to the terms within the national acute SLA covering the suspension of elective care provision as the result of a Major Incident.

East of England Ambulance Service NHS Trust

Casualty Triage



Appendix B

Mass Casualty Capacity Aide Memoire

- Has all acute hospital capacity been exploited, including unused, closed and escalation areas?
- Has all community hospital capacity, including escalation areas, been opened and utilised?
- Has additional capacity been created using existing Escalation Plans?
- Are all GPs and community healthcare teams working at capacity?
- Are all MIUs operating at capacity?
- Can patient transport services, local authorities, voluntary sector organisations and local taxi firms assist with transporting non critical patients?
- Are independent sector hospitals being used at capacity?
- Can patients ready for discharge or not requiring treatment be accommodated in local authority rest centres?
- Is there any potential capacity in the private nursing home sector?
- Consider the use of other premises as ad hoc treatment centres.
- Are there any temporary structures that could be used to supplement the ad hoc treatment centres?

Mass Casualty Resources

Supplies (Acute Trusts)

- Ensure laundry services run 24/7 and that adequate transport is in place to use linen supplies effectively.
- Make full use of disposables.
- Use the NHS Logistics emergency service.
- Contact local hotels, independent hospitals and boarding schools if additional linen is required.
- Activate appropriate call off contracts with suppliers.
- Request mutual aid.
- Consider purchasing necessary non specialist equipment from local retailers.

Catering (Acute Trusts)

- Activate business continuity arrangements.
- Change menus if required.
- Utilise contracts with existing suppliers.
- Use the NHS Logistics emergency service.
- Utilise Supermarket Emergency Assistance arrangements.
- Consider approaching local supermarkets.

Transport (Acute Trusts)

- Maximise use of Patient Transport Services.
- Maximise use of hospital volunteer drivers.
- Seek assistance from Local Authority for the use of school buses, taking account of the knock-on impact this may have if school buses are not available for the transportation of children to and from school.

East of England Ambulance Service

EEAST has the capability to provide trauma supplies & equipment to the scene of a mass casualty incident or other designated location. Some supplies are held on mass casualty vehicles, which are strategically located within the Eastern region. Each vehicle can provide sufficient resources for 20 paediatric and 80 adult casualties.

How Additional Staffing Resources Could be Made Available

Clinical Commissioning Groups

- Request additional staff via NHS England.
- Request out of hours providers to support.
- Utilise qualified CCG staff.
- Seek primary care personnel where available:
    - requests to both GPs and Practice Nurses.
- Utilise voluntary agencies.
- Utilise bank staff.
- Consider requests to private providers.
- Consider media requests for recently retired or other ex health service staff.

Community Healthcare

- Reprioritise community based services to free up staff.