



# BSRM Position Statement on the response to a Mass Casualty Event (MCE)

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## Summary statement:

*Rehabilitation Medicine specialist input is essential to achieve optimal outcomes after major trauma of all causes, including those associated with a Mass Casualty Event (MCE). To facilitate this, Rehabilitation Medicine specialists need to be embedded in local, regional and national Emergency Planning and Preparedness discourse to advise on resources and set up appropriate pathways and service links in advance. RM input is important from day one of a Mass Casualty Event for triage and release of 'downstream' beds and can offer the vital continuity required for the long tail of recovery such incidents create.*

- 1.** The important contribution that Rehabilitation Medicine (RM) makes to the management of Major Trauma has been clearly demonstrated during the set-up of the Major Trauma networks in England. Assessment of rehabilitation need is now mandated within days of admission following complex major trauma, being essential for the achievement of the best practice tariff. This is underpinned by National Core Trauma Standards and has been demonstrated to be cost effective.
- 2.** Rehabilitation Medicine therefore needs to be embedded in the NHS England national mass casualty framework which was established following the recent escalation in major incidents. This would ensure that from the outset of any such incident, there is sufficient availability of RM specialists to deliver timely assessment of rehabilitation needs of the injured, provide effective links with available resources and efficient flow of patients along the pathway. To establish an effective national rehabilitation network, RM specialists should contribute to emergency preparedness planning in every region of the UK.
- 3.** The early involvement of Rehabilitation Medicine physicians in advance planning for an MCE will ensure there is a knowledge base of personnel, reliable links to, and documentation of, regional rehabilitation services with appropriate staffing and pathways in place, to enable efficient and effective triage and flow of patients beyond acute settings.
- 4.** Injuries sustained in major incidents are likely to be severe and sometimes of unfamiliar causation, (e.g. blast or gunfire, including polytrauma, multiple amputation, open wounds and concurrent traumatic or hypoxic brain injuries). The rehabilitation of patients with these injuries may be complex and prolonged and will be best overseen by RM specialists with support from the Defence Rehabilitation services as appropriate, to ensure people achieve the best recoveries possible, including return to work, with minimal complications.

5. The establishment of Hyperacute rehabilitation units in several major trauma networks in England has been very successful and enabled patients to move out of acute surgical wards and into a rehabilitative setting much earlier than was previously possible, while ensuring there is immediate access to advice and interventions from all acute specialties when needed. There are currently only 58 beds commissioned as Hyper-acute rehabilitation beds in England and Wales, and only 8 of these are in London, (with none based in South London), which is one of the most likely targets for future terrorist attack, so it is strongly recommended that the provision of Hyperacute rehabilitation beds across the country is reviewed and expanded as part of emergency preparedness.

6. The overall success of any health intervention after an MCE will be contingent upon adequate resourcing along the whole patient pathway. Up-scaling and up-skilling of multi-disciplinary rehabilitation teams to meet the challenge of any surge in complex patients will be needed. Rehabilitation Medicine specialists working in the Trauma Networks have developed the skills to support these patients from very early after injury, and should be enlisted from day one of any MCE, so that they can facilitate delivery of an efficient, coordinated response, by providing a ‘helicopter view’ of prognosis and appropriate rehabilitation interventions along the whole recovery pathway.

## Key recommendations

1.	Each Trauma Network should produce an EPRR planning document describing the preparations required for the specialist rehabilitation response to an MCE, based on the framework outlined in the BSRM EPRR summary document and adapted for local use. This should include access to educational resources regarding unusual injury presentations (e.g. blast injuries), the psychological sequelae of an MCE for patients, bystanders and staff, and consideration given to the impact on rehabilitation equipment resources during a surge in demand.
2.	Each Trauma Network should have a nominated Trauma Rehabilitation Response Team (TRRT) led by a Consultant in Rehabilitation Medicine which will be activated immediately in the event of an MCE within the Network.
3.	The index Trauma Network TRRT should be involved from <b>DAY ONE</b> of an MCE, initially to facilitate the creation of bed capacity through the patient pathway and to start planning for the likely rehabilitation demand. Neighbouring Trauma Networks should go on immediate stand-by and be prepared to actively support.
4.	The Consultant in Rehabilitation Medicine leading the TRRT should be available for the Clinical Impact Assessment call chaired by the Lead National Medical Director which will take place within the first 24 hours of an incident (‘Rehabilitation issues’ is point 3 on the stipulated agenda).
5.	Active planning for a prolonged rehabilitation tail (lasting months and likely longer) should be undertaken as return to ‘business as usual’ for rehabilitation services will be severely delayed when compared to the acute sector following an MCE.