



When tragedy strikes

Reflections on the NHS response to the
Manchester Arena bombing and Grenfell Tower fire



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Introduction

When tragedy strikes, the NHS often lies at the heart of the response. Such was the case in 2017, when the NHS responded to a string of terrorist attacks in Manchester and London, and one of the UK's worst fires in modern times.

More than 100 people were killed in the terrorist incidents and the fire that tore through Grenfell Tower, with hundreds more needing physical or emotional care and support.

NHS staff were praised for running towards danger to help those caught up in the attacks, and for their acts of bravery. Frontline NHS responders, professionals, managers and the whole range of NHS staff, together with the other emergency services, acted quickly and effectively to provide treatment and care. Good planning held the health service in good stead.

To support NHS organisations with planning for major incidents, the NHS Confederation has conducted a series of interviews to capture the learning from the health service's response to the harrowing events of 2017.

Interviews were held with:

- Lord Bob Kerslake, chair of The Kerslake Arena Review
- Dr John Green, clinical director of the Grenfell Tower NHS Mental Health Response
- Professor Chris Moran, national clinical director for trauma, at NHS England.

The interviews reflect on key aspects of the responses by emergency, mental health, acute and community services, drawing out key issues for executive and non-executive healthcare leaders to consider.

The overarching message is simple: planning and rehearsal, multi-agency collaboration, and effective mental health support for both patients and staff are vital to providing the best possible care when tragedy strikes.

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1

The Manchester Arena bombing



Introduction

At 10.31pm on 22 May 2017, a suicide bomb exploded at Manchester Arena. Detonated following a concert by American singer Ariana Grande, the bomb killed 22 people, including children and young people. The incident triggered an immediate multi-agency partnership response.¹

More than 800 people suffered physical and psychological injuries after the bombing,² the deadliest attack on British soil since the 7/7 bombings in London. The events of the atrocity were unprecedented in Manchester, with emergency responders and the community mounting their biggest ever response to a terrorist attack.³

In July 2017, the Mayor of Greater Manchester, Andy Burnham, commissioned a review into the preparedness and emergency response to the attack. Chaired by Lord Bob Kerslake, the former head of the Civil Service, the review considered what went well, and identified key areas for learning. The review reported in March 2018.

In an interview with the NHS Confederation, Lord Kerslake reflected on the review's findings and the key issues for healthcare leaders to consider when planning for a major incident.

Operational discretion

Lord Bob Kerslake has not always had an extensive knowledge of stretchers. But when he chaired the review into the Manchester Arena attack, he quickly became something of an expert. And he discovered this apparently simple piece of equipment can in fact be surprisingly complicated.

When the first emergency teams arrived at the scene of the attack, they improvised a means of evacuating witnesses, using display boards and metal crowd barriers to carry the injured. Then, when ambulances arrived, spine boards and scoop stretchers – which fully immobilise a patient and are helpful if a spinal injury is suspected – came with them.

But using that equipment requires training. And so the ambulance service staff made a judgement call: to continue using improvised stretchers in some instances, meaning those who were not formally trained in the use of scoop stretchers could still help with evacuation.

It is an example of what Lord Kerslake characterises as “operational discretion”, and says it is something which is crucial to the successful management of a major incident.

This, he strongly emphasises, is not to say organisations should not be extensively planning for such events. “I think a key point [about the response to the Arena bombing] is that the Greater Manchester Resilience Forum had done a lot of planning, with exercises at the Trafford Centre [a shopping mall] and so on.

“I think what that allowed them to do was to act with confidence. So I think a key message is that if you've not had an exercise, you must do them. They are absolutely vital.”

But another key message is that “however well you plan, things won't go as the plans tell you they will”. What that means, he suggests, is that organisations need a plan which “both deals with: ‘Here's how things go if they go to plan, and then here's how people exercise their discretion operationally when [things] don't go to plan.’”

Dealing with the media

And he suggests that plan should include dealing with the media. The review report points to the intrusiveness of certain members of the press as a significant issue in the aftermath of the Manchester attack.

“If you’re doing an emergency planning exercise, I think it’s a very good idea to involve the more responsible local press in that planning,” Lord Kerslake says now. “That doesn’t happen as far as we could tell; it didn’t seem to have happened in Manchester.

“I think another learning point for me was that you need some way of managing the outside environment of the hospital with the press. So that if they’re going to be there, they’re in a proper space and they are not there in a big scrum which people have to push their way through.”

He says that while the review raised this and other issues of concern, “we were doing so in the context of a system that actually in many ways worked, and I think particularly the health systems worked well in many ways”.

The challenges of coordinated care

Asked about any room for improvement when it comes to healthcare, though, and he quickly highlights the challenges of coordinated care for victims who hail from a large geographic area.

“If you think of this particular concert, it was in Manchester but actually people came from all over the north west. So while they had good, coordinated care while they were in Greater Manchester, when

they moved back to their own areas, there wasn’t the same understanding, awareness and consistency of handling their situation,” explains Lord Kerslake.

“There was a very strong feeling that people felt great support at the beginning, and then as time went on and they moved back to their homes, the support in the area they lived in wasn’t as coordinated. So there’s quite a big question about how you deal with not just the immediate period, but also the longer term period.”

He says mental health services are a particular issue in this context. “Sometimes people don’t have symptoms of trauma until quite a long time afterwards. There was a mother I spoke to who had five or six operations in the hospital, but it wasn’t until July when she was home that the problems of depression surfaced. And then she found it really hard to get the appropriate care.”

When it comes to care coordination, he feels it’s valuable for those working in healthcare to understand the full range of colleagues with which they could collaborate. Chief among them: family liaison officers, the members of the police who support bereaved families.

“Their formal role is to help with the investigation and link the family [to it]. But in reality, they do so much more to help the family. And knowing that role is there, I think is something worth thinking about in the health service.”

Operational cultures

Worth thinking about too, he suggests, is how the differing cultures of all those organisations involved in a major incident might prove an obstacle to collaboration – and, more importantly, reflecting on how that might be overcome.

“More than 800 people suffered physical and psychological injuries after the bombing, the deadliest attack on British soil since the 7/7 bombings in London.”

“Each organisation has its own operational culture – the fire is different from the police, from the ambulance service. And those cultures are not wrong or right; they’ve evolved over time to suit those organisations.

“The issue,” he says, “is how do those cultures play out under pressure and stress. What we found is that there’s quite a tendency to default to the single organisational way of seeing things. The evidence we found was that the natural default is back to your own culture and your own organisation”.

He suggests, then, that it’s important to think about how a multi-agency approach can be embedded such that it remains in place at a time of high stress. In the Manchester attack, “health were in many ways better than others” is retaining that collaborative approach, he says.

“But nevertheless, they’ve got to deal with other organisations that are critical – the police, the fire, the ambulance – and how they handle that cultural point really is quite crucial.”

Key considerations

- Major incident exercises are vital.
- Emergency response plans should deal with what happens if things go to plan, and how people can exercise operational discretion when things do not.
- The plan should include dealing with the media and how to involve local press in the planning process.
- Consider a way of managing the outside environment of the hospital with the press.
- Think through how to deal with the longer-term period, as well as the immediate aftermath.
- Understand the full range of colleagues with which you could collaborate, particularly family liaison officers.
- Consider how the differing cultures of all the organisations involved in a major incident might prove an obstacle to collaboration and how that might be overcome.

Manchester Resilience Hub

The NHS Manchester Resilience Hub⁴ was established in response to the Manchester Arena attack.

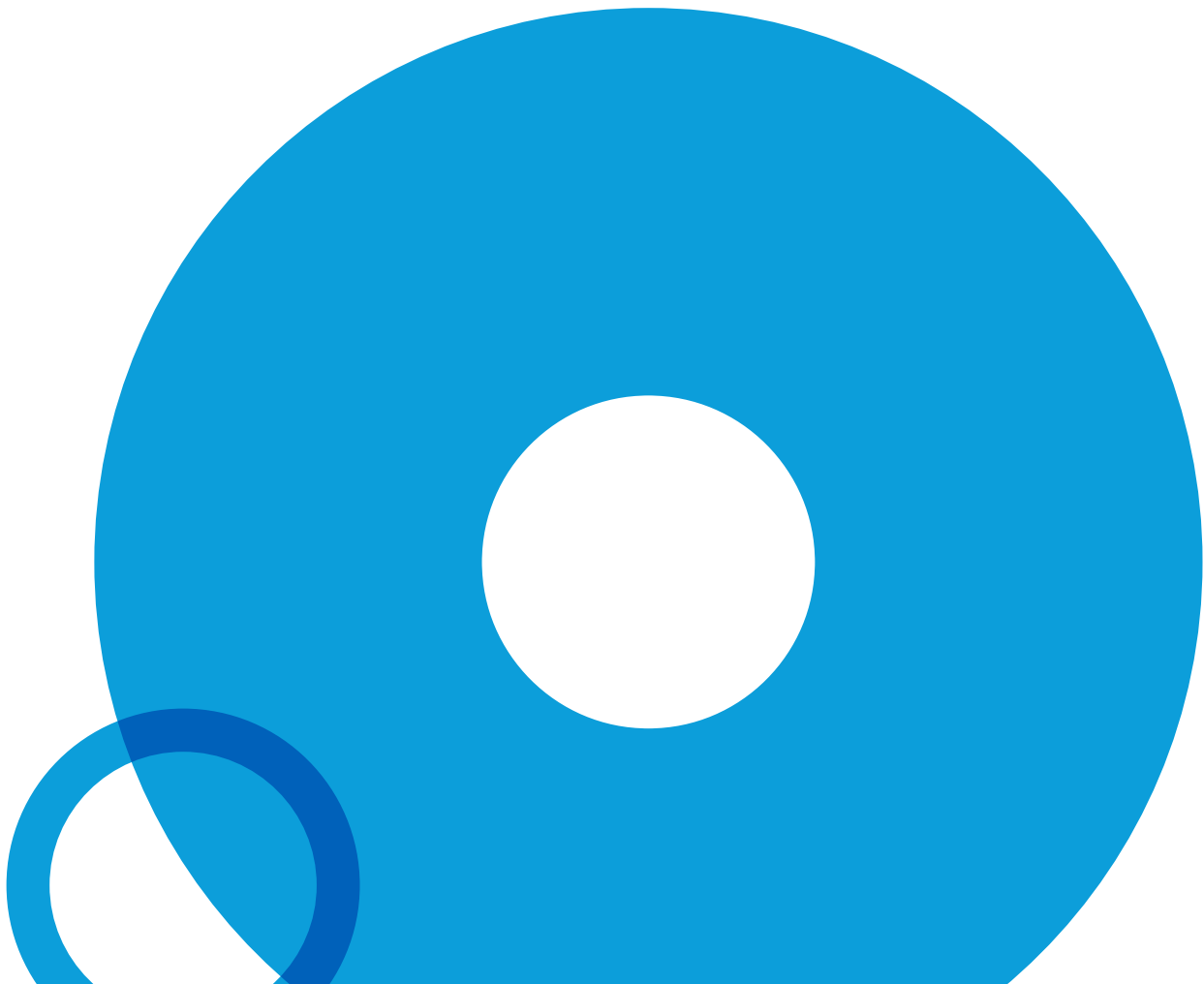
It coordinates the care and support for children, young people and adults whose mental health and/or emotional wellbeing has been affected. The Hub is based in Greater Manchester but is for everyone who was affected by the events at the arena.

The service is hosted by Pennine Care NHS Foundation Trust, working with other NHS and voluntary sector agencies. Staff are trained mental health professionals who are experts at working with people who have experienced a traumatic event.

As at March 2018, approximately 80 per cent of the 2,988 individuals supported by the Manchester Resilience Hub live outside of Greater Manchester.⁵

2

The Grenfell Tower fire



Introduction

In the early hours of 14 June 2017, a fire engulfed Grenfell Tower, a 24-storey residential tower block in west London. Seventy-two people died in the blaze, Britain's worst fire in a century.⁶ Harrowing eyewitness accounts recount residents jumping from the building while the fire raged.⁷

The tower burned for 60 hours, with pictures of the inferno beamed across the globe.

Since the 999 calls of 14 June, health and social care organisations across west London, together with voluntary sector organisations and community and faith-based groups, have provided physical and emotional health and wellbeing care and support to residents of the tower, their families and the wider community.

The mental health response following the fire has been described as the biggest operation of its kind in Europe, with the number of people affected likely to exceed 11,000.⁸

The NHS Confederation interviewed Dr John Green, the clinical director for the Grenfell Tower NHS Mental Health Response, to learn more about the response and what health and care organisations should consider when handling an incident of this nature.

Multi-agency planning

Dr John Green was in a hurry as he left the house on 14 June 2017. When he grabbed his car keys and headed out of the door, he only half registered the news reports about a major fire.

"I was driving down the A40 early in the morning when I was rung up by the divisional director on call, who indicated the fire was in our area," remembers Dr Green, the chief psychologist at Central and North West London NHS Trust.

Grenfell Tower was burning, and it quickly became clear the fire was on a huge scale. But Dr Green, who had previously coordinated the response to the 1999 Ladbroke Grove train crash, knew it made most sense for him to continue onto trust headquarters rather than head for North Kensington.

"On the first day, the site tends to be – inevitably – busy, people running around, ambulances in attendance, fire engines, rest centres being set up. So it's a very busy and inevitably slightly confused picture," says Green.

There is value then, in having some senior figures based away from the site of a major incident. But for Green, that meant the first priority was to make sure that everybody was in communication with everyone else.

"We made contact with my colleagues on the site, and also spoke to the agencies who were on site, like the Red Cross, just to make sure that we were coordinating with whatever it was that they were doing."

He also wanted to ensure good communication with the members of the public who were contacting healthcare services. "I knew that people would be wanting to get in touch; get some information," he reflects.

"We [usually] have a single point of access for referrals to our trust which is 24 hours a day, seven days a week. I spoke to them and it seemed sensible to guide the calls from patients, and anybody else that might be concerned, through them."

It was soon agreed that any Grenfell-related calls to NHS 111 would be diverted directly to the same team. "That was all important, because we wanted to make sure that people who wanted to reach us knew how to get in touch."

But he emphasises the day itself "is not the moment to start with complicated support for [psychological] trauma".

"Actually on the day, what you really want to provide is psychological first aid. And of course, there's a practical element. People have come out of Grenfell Tower – they don't have any clothing, they haven't been fed, they haven't had anything to drink, they've lost their phone. So they've got very immediate concerns."

Reaching out

He reports that in the first month following a major incident, a large proportion of the affected population will be "really quite disturbed by what's happened" and experience symptoms of trauma.

"It's really only around about six weeks that you start to be able to work out who might be going to have longer-term problems. There's no evidence that wading in before then will help, and in some cases it can interfere with the natural process of recovery."

He says that means the early activity of the Grenfell Tower NHS Mental Health Response team was focused primarily on providing information, listening and making connections. They had to do so with an awareness of the large population who might have been affected: not only those who lived in the tower, but those who knew people who did, and those who lived nearby and so had seen the fire unfold.

"We put together an outreach team who went and knocked on doors – more than 2,000 doors in the

local area – with staff on the streets talking to people, giving out the NHS trauma leaflet, speaking to people about their experiences," explains Dr Green.

Residents of the Tower and some of the neighbouring properties were relocated to hotels, and so members of the team also visited there. "We went around hotels and around the local area just to find out that people were OK, find out what they needed, find out whether they were getting what they needed."

Being visible

From this activity stemmed one lesson Green sees as small but critical when it comes to mental health support in the aftermath of a major incident. "Mental health staff don't normally wear a uniform. And so the first thing you need to do is get some high visibility yellow jackets, so people can actually pick out who you are."

The outreach team also made it possible to proactively identify those who might need additional support in the longer term. "Early on [after a major incident], people will seek help, but only around a third of people will come forward spontaneously. And for a lot of people, if they've been traumatised, it's quite distressing to think about what's happened. And therefore as soon as people start thinking about it, they try and shut it out of their mind, and of course that means they don't come forward for treatment.

"So you have to do screen and treat. In other words, you have to go out and actually try and identify who's been involved, who's been exposed, and we use a brief ten-item screen to identify people with post-traumatic stress disorder (PTSD). It's important to be assertive in going out – not just wait for everybody that comes, because some of them won't come."

"The mental health response following the fire has been described as the biggest operation of its kind in Europe, with the number of people affected likely to exceed 11,000."

A community-focused service

Dr Green thinks the trust has always been good at engaging local people in planning, but he argues the tragedy at Grenfell has reinforced this further. “I think it’s a very much community-focused service. It’s not simply about signposting to existing services; it’s about us all trying to work together to work out what’s needed, and to try and make sure we’ve got comprehensive care to identify where the gaps lie.”

That, of course, includes collaboration with other part of the health and care service. “This has been very much a collaborative effort, right from the start between ourselves and the clinical commissioning group, and others,” he says.

“If you are going to plan for a major incident, which you should do, then you need to plan it with all the agencies that might be involved. And that in itself is an opportunity to get some of those connections firmed up.”

Key considerations

- Have some senior figures based away from the site of a major incident and make sure everyone is in close communication.
- The day of a major incident is not the moment to start with complicated support for psychological trauma – provide psychological first aid.
- Make sure mental health staff are visible when reaching out to the community, so people can easily pick them out.
- When it comes to community outreach, be assertive in going out – don’t wait for people to come to you.
- When planning for a major incident, plan with all the agencies that might be involved.

Grenfell Outreach Team

The outreach team visits people in temporary accommodation, at community events and goes door-to-door to check if people need NHS help.

This is one example of their work, as reported on the Central and North West London NHS Foundation Trust website:⁹

On 22 April, the team was offering trauma screening to a tower block in the area. A resident opened her door and welcomed them into her home.

She expressed relief at their arrival. She had been waiting for the NHS to knock on her door, as she had heard from a friend who lived in a neighbouring block that the NHS had been door knocking. She sent her children into another room and said she knew she would be overcome with emotion.

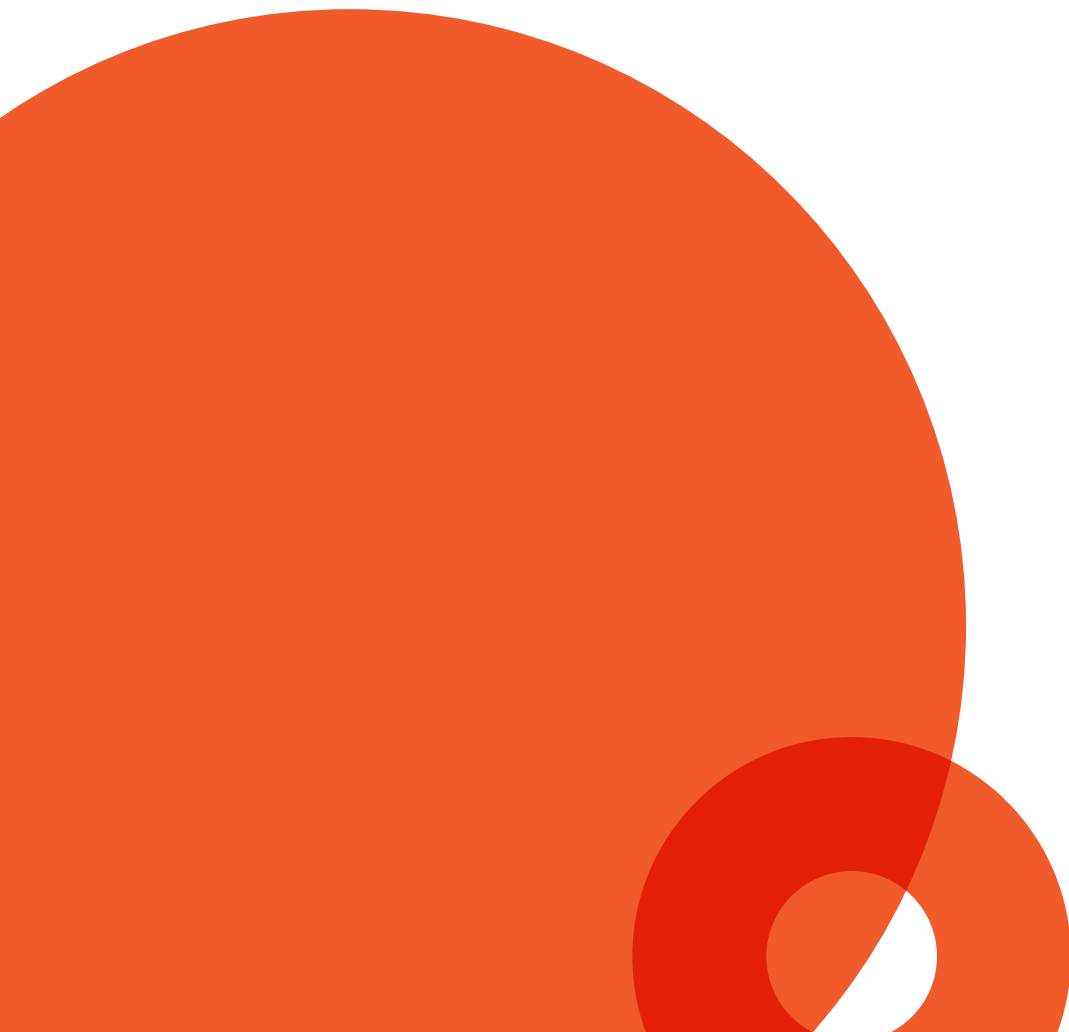
She had lost friends in the Tower, and was concerned for her children’s emotional wellbeing (having nightmares and no longer able to sleep independently).

They had kept their curtains closed for five months after the tragedy, as they couldn’t bear looking at the Tower and were relieved that the Tower is being covered.

The team referred the mother for trauma therapy and both children to child and adolescent mental health services.

3

Clinical response to terror attacks



Introduction

According to the Global Terrorism Database,¹⁰ the number of terrorist attacks resulting in fatalities in western Europe increased in 2016, despite an overall decline in the number of incidents.

Between March and September 2017, the UK was subject to five terror-related events causing loss or injury to life: Westminster Bridge, Manchester Arena, London Bridge, Finsbury Park and Parsons Green.

The events of 2017, and the incidents that came before them across the globe, underscore the need to prepare health and care systems and clinical staff for a different type of event than they would normally see in civilian practice.

In an interview with the NHS Confederation, Professor Chris Moran, national clinical director for trauma, reflected on the clinical response to terrorist attacks, providing advice for senior healthcare leaders.

Practise, practise, practise

Chris Moran can easily pinpoint the point at which NHS England's preparations for major incidents fundamentally changed: 13 November 2015.

That was the day Paris experienced a series of coordinated terrorist attacks, including a mass shooting at the Bataclan theatre. "What became really obvious at that point," says the national clinical director for trauma, "was we were facing a very different threat from that we were used to dealing with."

He explains: "Trauma surgeons in civilian practice generally do not deal with gunshot wounds; they do not deal with patients who've been blown up. And so it became very clear that we needed to prepare clinical staff for a difficult type of event than we'd normally see in civilian practice."

And so eight days after the attacks, Professor Moran chaired a national conference to determine just how the English system would deal with a Paris-style attack. "Not how you would manage it on scene," he emphasises, "but actually how hospitals would manage this scenario."

The result was a series of recommendations, drawing on the lessons learnt from the tragedies that had taken place over the English Channel. One of the most important: the need for individual hospitals to rehearse for such events.

"Paris had been incredibly lucky in one way in that they had just had, literally the day before, a big practice run for a mass-casualty event. And one of the first lessons that came out was that you have to practise for these events; you have to practise with desktop exercises, going through what would happen on the day, and you need to practise a real-life simulation as well."

"The events of 2017, and the incidents that came before them across the globe, underscore the need to prepare health and care systems and clinical staff for a different type of event than they would normally see."

Embracing rehearsal and planning

Little wonder, then, that he urges board members at NHS organisations to “embrace rehearsal and planning”.

“I’m a pragmatist, I live in the real world, I know that people do not read their major incident plans from cover to cover – it’s just not what happens,” he admits. “But hospitals can ensure that everybody knows what their role is going to be if an event occurs – making sure staff know where their muster points are, where they’re supposed to go to, what their most likely role is going to be.

“I think it’s important that senior members of the executive team know exactly what their roles are going to be as well.”

Ripple effect

It is also important they understand the impact of major incident extends far beyond the front door of a hospital, and ripples through the wider health and care system – and for a long period of time.

“When the scene is clear, and a major incident is declared over, that’s a really key point for the police, fire and ambulance services. But actually, for the health service, it means that incident is really just beginning,” he says.

Different services can expect high workload at different points, he explains. “For the fire brigade and the paramedics, it’s perhaps five hours on the scene; for the emergency department it’s a very busy four hours receiving patients; for the operating theatres and intensive care, it’s then a very busy three to four days; and then followed for the hospital by a very busy two to three week period.

“And for psychological care, the problems really only start to come up after about two months. The experience in Manchester is that the psychological impact, the workload for psychological services, appeared to reach its peak at between six and nine months.”

Looking after staff

In short, NHS leaders need to be planning how organisations will collaborate to offer the best care over the months following the incident – not just over days and weeks. And when it comes to meeting mental health needs, it is about considering staff – all members of staff – as well as patients.

“Everybody thinks of the doctors and nurses, because that’s who the press often focus on. But actually, doctors and nurses are pretty resilient. I’m not saying they don’t need support – but, for instance, it’s my day job to see people with devastating injuries from motorbike accidents. It’s not the day job of the transfusion technician, or the porter. So I think one thing that has become really clear is that you need to support staff through the whole system.”

Improving care

And he thinks that, in trauma, lie lessons in how to improve care more broadly. “I believe the major trauma networks are an exemplar of how you can hugely improve acute care by having clinical teams working in networks,” says Professor Moran, who is also orthopaedic trauma surgeon at Nottingham University Hospitals NHS Trust.

“The key is that it’s not a ‘them and us’: it’s not the great major teaching hospital and then the small district general – it is a partnership that’s built from the bottom up and not imposed from above; a network where people work together and bring their different clinical skills and perspective.

“It’s about bringing clinical teams and their management teams together in a room and working together to work out what’s best for the patient, what’s in the best interests of the patient. Because in general, what’s in the best interest of the patients is also what’s in the best interest of the NHS.”

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The need for education

Professor Moran says he is delighted several of the measures put in place after the Paris attacks were “incredibly helpful” by the time of the terrible events in Westminster, Manchester and London Bridge. But he knows there is always more than can be done, and is particularly keen to see improvements to clinical education on how to manage injuries resulting from terrorist attacks.

“It’s not that people don’t know the basics, but even in East London where they deal with lots of stabbings, they don’t deal with that many gunshot wounds, and these are mainly from handguns. We don’t deal with wounds from military-grade weapons. So I believe there’s a lot more that could be done, supporting clinical education, not just for surgeons but for intensive care, anaesthetics and emergency reception.”

Key considerations

- Individual hospitals must rehearse for mass-casualty events: practise with desktop exercises, going through what would happen on the day, and practise a real-life simulation.
- Ensure everybody knows what their role is going to be if an event occurs – make sure staff know where their muster points are, where they are supposed to go to, what their most likely role is going to be.
- Senior members of the executive team should know exactly what their roles are going to be.
- Understand the impact of major incidents extends far beyond the front door of a hospital, and ripples through the wider health and care system – and for a long period of time.
- Plan how organisations will collaborate to offer the best care over the months following the incident – not just over days and weeks.
- When it comes to meeting mental health needs, consider staff – all members of staff – as well as patients.

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