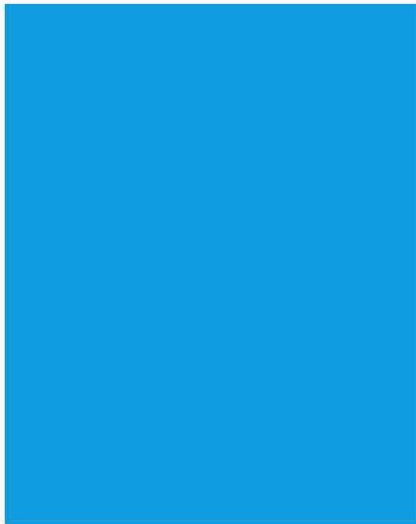


NHS Commissioning Board  
Emergency Preparedness  
Framework 2013



# NHS Commissioning Board Emergency Preparedness Framework 2013

<b>Date</b>	21 March 2013
<b>Audience</b>	<ul style="list-style-type: none"> <li>• NHS Commissioning Board directors of operations and delivery</li> <li>• NHS Commissioning Board regional directors</li> <li>• NHS Commissioning Board area team directors</li> <li>• NHS Trust and NHS Foundation Trust chief executives</li> <li>• Ambulance Service chief executives</li> <li>• Clinical commissioning groups</li> <li>• Accountable emergency officers</li> </ul>
<b>Copy</b>	<ul style="list-style-type: none"> <li>• Members of local health resilience partnerships (LHRPs)</li> <li>• NHS Commissioning Board emergency planning leads</li> <li>• Public Health England (PHE)</li> </ul>
<b>Description</b>	<p>Please read this document in the context of:</p> <ul style="list-style-type: none"> <li>• the NHS Commissioning Board Business Continuity Management Framework (service resilience) (2013)</li> <li>• NHS Commissioning Board Command and Control Arrangements (2013)</li> <li>• the NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response</li> <li>• the Civil Contingencies Act (2004)</li> </ul>
<b>Cross Reference</b>	<p><a href="http://www.commissioningboard.nhs.uk/epr/">http://www.commissioningboard.nhs.uk/epr/</a></p> <p>Further links are listed in section 18.</p>
<b>Action Required</b>	Accountable emergency officers must make sure that their organisations and sub-contractors work to these core standards.
<b>Timing</b>	1 <sup>st</sup> April 2013
<b>Contact Details</b>	<p><a href="mailto:NHSCB.EPRR@nhs.net">NHSCB.EPRR@nhs.net</a></p> <p>NHS Operations, Quarry House, Leeds LS2 7UE.</p>

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## 1. Executive Summary

- 1.1 The NHS needs to be able to plan for, and respond to, a wide range of incidents that could impact on health or patient care. These could be anything from prolonged period of severe pressure, extreme weather conditions, an outbreak of an infectious disease, or a major transport accident. A significant incident or emergency is any event that cannot be managed within routine service arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or a local authority.
- 1.2 The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with such incidents while maintaining services to patients. NHS funded organisations, including commissioners and providers of NHS funded care, whilst not all Category one responders, must also show they can deal with such incidents, this programme of work is referred to in the health community as emergency, preparedness resilience and response (EPRR).
- 1.3 EPRR remains a key priority for the NHS and the requirements for EPRR is set out in the NHS Commissioning Board planning framework ('Everyone Counts: Planning for Patients'), the NHS standard contract and through this the NHS Commissioning Board Emergency Planning Framework (2013). These responsibilities are detailed in the '*NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR)*'.
- 1.4 New arrangements for local health EPRR will start from 1 April 2013 as part of the changes that the Health and Social Care Act (2012) is making to the health system in England. From 1 April 2013:
  - a. the EPRR responsibilities of strategic health authorities (SHAs) and primary care trusts (PCTs) will be transferred to the NHS commissioning board (NHS CB) and to clinical commissioning groups (CCGs);
  - b. local health resilience partnerships (LHRPs) will be the forum for coordination, joint working and planning for EPRR across all relevant health bodies; and
  - c. NHS organisations will nominate accountable emergency officer to assume executive responsibility and leadership at service level for EPRR.
- 1.5 From 1 April 2013, this guidance supersedes both the '*The NHS Emergency Planning Guidance 2005*' and the '*Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013*'.

## Structure of this Document

- 1.6 Section 6 describes definitions of significant incident and emergency and the incident levels to be used in the event of an incident occurring.
- 1.7 Section 7 describes the underpinning requirements and principles applicable to all NHS funded organisations which are set out in detail in the *NHS CB core standards for EPRR*. The responsibilities under the Civil Contingencies Act (2004) for 'category one' and 'category two' responders are also explained.
- 1.8 Section 88 describes the NHS EPRR service-wide objective, underpinning doctrine and the underpinning approach (co-operation, information sharing, risk assessment, communicating with the public and regular exercising and evaluating of plans).
- 1.9 Section 9 outlines the EPRR roles and responsibilities for the NHS Commissioning Board; Directors of Public Health in local authorities, Public Health England, NHS funded organisations, Clinical Commissioning Groups and accountable emergency officers.
- 1.10 Section 10 sets out the emergency planning cycle, from risk management, training staff and writing and validating plans. The section also describes integrated emergency planning through the local health resilience partnerships and local resilience fora.
- 1.11 Section 12 introduces business continuity management which is an essential tool in establishing an organisation's resilience and gives organisations a framework for identifying and managing risks that could disrupt normal service. This links to the more detailed information provided by the *NHS CB Business Continuity Management Framework (service resilience) (2013)*.
- 1.12 Section 13 describes the response alerting mechanisms by which incidents are escalated throughout the NHS. Mechanisms include the *NHS CB Command and Control Framework (2013)*.
- 1.13 Section 13 describes the process for recovering services following an incident.
- 1.14 Finally section 15 explains the processes by which the NHS CB will seek assurance that NHS funded organisation are compliant with the core standards for EPRR.

## **2. Purpose of this Document**

- 2.1 The purpose of the document is to provide the framework for all NHS funded organisations to meet the requirements of the [Civil Contingencies Act \(2004\)](#), the [Health and Social Care Act \(2012\)](#), the [NHS standard contracts](#) and the NHS CB EPRR [Core Standards \(2013\)](#), NHS CB [Command and Control \(2013\)](#) and NHS CB [Business Continuity Management Framework \(2013\)](#).

## **3. Who is this Document for?**

- 3.1 This NHS emergency preparedness framework contains principles for effective health emergency planning. It is strategic national guidance for all NHS funded organisations in England.
- 3.2 The principles set out in this document apply to:
- a. all NHS organisations at each level, including NHS Commissioning Board;
  - b. providers of NHS funded care;
  - c. clinical commissioning groups (CCGs);
  - d. GPs; and
  - e. other primary and community care organisations.
- 3.3 All accountable emergency officers and emergency preparedness managers must be familiar with the principles of emergency preparedness, resilience and response (EPRR) and be confident of their roles and responsibilities in planning for and responding to significant incidents and emergencies.

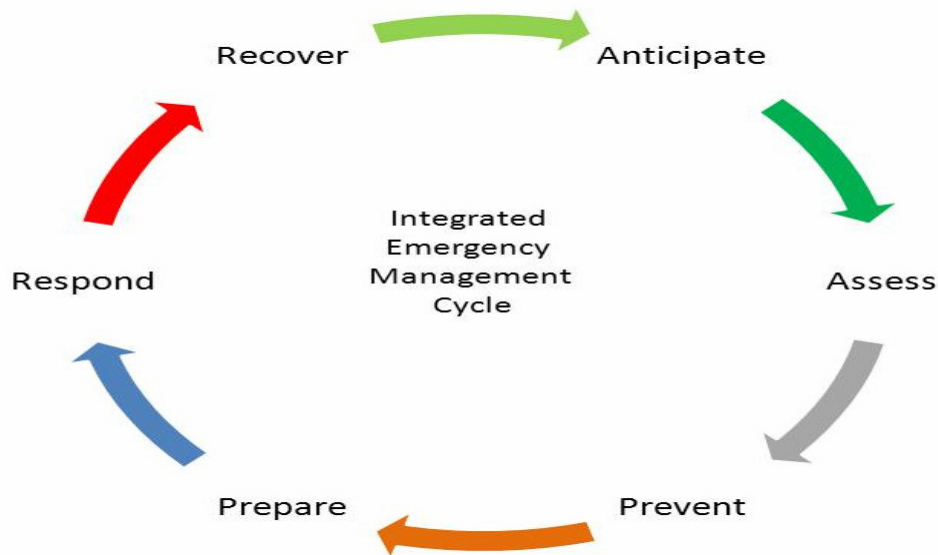


## **4. Background**

- 4.1 The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident. This work is referred to in the health service as 'emergency preparedness resilience and response' (EPRR).
- 4.2 Under the Civil Contingencies Act (2004), 'category one' responders, such as Acute Trusts and Ambulance NHS Trusts, Public Health England and the NHS Commissioning Board, must show that they are working with other responders to assess risks, develop and maintain plans, share information and co-operate on civil contingency response, and can manage incidents events while maintaining services to patients.
- 4.3 Under the Health and Social Care Act (2012), the NHS Commissioning Board must be 'properly prepared for dealing with an emergency' and must monitor and control all service providers to make sure they too are prepared.
- 4.4 NHS funded organisations must also be able to maintain continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action. This is known as business continuity management.

## 5. Introduction

- 5.1 This NHS CB emergency preparedness framework (2013) describes a set of general principles to guide all NHS organisations in developing their ability to respond to a significant incidents and emergencies and to manage recovery locally, regionally, or nationally, within the context of the requirements of the Civil Contingencies Act (2004). From 1 April 2013, this guidance supersedes both the 'The NHS Emergency Planning Guidance 2005' and the 'Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013'.
- 5.2 The document describes the principles that underpin EPRR, and sets out the roles and functions of the Secretary of State for Health, the Department of Health (DH), the NHS Commissioning Board (NHS CB), Public Health England (PHE), and Directors of Public Health (DsPH) working in local authorities. It also describes how EPRR services will be delivered at all levels, how this will align with wider multi-agency civil resilience, and the steps being taken to implement the new approach.
- 5.3 Equivalent guidance is provided by Health Departments in devolved administrations. Health emergency planning guidance for Scotland, Wales and Northern Ireland can be accessed on the respective websites for the health services in the Devolved Administrations.
- 5.4 The document builds upon the philosophies of NHS resilience, NHS organisations must use the Integrated Emergency Management (IEM) cycle to anticipate, assess, prevent, prepare, respond and recover from disruptive challenges. The IEM cycle ensures a constant review of activity and therefore robust preparedness arrangements.



- 5.5 Governance for EPRR may be best achieved through the linkage of emergency planning and business continuity to the organisation's Risk Management Committee (or equivalent).

### Applicable Information and Guidance

- 5.6 This document should be read in the context of:
- a. The [Civil Contingencies Act 2004](#)<sup>1</sup> and associated formal Cabinet Office Guidance;
  - b. The [Health and Social Care Act 2012](#)<sup>2</sup>;
  - c. the requirements for Emergency Preparedness as set out in the NHS Commissioning Board planning framework (*[Everyone Counts: Planning for Patients](#)*<sup>3</sup>);
  - d. the requirements for EPRR as set out in the applicable [NHS standard contract](#)<sup>4</sup>;
  - e. NHS Commissioning Board [EPRR documents and supporting materials](#)<sup>5</sup>, including:
    - [NHS Commissioning Board Business Continuity Management Framework \(service resilience\) \(2013\)](#);
    - [NHS Commissioning Board Command and Control Framework for the NHS during significant incidents and emergencies \(2013\)](#);
    - NHS Commissioning Board Model Incident Response Plan (national, regional and area team) (2013);
    - [NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response \(EPRR\)](#);
  - f. National Occupational Standards (NOS) for Civil Contingencies – [Skills for Justice](#)<sup>6</sup>;
  - g. [BSI PAS 2015](#) – Framework for Health Services Resilience<sup>7</sup>;
  - h. [ISO 22301](#) Societal Security - Business Continuity Management Systems – Requirements<sup>8</sup>.

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<sup>1</sup> <http://www.legislation.gov.uk/ukpga/2004/36/contents>

<sup>2</sup> <http://www.legislation.gov.uk/ukpga/2012/7/enacted>

<sup>3</sup> <http://www.commissioningboard.nhs.uk/everyonecounts/>

<sup>4</sup> <http://www.commissioningboard.nhs.uk/nhs-standard-contract/>

<sup>5</sup> [www.commissioningboard.nhs.uk/eprp/](http://www.commissioningboard.nhs.uk/eprp/)

<sup>6</sup> <http://skillsforjustice.com/NOS>

<sup>7</sup> <http://shop.bsigroup.com/en/ProductDetail/?pid=00000000030201297>

<sup>8</sup> [http://www.iso.org/iso/catalogue\\_detail?csnumber=50038](http://www.iso.org/iso/catalogue_detail?csnumber=50038)

## 6. Significant Incident and Emergency

- 6.1 This section describes the definition of significant incidents and emergencies as they may apply to NHS funded organisations and the varying scale of these incidents.
- 6.2 A significant incident or emergency can be described as any event that cannot be managed within routine service arrangements. Each require the implementation of special procedures and may involve one or more of the emergency services, the wider NHS or a local authority, a significant or emergency may include;
- a. Times of severe pressure, such as winter periods, a sustained increase in demand for services such as surge or an infectious disease outbreak that would necessitate the declaration of a significant incident however not a major incident;
  - b. Any occurrence where the NHS funded organisations are required to implement special arrangements to ensure the effectiveness of the organisations internal response. This is to ensure that incidents above routine work but not meeting the definition of a major incident are managed effectively.
  - c. An event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. The term “major incident” is commonly used to describe such emergencies. These may include multiple casualty incidents, terrorism or national emergencies such as pandemic influenza.
  - d. An emergency is sometimes referred to by organisations as a major incident. Within NHS funded organisations an emergency is defined as the above for which robust management arrangements must be in place.
- 6.3 The term significant incident or emergency is deliberately broad to ensure that potential incidents are not missed. It recognises the fundamental importance of community confidence and trust in the NHS organisational response to any incidents. NHS funded organisations must have in place Incident response plans that reflect organisational triggers for incident level escalation and de-escalation as identified in section 12.
- 6.4 In the first instance NHS organisations must consider declaring a significant incident before escalating to a major incident. A significant incident is when their own facilities and/or resources, or those of its neighbours, are overwhelmed. The specific triggers for escalation and the process for managing this must be identified in the respective incident plan which must also describe the process for escalation to a major incident.

- 6.5 A significant incident or emergency to the NHS may not be any of these for other agencies, and equally the reverse is also true. An incident may present as a variety of different scenarios, they may start as a response to a routine emergency call or 999 response situation and as this evolves it may then become a significant incident or be declared as a major incident, examples of these scenarios are:
- a. **Big Bang** – a serious transport accident, explosion, or series of smaller incidents;
  - b. **Rising Tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action;
  - c. **Cloud on the Horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action;
  - d. **Headline news** – public or media alarm about an impending situation;
  - e. **Internal incidents** – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime;
  - f. **CBRN(e)** – Deliberate (criminal intent) release of chemical, biological, radioactive, nuclear materials or explosive device;
  - g. **HAZMAT** – Incident involving Hazardous Materials; and
  - h. **Mass casualties.**

## Incident Levels

6.6 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 CB Incident levels	
<b>Alert</b>	<b>Dynamic Risk Assessment</b>	<b>Declaration of Incident level</b>	<b>1</b>	A health related incident that can be responded to and managed by local health provider organisations that requires co-ordination by the local CCG.
			<b>2</b>	A health related incident that requires the response of a number of health provider organisations across an NHSCB area team boundary and will require an NHSCB Area Team to co-ordinate the NHS local support.
			<b>3</b>	A health related incident, that requires the response of a number of health provider organisations across and NHSCB area teams across an NHS CB region and requires NHS CB Regional co-ordination to meet the demands of the incident
			<b>4</b>	A health related incident, that requires NHSCB National co-ordination to support the NHS and NHS CB response

## 7. Underpinning Requirements and Principles of EPRR

- 7.1 Under the NHS Constitution 2012, the NHS is there to help the public when they need it most; this is especially true during a significant or emergency.
- 7.2 Each NHS funded organisation must therefore ensure it has robust and well tested arrangements in place to respond and recover from these situations.
- 7.3 Extensive evidence shows that good planning and preparation for any significant incident or emergency saves lives and expedites recovery.
- 7.4 The Civil Contingencies Act 2004 (CCA) delivers a single, framework for the provision of civil protection in the UK. The principal objectives of the Act are to ensure consistency of planning across all government departments and its agencies, whilst setting clear responsibilities for frontline responders at a local level.
- 7.5 The Act divides responder organisations into two categories, depending on the extent of their involvement in civil protection work, and places a proportionate set of duties on each.

### *Category One Responders*

- 7.6 Category one responders are those organisations at the core of emergency response (e.g. emergency services, local authorities). The category includes all Acute Trusts and Ambulance NHS Trusts, Public Health England (PHE) and the NHS Commissioning Board (NHS CB).
- 7.7 Category one responders have legal responsibilities in six specific areas, which are:
- a. **co-operating with other responders;**
    - co-operate with other responder organisations to enhance co-ordination and efficiency when planning for an emergency; and
    - co-operate with other responder organisations to enhance co-ordination and efficiency when responding to and recovering from an emergency.
  - b. **risk assessment;**
    - assess the risk of emergencies occurring within their area and use this to inform contingency planning;
    - collaborate with other organisations to compile community, local or national risk registers; and
    - ensure internal corporate risk management processes to include risk to continuation of services.
  - c. **emergency planning;**
    - ensure emergency plans are in place in order to respond to emergencies linked with relevant risk registers;
    - ensure validation and exercising of emergency plans;

- ensure appropriate senior level command and decision making 24/7;
  - ensure appropriate Incident Coordination Centre (ICC) facilities to control and coordinate the response to an emergency;
  - ensure relevant response staff are trained to an appropriate level for their role in response; and
  - ensure robust communication mechanisms.
- d. **communicating with the public;**
- maintain arrangements to make available information on emergency preparedness matters to the public;
  - maintain arrangements to warn, inform and advise the public in the event of an emergency.
- e. **sharing information; and**
- share information with other local responder organisations to enhance co-ordination both ahead of and during an emergency.
- f. **business continuity.**
- To maintain plans to ensure that they can continue to deliver their functions in the event of an emergency so far as is reasonably practicable
  - Assess both internal and external risks whilst developing and reviewing Business Continuity Plans (BCPs)

7.8 Primary care, community providers, mental health and other NHS organisations (NHS Blood and Transplant, NHS Logistics and NHS Protect) are not listed in the Civil Contingencies Act 2004. However, Department of Health (DH) and NHS CB guidance expects them to plan for and respond to incidents in the same way as category one responders in a manner which is proportionate to the scale and services provided.

7.9 As part of the Cabinet Office Capabilities Programme, there are several health work streams which are led by the DH including: mass casualties; infectious diseases; and essential services (health). The DH may require NHS funded organisations to contribute to any applicable work streams led by DH or by other Government departments. Detailed information can be found on the UK Resilience and Home Office websites.

#### *Category Two Responders*

- a. category two responders, such as Clinical Commissioning Groups (CCGs) and NHS Property Services, are seen as '*co-operating bodies*'. They are less likely to be involved in the heart of the planning, but they will be heavily involved in incidents that affect their sector through co-operation in response and the sharing of information;
- b. although category two responders have a lesser set of duties, it is vital that they share relevant information with other responders (both category one and two) if EPRR arrangements are to succeed;



- 7.10 Category one and two responders come together to form local resilience forums (LRF) based on police areas. These forums help to co-ordinate activities and facilitate co-operation between local responders. For the NHS, the strategic forum for joint planning for health emergencies is via the Local Health Resilience Partnerships (LHRPs) that will support the health sector's contribution to multi-agency planning through Local Resilience Fora (LRFs) – see page 44.
- 7.11 Further information can be found at:  
<http://www.cabinetoffice.gov.uk/content/civil-contingencies-act>

### **Requirements applicable within the Health and Social Care Act (2012)**

- 7.12 The Health and Social Care (2012) Act embeds the requirement of NHS services to respond effectively to incidents and emergencies.
- 7.13 The key elements are:
- a. The NHS Commissioning Board and each Clinical Commissioning Group must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency.
  - b. The NHS Commissioning Board must take steps as it considers appropriate for securing that each relevant service provider is properly prepared for dealing with a relevant emergency.
  - c. The NHS Commissioning Board must take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by the clinical commissioning groups and relevant service providers for which it is a relevant emergency

## 8. The NHS Service-wide Objective

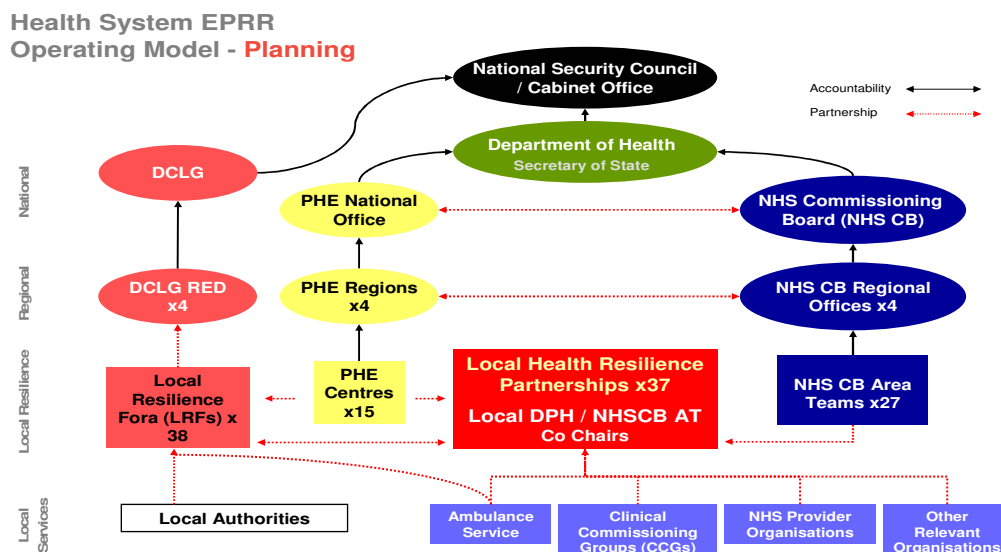
- 8.1 The NHS service-wide objective for emergency preparedness, resilience and response is:

*To ensure that the NHS is capable of responding to significant incidents or emergencies of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.*

### Principles

- 8.2 The underpinning principles for NHS emergency preparedness, resilience and response are:
- the management of an incident should be at the level closest to the people affected by the incident as is practical.
  - speed and flexibility at local operational level, delivered by acute health care providers, ambulance services, primary care providers, Public Health England (PHE), NHS Blood and Transplant (NHS BT), NHS Direct (NHS D)/ 111 services, NHS Professionals, independent and third sector healthcare and staffing providers;
  - active mutual aid across organisational boundaries, across national boundaries within the UK and across international boundaries where appropriate; and
  - a strong central capacity in the NHS Commissioning Board (NHS CB) (at area team, regional and national levels) to oversee the health service working with the Department of Health (DH).

The diagram below shows the NHS CB Emergency preparedness, resilience and response (EPRR) planning structure and its interaction with key partner organisations.



- 8.3 It is the nature of significant incidents and emergencies that they are unpredictable and each will present a unique set of challenges. The task is not to anticipate them in detail. It is to have a set of expertise available and to have developed a set of core processes to handle the uncertainty and unpredictability of whatever happens.
- 8.4 The underpinning principles apply to all NHS funded organisations including commissioners and providers of NHS funded care.

### **NHS Standard Contracts and NHS CB Emergency Preparedness Framework**

- 8.5 The minimum core standards, which NHS funded organisations must meet, are set out in the NHS CB Core Standards for EPRR. These standards are in accordance with the Civil Contingencies Act 2004 (CCA), the Health and Social Care Act 2012, the NHS Commissioning Board planning framework (*'Everyone Counts: Planning for Patients'*) and the NHS standard contract.
- 8.6 The term NHS funded organisations reflects the commissioning arrangements in which, in addition to traditional NHS commissioning and provider organisations, non-NHS commissioners and providers from the independent or third sectors may be responsible for health service provision to significant parts of the population. Therefore all NHS work undertaken by independent and third sector providers must be compliant with the requirements of the NHS CB Core Standards for EPRR (2013).
- 8.7 The following lists provide a summary of the requirements which are set out in detail in the [NHS CB Core Standards for EPRR](#) (2013).

#### *General*

- 8.8 NHS funded organisations must:
- a. nominate an accountable emergency officer who will be responsible for EPRR (see section 0);
  - b. contribute to area planning for EPRR through local health resilience partnerships (LHRPs) and other relevant groups; and
  - c. contribute to an annual NHS CB report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.

## *Incident Response Plans*

### 8.9 NHS funded organisations must:

- a. have suitable, up to date incident response plans which set out how they plan for, respond to and recover from emergency, significant incidents or major incident. Incident response plans must:
  - have appropriate governance arrangements;
  - set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols;
  - set out how surges in demand will be managed;
  - link plans to local, regional and national risk registers;
  - link the incident response plan to threat-specific incidents (for example: CBRNE, mass casualty incidents, pandemic flu, patients with burns requiring critical care, and severe weather);
  - be consistent, interchangeable able to work across organisational boundaries of NHS organisations, e.g. *National Ambulance Service Guidance for Preparing an Emergency plan (2013)*; and
  - have arrangements reviewed and updated on an annual basis.
- b. test these plans through:
  - one communications exercise every six months;
  - one desktop exercise every year; and
  - one major live or simulated exercise every three years;
- c. develop an Exercise Lessons Programme that will capture what lessons have been identified through the testing and exercising, (did it work, what needs doing);
- d. share lessons identified and learnt with the wider NHS;
- e. have suitably trained, competent staff and the right facilities (incident coordination centres) available round the clock to effectively manage a significant incident or major incident; and
- f. share their resources as required to respond to a significant incident or emergency.
- g. Ambulance Service Trust whose boundaries are coterminous with a number of LRF/LHRP must work in concert with these organisations to ensure appropriate resourcing in planning, testing and exercising incident response plans.

### *Business Continuity (Service Resilience Planning)*

- 8.10 NHS funded organisations must have suitable, up to date business continuity plans which set out how they will:
- a. maintain continuity of key services when faced with disruption from either an identified local risk or via an internal incident (recognising the interdependencies of the organisations critical activities and that plans are aligned with all internal and external stakeholders); and
  - b. resume services which have been disrupted by, for example, severe weather, IT failure, an infectious disease, a fuel shortage or industrial action.
- 8.11 This planning should align with [ISO 22301](#) and [PAS 2015](#) and be in accordance with the NHS Commissioning Board Business Continuity Management Framework (service resilience) (2013). Some elements of ISO 22301 must be done in partnership with other health organisations and planning needs to recognise the patient care pathway and the patient's needs throughout each stage, testing and exercising these arrangements must follow the principles described in section 10.12.
- 8.12 These business continuity management plans will:
- a. include governance and management arrangements linked to relevant risks and align with British standards;
  - b. take into account the organisation's prioritised activities, the analysis of the effects of disruption and the actual risks of disruption;
  - c. identify the activation procedures and escalation processes;
  - d. identify the individual recovery steps to ensure the service can continue to operate;
  - e. specify how they will be used, maintained and reviewed; and
  - f. specify how they will be communicated to and accessed by staff.

### **Co-operation (between local responders – including mutual aid)**

- 8.13 Under the Civil Contingencies Act, co-operation between local responder bodies is a legal duty.
- 8.14 The Department for Communities and Local Government (DCLG), Resilience and Emergencies Division (DCLG RED) is responsible for providing the Government liaison function on resilience issues at and below the national level, liaising with and between both Local Resilience Forums and Lead Government Departments. DCLG may establish an Operations Centre to co-ordinate communications during and after a civil emergency and may feed directly into CCS if requested. RED provides a two way conduit between

LRFs and Central Government. RED can be alerted to civil emergencies via their Duty Officers and the RED Control e-mail. The Division acts as a single team with Resilience Advisors based in London, Leeds, Birmingham and Bristol providing a Government first point of contact for all LRFs in England.

- 8.15 At the local level, it is important that planning for significant incidents and emergencies is co-ordinated within individual NHS organisations, between NHS funded organisations and at a multi-agency level with emergency services, local authorities, voluntary agencies, the independent health and social care sector and other partner organisations. The NHS CB area team, either individually or working in groups, will undertake the co-ordination role for the NHS in local communities. This role of cooperation for EPRR is a statutory responsibility of all current healthcare organisations that are covered by the CCA 2004 and this framework.
- 8.16 The principal mechanism for multi-agency co-operation at a local level is the LRF. This is based on police force areas. The recommended health sector membership of LRFs is Ambulance Trusts, Public Health England and a director of the NHS commissioning board area team.
- 8.17 From 1 April 2013, the NHS CB is responsible for establishing and maintaining appropriate co-ordination toolkit/framework to enable NHS organisations to plan and cooperate appropriately and to performance-manage those organisations for this aspect of their responsibilities. The LHRPs are a key component of this process.
- 8.18 Training, exercising and testing of significant incident and emergency plans within individual NHS organisations, between NHS funded organisations and with multi-agency partners is an important part of emergency preparedness and must follow the process outlined in this framework.

#### *Mutual Aid*

- 8.19 Successful response to emergencies in the UK has demonstrated that joint working can resolve very difficult problems that fall across organisational boundaries. Large scale events have shown that single organisations, acting alone, cannot resolve the myriad of problems caused by what might, at first sight, appear to be relatively simple emergencies caused by a single source;
- a. mutual aid can be defined as an arrangement between Category one and two responders and other organisations not covered by the CCA, within the same sector or across sectors and across boundaries, to provide assistance with additional resource during an emergency that may overwhelm the resources of a single organisation; and
  - b. within the health sector mutual aid arrangements exist between organisations and must be regularly updated to ensure they are in line with current service provision.

### *Networks (Critical Care, Trauma, Burns, 111, NHS BT)*

- 8.20 Clinical networks exist in many specialist areas of care and ensure that patients can access the optimum care for their condition. These networks usually have one or two designated specialist centres reinforced by a network of supporting centres. This arrangement effectively ensures mutual aid within the network and most networks also link more widely to neighbouring networks to enable mutual aid when needed.

### **Information Sharing**

- 8.21 Under the CCA, local responders have a duty to share information with other categorised responder organisations and this is seen as a crucial element of civil protection work, underpinning all forms of co-operation.
- 8.22 NHS Incident Response Plans (IRPs) must be available in the public domain. However, it is not always possible to share sensitive or confidential information with partner agencies and/or the public.
- 8.23 NHS funded organisations should consider formally the information that will be required to plan for a significant or major incident. They should determine what information can be made available in the context of the CCA and the [Freedom of Information Act 2000](#), while maintaining the confidentiality of, for example, staff telephone contact numbers.
- 8.24 Information sharing should continue along informal routes, with formal information requesting mechanisms only used as a fallback and in line with agreed plans.
- 8.25 The role of Caldecott Guardians in supporting the discharge of responsibilities in relation to disclosure of information should be taken into account.

### **Legal Framework, Public Enquiries, Coroners Inquests and Civil Action**

- 8.26 The day to day management of people and patients the NHS is subject to legal frameworks, duty of care and moral obligation. This does not change when responding to an emergency, significant incident, major incident or events that generate high profile media attention however public and legal scrutiny can become greater.
- 8.27 Following a significant incident or emergency or event that has generated high profile media attention a number of legal investigations and challenge can and will be made. These may include Coroners Inquests, Public Enquiries, Criminal Investigations and Civil Action.

- 8.28 These processes can occur many years after the incident, e.g. the Public Enquiry into the Marchioness river boat disaster in 1989 was held 11 years after the event and Hillsborough also of 1989 a further public enquiry and independent review held in 2012 held 23years after the event and identifying a number of changes to how large scale sporting events should be managed.
- 8.29 When planning for and responding to a significant incident or emergency or an event that has generated high media attention it is essential that any decisions made and actions taken are recorded and stored in a way that can be retrieved at a later date to provide evidence. It may be necessary to provide all relevant documentation immediately afterwards therefore robust and auditable systems for documentation and decision making must be maintained.



## 9. Roles and Responsibilities

- 9.1 This section replaces the '[Summary of the principal roles of health sector organisations' \(from 2013\)](#) and outlines the EPRR roles and responsibilities of:
- a. The Department of Health (DH)
  - b. the NHS Commissioning Board (NHS CB);
  - c. Directors of Public Health in local authorities;
  - d. Public Health England (PHE);
  - e. NHS funded organisations;
  - f. Clinical Commissioning Groups (CCGs);
  - g. Commissioning Support Unit (CSU);
  - h. Operational Delivery Network (ODN); and
  - i. the role of Accountable Emergency Officers.

### Department of Health

- 9.2 The EPRR role of the DH is to:
- a. identify EPRR policy requirements for the health sector and communicate these, as appropriate, to the NHS CB, PHE and other health sector Arm's Length Bodies;
  - b. provide assurance to Ministers, Cabinet Office and other Government Departments of the health system preparedness for and contribution to the UK Government's response to domestic and international emergencies, in line with the National Risk Assessment (NRA);
  - c. as the lead Government Department, ensure that plans are in place for identified risks to health in the National Risk Register (NRR) and associated planning assumptions, taking advice from PHE;
  - d. ensure the coordination of the whole system response to high-end risks impacting on public health, the NHS and the wider health care system;
  - e. support the UK central Government response to emergencies including Ministerial support and briefing informed by data and reports provided by the NHS CB and PHE;
  - f. take other action as required on behalf of the Secretary of State for Health to ensure a national emergency is appropriately managed; and

- g. work internationally and with devolved administrations for planning and responding to relevant emergencies.

### **NHS Commissioning Board**

- 9.3 The EPRR deliverables of the NHS CB are described in the NHS core standards for EPRR and are summarised in section 6 of this document. The EPRR role and responsibilities of NHS CB are:
- a. to set a risk-based EPRR implementation strategy for the NHS;
  - b. at all levels ensure there is a comprehensive NHS EPRR system and assure itself that the system is fit for purpose;
  - c. at all levels lead the mobilisation of the NHS in the event of an emergency or incident;
  - d. at all levels work together with PHE and where appropriate to develop joint response plans; and
  - e. at all levels undertake its responsibilities as a Category one responder under the Civil Contingencies Act 2004 (CCA).

#### *NHS CB – National*

- 9.4 In terms of EPRR, the NHS CB at national level will:
- a. support the Regional Directors and the Chief Operating Officer to implement the new EPRR model;
  - b. participate in national multi agency planning processes including risk assessment, exercising and assurance;
  - c. provide leadership and coordination to the NHS and national information on behalf of the NHS during periods of national emergencies;
  - d. support the response to incidents that affect two or more NHS regions;
  - e. act as the national link on EPRR matters between the NHS CB, the DH and PHE;
  - f. provide assurance to DH of the ability of the NHS to respond to emergencies including assurance of capacity and capability to meet NRA requirements as they affect the health service;
  - g. provide support to DH in their role to the UK central Government response to emergencies; and
  - h. action and requests from NHS organisations for military assistance through DH if requested by the regional team.

### *NHS CB – Regions*

- 9.5 In terms of EPRR, the NHS CB at regional level will be:
- a. accountable for the establishment of local health resilience partnerships (LHRPs) across the region, coordinating with Public Health England and local government;
  - b. responsible for ensuring each LHRP / local resilience forums (LRF) has a designated lead NHS CB area team;
  - c. providing strategic EPRR advice and support to NHS CB area teams;
  - d. ensuring integration of NHS CB area team and LHRP emergency plans to deliver a unified NHS response across more than one LHRP, including ensuring the provision of surge capacity; and
  - e. maintaining capacity and capability to coordinate the regional NHS response to an emergency 24/7.

### *NHS CB – Area Teams*

- 9.6 In terms of EPRR, the NHS CB area teams will be:
- a. responsible for ensuring the local roll-out of LHRPs, coordinating with PHE and local government partners;
  - b. ensuring the NHS has integrated plans for significant incidents and emergencies in place across the local area and within health economies;
  - c. where appropriate, developing joint emergency plans with PHE and local authorities, through the LHRP;
  - d. seeking assurance, through the LHRP, that there are appropriate information governance agreements in place to enable the sharing of individual identifiable information in a timely manner in response to an emerging or ongoing event within the relevant legislative / regulatory frameworks;
  - e. seeking local health economies assurance of the ability for NHS funded organisations to respond to, and be resilient against, emergencies that cause increase demand or disruption to patient services;
  - f. discharging the local NHS CB EPRR functions and duties;
  - g. providing the NHS co-chair of the LHRP who will also represent the NHS on the LRF;

- h. providing the capability to lead the NHS response to an emergency at a local level;
- i. providing a 24/7 on-call roster for NHS emergency response in the local area, comprising staff with the appropriate competences and authority to coordinate the health sector response to an emergency; and
- j. determining, the impact on NHS resources and with advice from the Director of Public Health (DPH), at what point the lead role in response to a public health incident or emergency will transfer, if required, to the NHS.

## Local Authorities

9.7 The health EPRR role of the Local Authorities (LA), via their DPH is to:

- a. provide leadership for the public health system within their local authority area;
- b. take steps to ensure that plans are in place to protect the health of their populations and escalate any concerns or issues to the relevant organisation or to the LHRP as appropriate;
- c. identify and agree a lead DPH within an LRF area to co-chair the LHRP and to co-ordinate LA public health input to preparedness and planning for emergencies at the LRF level by;
  - co-ordinating issues from fellow DPH in LAs within the LHRP area;
  - collaborating with DPH colleagues to ensure the lead DPH is fully appraised of issues affecting all LAs to inform the work of the LHRP;
  - communicating with colleague DPH and PHE local centre director to ensure a coherent public health approach within the LHRP;
- d. provide initial leadership with PHE for the response to public health incidents and emergencies within their local authority area. The DPH will maintain oversight of population health and ensure effective communication with local communities. PHE will deliver and manage the specialist health protection services; and
- e. fulfil the responsibilities of a Category 1 responder under the CCA.

## Public Health England (PHE)

9.8 The EPRR role of the PHE is to:

- a. set a risk-based national EPRR implementation strategy for PHE;
- b. ensure there is a comprehensive EPRR system that operates for public health at all levels and assure itself that the system is fit for purpose;
- c. be responsible for leading the mobilisation of PHE in the event of an emergency or incident;
- d. work together with the NHS at all levels and where appropriate develop joint response plans;
- e. deliver public health services including, but not limited to, surveillance, intelligence gathering, risk assessment, scientific and technical advice, and microbiology services to emergency responders, Government and the public during emergencies, at all levels;
- f. participate in and provide specialist expert public health input to national, sub-national and LHRP planning for emergencies; and
- g. undertake, at all levels, its responsibilities on behalf of Secretary of State for Health as a Category one responder under the CCA (2004).

### *PHE – Nationally*

9.9 The EPRR role of PHE Nationally is to:

- a. provide support to DH to fulfil its role in the UK central Government's National Risk Assessment (NRA) process;
- b. ensure the delivery of the PHE elements of the national EPRR strategy across England;
- c. support the Regional Directors to implement the new EPRR model;
- d. participate in national multi-agency planning processes including risk assessment, exercising and assurance;
- e. provide leadership and coordination of PHE and national information on behalf of the PHE during periods of national emergencies;
- f. support the response to incidents that affect two or more PHE regions;
- g. act as the national link on EPRR matters between PHE, DH and NHS CB; and
- h. provide assurance to DH of the ability of PHE to respond to emergencies.

### *PHE – Regional Offices*

- 9.10 The EPRR role of PHE regional offices is to:
- a. ensure the delivery of the national EPRR strategy across their region;
  - b. support the NHS CB with the establishment of LHRPs across the region, coordinating with local government;
  - c. provide strategic EPRR advice and support to PHE Centres;
  - d. ensure integration of PHE emergency plans to deliver a unified public health response across more than one LHRP, including ensuring the provision of surge capacity; and
  - e. maintain PHE's capacity and capability to coordinate regional public health responses to emergencies 24/7.

### *PHE Centres*

- 9.11 The EPRR role of the PHE centres is to:
- a. support the NHS CB with local roll-out of LHRPs, coordinating with local government partners;
  - b. ensure that PHE has plans for emergencies in place across the local area;
  - c. where appropriate, develop joint emergency plans with the NHS and local authorities, through the LHRP;
  - d. provide assurance of the ability of PHE to respond in emergencies;
  - e. discharge the local PHE EPRR functions and duties;
  - f. provide a representative to the LHRP who will also represent the PHE on the LRF;
  - g. have the capability to lead the PHE response to an emergency at a local level; and
  - h. ensure a 24/7 on-call roster for emergency response in the local area, comprising staff with the appropriate competencies and authority to coordinate the health protection response to an emergency, establish a STAC when requested to do so.

## NHS Funded Providers

9.12 The EPRR role of NHS Funded providers is described in the NHS core standards for EPRR and as summarised in section 8.

## Clinical Commissioning Groups (CCGs)

9.13 In summary, the EPRR role of CCGs is to:

- a. ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements;
- b. support NHS CB in discharging its EPRR functions and duties locally;
- c. provide a route of escalation for the LHRP should a provider fail to maintain necessary EPRR capacity and capability;
- d. fulfil the responsibilities as a Category two responder under the CCA including maintaining business continuity plans for their own organisation;
- e. be represented on the LHRP (either on their own behalf or through representation by a 'lead' CCG); and
- f. seek assurance provider organisations are delivering their contractual obligation.

### *Planning and Prevention*

- g. co-operate and share relevant information with category one responders but they will be engaged in (LHRP) discussions where they will add value. They must maintain robust business continuity plans for their own organisations.
- h. corporately, CCGs will support the NHS CB in discharging its EPRR functions and duties locally, ensuring representation on the LHRP and engaging in health economy planning groups.
- i. include relevant EPRR elements (including business continuity planning) in contracts with provider organisations in order to:
  - ensure that resilience is “commissioned-in” as part of standard provider contracts and to reflect local risks identified through wider, multi-agency planning;
  - reflect the need for providers to respond to routine operational pressures, e.g. winter, failure of providers to continue to deliver high quality patient care, provider trust internal major incidents;;

- enable NHS-funded providers to participate fully in EPRR exercise and testing programmes as part of NHS CB EPRR assurance processes.
- j. maintain performance levels, CCGs need to provide their commissioned providers with a route of escalation on a 24/7 basis. Conversely, the NHS CB will need a conduit in which to mobilise relevant support provider arrangements during significant and widespread incidents (see Response below).
  - k. develop, test and update their own business continuity plans to ensure they are able to maintain business resilience during any disruptive event or incident.

### *Escalation*

- l. ensure robust escalation procedures are in place such that if an NHS funded provider has a problem (rather than an immediate emergency or significant incident), the locally-agreed route for escalation (whether out of hours or during normal business hours) is available via the CCGs. This will require CCGs to establish their own 24/7 on-call arrangements, this may include working in collaboration with other local CCGs to provide cost effective robust arrangements.

### *Response*

- m. as Category two Responders under the CCA, CCGs must respond to reasonable requests to assist and co-operate.
- n. support the NHS CB Area Team should any emergency require wider NHS resources to be mobilised. CCGs must have a mechanism in place to support NHS Area Teams to effectively mobilise and co-ordinate all applicable providers that support primary care services should the need arise
- o. maintain service delivery across their local health economy to prevent business as usual pressures and minor incidents within individual providers from becoming significant or major incidents. This could include the management of commissioned providers to effectively coordinate increases in activity across their health economy which may include support with surge in emergency pressures. CCGs need a process that enables them to escalate incidents to the NHS CB area team as applicable.
- p. some, but not all, CCGs may become more involved in the provision of emergency response, for example:
  - where there are specific risks identified in local risk registers, such as hazardous materials nuclear, chemical or biological; and



- where there is a significant issue of geographic remoteness or complexity, which may compromise a NHS CB area team to act alone as a Category one responder. In such circumstances, the area team may request support from CCG members to become part of the initial health response. This will be through agreement between the area team and the relevant CCG staff who will act on behalf of the NHS CB locally during the initial stages of an incident. Under any such agreement, the NHS CB is still responsible for ensuring an effective response is delivered and retains command and control.

### **Commissioning Support Unit (CSU)**

- 9.14 The role of the Commissioning Support Unit (CSU) will provide efficient, locally-sensitive and customer-focused commissioning support services allowing CCGs to maximise their investment in frontline healthcare services for communities and improving the delivery of health outcomes for patients. For some support activities, CCGs may choose to appoint their own internal staff while for others they will have a choice of using the new NHS CSUs or other sources of commissioning support.
- 9.15 As part of transitioning to the new Health and Social Care system, CCGs are likely to need support in carrying out:
- a. transformational commissioning functions, such as service redesign;
  - b. transactional commissioning functions, such as market management, healthcare procurement, contract negotiation and monitoring, information analysis and risk stratification.

### **Operational Delivery Network (ODN)**

- 9.16 The role of the Operational Delivery Network (ODN) will complement the newly created Strategic Clinical Networks and will ensure the delivery of safe and effective services across the patient pathway and help secure the best health outcomes for patients. ODNs will cover areas such as neonatal intensive care, adult critical care, burns and trauma and are focussed on coordinating patient pathways between providers over a wide area to ensure access to specialist support and expertise.
- 9.17 ODNs will be established across England and work with other organisations in the new healthcare system including Clinical Senates, academic health science networks and local professional networks. The clinical network should be included in the planning for and in responding to incidents or outbreaks in order to:
- a. Identify baseline capability; maximise treatment options that could be made available;

- b. identify early on and plan for escalation opportunities and any associated risks using detailed local knowledge;
- c. support mutual aid (equipment, consumables, clinical advice) between clinical services within or across or between networks and across network geographical boundaries;
- d. support identification of minimal data requirements to help manage the incident/outbreak effectively with minimal burden on the clinical staff reporting; and
- e. support communication on the incident and response with clinical staff.

Clinical networks can also help share rapid learning from incidents/outbreaks to support planning and business continuity in the future and elsewhere.

### **Accountable Emergency Officers**

9.18 This section defines the role of 'Accountable Emergency Officers' for Emergency Preparedness, Resilience and Response (EPRR).

- a. the Health and Social Care Act 2012 places upon NHS-funded organisations the duty to have an accountable emergency officer with regard to EPRR. Chief executives/accountable officers of organisations commissioning or providing care on behalf of the NHS will designate the responsibility for EPRR as a core part of the organisations governance and its operational delivery programmes. Chief executives/accountable officers will be able to delegate this responsibility to a named director e.g. in the case of the NHS CB to Regional and Area Directors who will become the responsibility officers for their geographical area.
- b. chief executives/accountable officers of organisations commissioning or providing care on behalf of the NHS will be aware of factors within organisations which will negatively impact on public protection within their health community as a result of a significant incident or emergency.
- c. chief executives/accountable officers of organisations commissioning or providing care on behalf of the NHS will be aware of their legal duties to ensure preparedness to respond to a significant incident or emergency within their health community to maintain the public's protection and maximise NHS response.
- d. chief executives/accountable officers of organisations commissioning, or providing care, on behalf of the NHS are responsible for the identification of an accountable emergency officer who is the board-level director responsible for EPRR and who will have executive authority and responsibility for ensuring the organisation complies with legal and policy requirements. They should be a highly visible, senior and authoritative individual who provides assurance to the board that strategies, systems, training, policies and procedures are in place to

ensure an appropriate response from the Trust in the event of a major incident or civil contingency event.

- e. the accountable emergency officer (director of EPRR) shall be supported where appropriate by a non-executive director, or appropriate other board member, to endorse assurance to the board that the organisation is meeting its obligations with respect to EPRR and relevant statutory obligations under the CCA. This will include assurance that the organisation has allocated appropriate resources to meet these requirements, which may include the support of trained and competent emergency planning officers and business continuity managers as appropriate.
- f. specifically, the accountable emergency officer (director of EPRR) will be responsible for:
  - ensuring that the organisation is compliant with the EPRR requirements as set out in the CCA, the Health and Social Care Act (2012), the NHS planning framework and the NHS standard contract as applicable;
  - ensuring that the organisation is properly prepared and resourced for dealing with a significant incident or emergency;
  - ensuring their organisation, and any providers they commission, have robust business continuity planning arrangements in place which are aligned to the Framework for Health Services Resilience (PAS 2015) and ISO 22301;
  - ensuring the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and parties in the local community(ies) served;
  - ensuring that the organisation complies with any requirements of the NHS Commissioning Board, or agents thereof, in respect of the monitoring of compliance;
  - providing the NHS CB, or agents thereof, with such information as it may require for the purpose of discharging its functions; and
  - ensuring that the organisation is appropriately represented at, and effectively contributes to, any governance meetings, sub-groups or working groups of the LHRP or LRF.

## **The Voluntary Aid Societies (VAS)**

- 9.19 The responsibilities given by the Civil Contingencies Act 2004 (CCA) on Category one and Category two responders to co-operate with partners emphasises the need to maximise the benefits that Voluntary Aid Societies (VAS) can bring and their potential to contribute towards the successful outcome of an incident. They can have a role in responding to an event to help alleviate pressure on the statutory bodies by providing humanitarian services. They also have a role to play in responding to emergencies; that is, during the consolidation and recovery phases when emergency services personnel and personnel from other responding NHS organisations may be fully deployed elsewhere.
- 9.20 Many NHS ambulance services have worked with VAS to develop a set of competencies and knowledge which define the capabilities of VAS personnel, and have used these as the basis for developing formal Memoranda of Understanding (MOU) to ensure that, in the event that requires their assistance, that there are common, understood standards for operating, responding to, and supporting professional input.

## **Department for Communities and Local Government (DCLG)**

- 9.21 In the event of an incident or emergency, DCLG will immediately take steps to ensure that they can provide support to the local emergency response via their resilience and Emergencies Division (RED), where necessary and as appropriate. This could involve any, or all, of the actions below, depending upon the nature of the incident:
- a. establishing whether Strategic Co-ordinating Groups (SCG) have been set up, or are on standby, then maintaining immediate lines of communication with them, including identifying whether there are likely to be issues arising or capability gaps emerging which may require Central Government support or input;
  - b. deploying a Government Liaison Officer (GLO) once an SCG has been established, unless alternative arrangements have been agreed. In some cases, such as a terrorist or nuclear emergency, the Lead Department may deploy the GLO and DCLG will support this through deploying a Consequence Management Liaison Officer as part of a multidisciplinary Government Liaison Team.
  - c. ensuring a Strategic Local Recognised Information Picture (or other incident specific, nationally agreed, reporting template) is developed and maintained for each SCG; it is established in order to support local response efforts and to contribute to the national appreciation of the situation;

- d. where appropriate, developing and maintaining a multi-SCG Strategic Recognised Information Picture (or other incident specific, nationally agreed, reporting template) where an incident affects a number of LRF / SCG areas, or has the potential to do so, to add value to the local and/or national response;
- e. establishing and maintaining immediate lines of communication with the Lead Government Department and the Cabinet Office. As part of this process, agreeing the level and frequency of on-going reporting requirements including providing the local or multi-SCG Strategic Recognised Information Picture (to be agreed on a case by case basis with the Lead Government Department and the Cabinet Office in situations where COBR is activated) to feed into the national picture co-ordinated by COBR or the Lead Government Department as appropriate;
- f. activating an Operations Centre(s) (OpC), if required, in order to provide a focal point for the collection and collation of information on the situation, a point of contact for local responders, and to engage as necessary other bodies to provide the local or multi-SCG picture to local responders and Government as necessary;
- g. working with partners to identify priorities and providing advice to COBR and Lead Government Departments to support national discussions on the deployment of scarce resources across the affected area;
- h. facilitating mutual aid arrangements between LRFs;
- i. assisting local responders deliver a co-ordinated and coherent public message through sharing Government's lines to take;
- j. be ready on request to provide information to local MPs in affected constituencies;
- k. whilst the SCG is still standing, provide incident situation reports and advice to brief the Lead Government Department organising Ministerial or VIP visits in consultation with local partners;
- l. enabling the transition from response to recovery by ensuring an effective handover from DCLG RED GLOs to Lead Government Department officials taking up responsibility for supporting local responders and any Recovery Co-ordinating Group(s); and
- m. using the DCLG RED as the main point of contact reduces the risk of duplicated requests from different Central Government departments, thereby minimising the burden on local responders. Where required by the scale or duration of the emergency, the DCLG RED will draw on staff and expertise from across DCLG and other Government departments.

## Multi-SCG Response Co-ordinating Groups (ResCG)

- 9.22 Whilst most emergencies are dealt with by local responders at a local level through Strategic Co-ordinating Groups, a multi-SCG Response Co-ordinating Group (ResCG) may be convened where the local response has been or may be overwhelmed and wider support is required, or where an emergency affects a number of neighbouring Strategic Co-ordinating Groups and would benefit from co-ordination (e.g. to obtain a consistent, structured approach) or enhanced support. [In situations where there are a number of concurrent incidents on-going across England, COBR will be used to draw together the national picture].
- 9.23 In such circumstances, DCLG may, on its own initiative or at the request of local responders or the Lead Government Department in consultation with the Cabinet Office, convene a ResCG in order to bring together appropriate representatives from local responders or SCG, if established. Where relevant, the membership may be augmented, including by representatives from Central Government departments and agencies with a regional presence (such as the Ministry of Defence and the Maritime and Coastguard Agency) and other agencies such as voluntary organisations, utilities and transport operators.
- 9.24 The precise role of the ResCG may vary depending on the nature of the emergency. However, the role is likely to cover:
- a. developing a shared understanding of the evolving situation, including horizon scanning to provide early warning of emerging significant challenges;
  - b. assessing the emergency's actual and/or potential impact;
  - c. reviewing the steps being taken to manage the situation, and any assistance that may be needed/offered, including through facilitating mutual aid arrangements between SCG responders if required;
  - d. ensuring an effective flow of communication between and across local and national levels, including reports to the national level on the response effort, to ensure that the national input is co-ordinated with the local effort;
  - e. co-ordinating a coherent and consistent public message; and
  - f. identifying any issues which cannot be resolved at local level and need to be escalated to the national level, including advising on priorities and guiding the deployment of scarce resources across the area: and
  - g. recovery and the return to business as usual.

- 9.25 Such gatherings are most likely via a tele/videoconference, though there may be occasions when a face to face meeting is more appropriate. The ResCG would normally be chaired by DCLG unless otherwise agreed. DCLG staff would normally take the lead in confirming the form the meeting will take and attendance. They would also:
- a. draw up the agenda;
  - b. circulate papers and other relevant information to committee members as necessary;
  - c. provide the formal record of discussions and decisions; and
  - d. explain the exact organisational and logistical arrangements for the ResCG that will depend on the scale and nature of the incident.
- 9.26 ResCGs will observe the principle of subsidiary – in which it is recognised that decisions should be taken at the lowest appropriate level. The ResCG will not interfere in local command and control arrangements but will provide a mechanism for ensuring that local responders can be as fully informed as possible in the decisions they have to take. Where arrangements already exist for the co-ordination of mutual aid (e.g. the Police National Information Co-ordination Centre (PNICC) is the mechanism for police resources), the ResCG will complement such arrangements and add value by taking a multi-agency overview.

## **10. Risk Management**

- 10.1 Risk management is seen in the Civil Contingencies Act 2004 (CCA) as the first step in the emergency planning and business continuity processes. It ensures that local responders make plans that are sound and proportionate to risks.
- 10.2 Within each Local Resilience Forum (LRF), NHS funded organisations have responsibility in the context of multi-agency planning to contribute to the Community Risk Register. NHS funded organisations will therefore need to undertake risk assessment exercises appropriate to their facilities and services.
- 10.3 Risk assessment undertaken at a regional and national level, should be informed by local risk assessments.
- 10.4 An agreed methodology for risk assessment is available on the Cabinet Office website.

### **Incident Response Plans**

- 10.5 Incident response plans should contain a framework for response. There should be enough background information so that the responders have sufficient science to make informed decisions. They should include a command and control framework to manage the response, and a sufficient amount of operational procedures that the responders can choose which to use depending on the incident and the issues it presents.
- 10.6 Ambulance services should refer to the 'National Ambulance Service Guidance for Preparing an Emergency Plan (2013)' published by the National Ambulance Resilience Unit (NARU).
- 10.7 The minimum standards, which NHS funded organisations and providers of NHS funded care must meet, are set out in the 'NHS Commissioning Board Core Standards for EPRR'. These standards are in accordance with the Civil Contingencies Act (2004) (CCA), the Health and Social Care Act (2012), the NHS Commissioning Board (NHS CB) Planning Framework ('Everyone Counts: Planning for Patients') and the NHS standard contract.

### **Training**

- 10.8 Training staff to respond to significant incidents and emergencies is of fundamental importance. NHS organisations are familiar to responding to routine, everyday challenges by following usual business practices; yet very few respond to significant incident or emergencies on a frequent basis. If staff are to respond to an emergency in a safe and effective manner they require the tools and skills to do so in line with the role to which they are assigned to.



- 10.9 Core standards for NHS incident training are contained within the Skills for Justice National Occupational Standards (NOS) framework. [Model competencies](#) for NHS incident commanders had been published and should be referred to when selecting members of the rotas and to identify their training needs.
- 10.10 Training needs to be on-going, to ensure skills are maintained. Not only do staff change jobs and organisations, but if the skills are not used on a regular basis then they are soon forgotten. Therefore an accurate data base must be kept and a cycle of regular updates must form part any training strategy.

## Exercising

- 10.11 Plans developed to allow organisations to respond efficiently and effectively, must be tested regularly using a table top and live exercises, or through any other recognised and agreed process. Roles within the plan (not individuals) are exercised to ensure any specific role is fit for purpose and encapsulates all necessary functions and actions to be carried out during an incident. The outcome of testing and exercising must identify and log, did it work and what needs changing. The log must also identify what has changed. This information provides an audit tool that lessons have been learnt and is also key information during any inquiry process.
- 10.12 Through the exercising process, individuals have the opportunity to practice their skills and increase their confidence, knowledge and skill base in preparation for responding at the time of a real incident. Exercises should not be conducted solely as a single agency event but should reflect the identified risks and the involvement of commissioners and co-responders as appropriate. Learning from exercises must be cultivated into developing a method that supports personnel and organisational goals and is part of an annual plan validation and maintenance programme.
- 10.13 Each NHS funded organisation is required to undertake the following:

### *Communications Exercise*

- a. these exercises are required to be undertaken every **6 months**. These are to test the ability of the organisation to contact key staff and other NHS and partner organisations 24/7. These could include testing paging services as well as telephone and email systems. These unannounced exercises should be tested both in and out of office hours on a rotational basis.

### *Command Post Exercise*

- a. these exercises are required to be undertaken every **6 months**. This type of exercise will test the operational element of command and control and requires the setting up of the Incident Coordination Centre (ICC). This provides a practical test of equipment, telephone and IT

facilities and provides familiarity to those undertaking roles within the ICC. This can be incorporated into communications or live exercise;

- b. in conjunction with local command post exercises (CPXs), NHS organisations should also test their links with their multi-agency partners' incident co-ordination centres. All agencies/organisations should be positioned at ICCs as they would be in a real incident. These test communication arrangements and the flow of information up and down the chain of command; and
- c. if an organisation has had reason to activate their ICC for a real incident then this supersedes the need to run an exercise, providing lessons identified are captured and developed.

### Tabletop Exercise

- a. these exercises are required to be undertaken every **12 months**. These are exercises where relevant staff and partner agencies are brought together to discuss the response to a significant incident, emergency, within the same room. These exercises work through a particular scenario and can provide validation to new plan. Participants are able to interact and gain knowledge of other agencies/organisations roles and responsibilities generating levels of realism.

### Live Exercise

- a. these exercises are required to be undertaken every **three years**. These are a live test of arrangement and include the operational and practical element of emergency response. This could include simulated casualties being brought to an Emergency Department or the setting up of a mass countermeasure centre. These are very useful in validating operational aspects of an incident response plan;
- b. if an organisation has had reason to activate their plan for a real incident then this supersedes the need to run an exercise, providing lessons identified are captured and developed; and
- c. under interoperability there is an expectation that NHS organisations will actively participate with exercises run by multi-agency partners including the LRF where relevant to health.

10.14 NHS funded organisations are required to share information of lessons identified and learnt from training, exercising, emergency or significant incidents, across the wider NHS through a common process and co-ordinated through the LHRP strategic groups. Working collaboratively will improve organisational cohesion, ensure our patients and public are safeguarded during a crisis such as an emergency or significant incident.

## Vulnerable Persons

- 10.15 Within the Civil Contingencies Act 2004, the particular needs of vulnerable persons are recognised. The general definition of vulnerable persons is: people present or resident within an area known to local responders who, because of dependency or disability, need particular attention during emergencies.
- 10.16 In terms of the Act, vulnerable persons are defined as those:
- a. under the age of 16. Particular attention should be paid therefore to schools, nurseries, childcare centres and medical facilities for children;
  - b. inhibited in physical movement, whether by reason of age, illness (including mental illness), disability, pregnancy or other reason. Again, attention should be paid to hospitals, residential homes and day centres likely to be housing any of these people and also to means of accessing records for those resident in the community whose address is recorded on lists held by health services, local authorities and other organisations; and
  - c. deaf, blind and visually impaired or hearing impaired. The means of accessing these people during an emergency or when one is likely, should be recorded in plans.
- 10.17 Children - may be involved in a significant incident or emergency, either as casualties or as members of families or groups caught up in the event. Plans need to reflect procedures for dealing with paediatric casualties arising either directly or indirectly from an incident.
- 10.18 Non-English-speaking Communities and Faith Groups - At the scene of an incident simple language guides will generally be available to assist with incident management. Existing arrangements within a Trust may be sufficient for dealing with the usual number of people from the non-English speaking communities and faith groups. However, the scale of an incident, or the particular nature of the incident, or the particular group involved in an incident, may require assistance being sought from other sources. NHS funded organisations should identify the mechanism for obtaining this help in preparing their plans.
- 10.19 People with Learning Difficulties or with mental illness – trusts' existing facilities and procedures may be sufficient to assist people with learning difficulties and those with mental illness during the course of a significant incident. However, there may be small numbers for whom additional and/or specialist assistance may be required. Trusts should identify the mechanism for obtaining this help in preparing their plans.

## Local Health Resilience Partnerships

- 10.20 It is particularly important for NHS funded organisations to ensure their ability to work as part of a multi-agency response across organisational boundaries, ensuring the ability to provide and give mutual aid within the context of Local Resilience Forums (LRFs).
- 10.21 From 1 April 2013, Local Health Resilience Partnerships (LHRPs) will provide strategic forums for joint planning for emergencies for the new health system and will support the health sector's contribution to multi-agency planning through LRFs. As such, the LHRP boundaries are generally coterminous with LRF boundaries.
- 10.22 The Department of Health (DH) sets national health EPRR strategy based the Cabinet Office National Risk Assessment (NRA). The NHS CB and Public Health England (PHE) are responsible for ensuring implementation and delivery of the NHS and public health elements of that respectively. Locally the LHRP plans will also take account of the community risk register developed by the LRF.
- 10.23 The LHRP will coordinate health input and support to the NHS CB, Local Government and PHE in ensuring that member organisations develop and maintain effective health planning arrangements for emergencies, significant incidents and major incidents. Specifically, they must ensure:
- a. that the plans reflect strategic leadership roles, ensuring robust service and local LHRP level response to these incidents;
  - b. coordination between health organisations at a health economy is included within the plans;
  - c. that there is opportunity for co-ordinated exercising of local LHRP and service level plans in accordance with DH policy and the CCA 2004; and
  - d. that the health sector is integrated into appropriate wider EPRR plans and structures of civil resilience partner organisations within the LRF area(s) covered by the LHRP.
- 10.24 LRFs lead the multi-agency EPRR planning for any emergency, significant or major incident, whether or not they relate to, or impact on, health. LHRPs co-ordinate EPRR across the health system and provide health input to LRFs.

- 10.25 LHRPs will ensure co-ordinated planning for emergencies impacting on health or continuity of patient services and effective engagement across LHRP and local health economies. LHRP Co-chairs will be the key links with:
- a. LRF chairs;
  - b. Director of Public Health (DPH) colleagues, PHE;
  - c. Health sector EPRR leads;
  - d. Local Authority Chief Executives and EPRR teams; and
  - e. other senior emergency preparedness leads for local agencies.
- 10.26 The DPH Co-chair will have a specific responsibility to provide public health expertise and co-ordinate public health input.
- 10.27 The NHS Co-chair will provide local leadership on EPRR matters to all providers of NHS funded care and maintain engagement with CCGs to ensure resilience is commissioned effectively, reflecting local risks.
- 10.28 A model terms of reference and concept of operations for LHRPs have been published<sup>9</sup> to provide a standardised approach across England. It is expected that these models will be adapted as applicable to the local health sector, whilst recognising the value in consistency of approach for all stakeholders.

#### *Accountability*

- a. LHRPs are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations; and
- b. each constituent organisation remains responsible and accountable for their effective response to emergencies in line with their statutory duties and obligations. The LHRP provides a strategic forum for joint planning and preparedness for emergencies, supporting the health sector's contribution to multi-agency planning and preparation for response through LRFs.

#### *Membership*

- a. members of the LHRP will be executive representatives, who are able to authorise plans and commit resources on behalf of their organisations, they must be able to provide strategic direction for health EPRR in their area;
- b. individual members of the LHRP must be authorised by their employing organisations to act in accordance with their organisational governance arrangements and their statutory status and responsibilities; and

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<sup>9</sup> <http://www.commissioningboard.nhs.uk/ourwork/gov/epr/>

- c. the specific competencies for NHS and DPH co-chairs have been published<sup>1011</sup>.

### *Working Groups*

- a. due to the strategic nature of the LHRPs, the co-chairs will determine the need for any specific working groups to reflect locally identified risks to the community; and
- b. it is for the co-chairs of the LHRP and the Chair of the corresponding LRF to agree the coordinated approach to health planning between any existing LRF health sub-groups (or equivalent) and LHRPs mindful of the need to avoid any duplication. The LHRPs will be the principal strategic health planning groups for their local areas.

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<sup>10</sup> <http://www.commissioningboard.nhs.uk/ourwork/gov/epr/>

<sup>11</sup> <http://www.dh.gov.uk/health/2012/07/resilience-partnerships/>

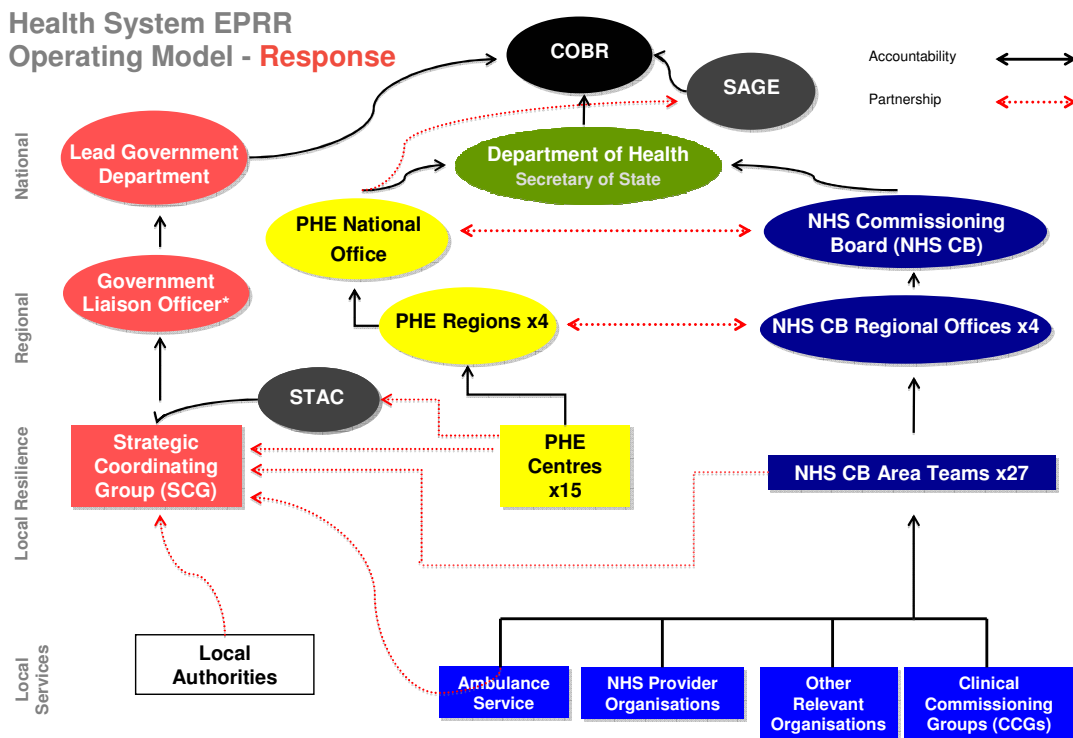
## 11. Organisational Resilience

- 11.1 Detailed information on business continuity is available in the [NHS CB Business Continuity Management Framework \(Service Resilience\) \(2013\)](#).
- 11.2 Business continuity management (BCM) is an essential tool in establishing an organisation's resilience to maintain their business prioritised activities and gives organisations a framework for identifying and managing risks that could disrupt normal service.
- 11.3 An organisation's business continuity management system (BCMS) helps it to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect.
- 11.4 Disruptions can be caused by periods of severe pressure (for example, in winter), a long-term increase in demand for services, external emergencies and disasters, external environment (for example, power failures, severe weather) or from within an organisation (for example, systems failures, loss of key staff). Planning to tackle these effects goes way beyond the initial emergency response.
- 11.5 Risk assessments should take into account community risk registers and at very least include worst-case scenarios for:
- a. severe weather (including snow, heatwave, prolonged periods of cold weather and flooding);
  - b. pandemic influenza;
  - c. staff absence (including industrial action);
  - d. the working environment, buildings and equipment;
  - e. fuel shortages;
  - f. surges in activity;
  - g. IT and communications;
  - h. supply chain failure; and
  - i. associated risks in the surrounding area (e.g. COMAH and iconic sites).
- 11.6 A business continuity event is any incident requiring the Invocation or act of declaring that the organisation's business continuity arrangements, need to be put into effect in order to continue delivery of key products or services. For NHS organisations there may be a long 'tail' to an emergency event, for example, loss of facilities, provision of services to patients injured or affected in the event or psychological support to victims and/or staff.
- 11.7 Whilst business continuity and emergency planning are usually separate processes within an organisation, an incident may occur that requires the trigger of business continuity arrangements and an emergency response. The skills to develop business continuity plans are complementary to those involved in emergency planning and may therefore need to be undertaken by separate officers. However, it is critical that both plans are integrated and complementary of each other.

## 12. Emergency Response

12.1 In order for the NHS to be able to respond to a wide range of incidents and emergencies that could affect health or patient care, the appropriate alerting processes need to be in-place to inform those responsible for coordinating the applicable response.

The diagram below shows the NHS Commissioning Board (NHS CB) EPRR response structure and its interaction with key partner organisations.



### Alerting mechanism to be used in the event of a significant incident or emergency.

12.2 Ambulance trusts have specific responsibilities in terms of alerting NHS funded organisations in the event of a significant incident or emergency if known. These are:

- immediately notify, or confirm with police and fire controls, the location and nature of the incident, including identification of specific hazards, for example, chemical, radiation or other known hazards;
- alert the most appropriate receiving hospital(s) based on local circumstances at the time; and
- alert the wider health community as the incident dictates.

12.3 Whilst many incidents are triggered by 'big bang' events such as traffic accidents, explosions etc, there are other potential circumstances where an NHS significant incident is triggered by a 'rising tide' or non-acute traumatic

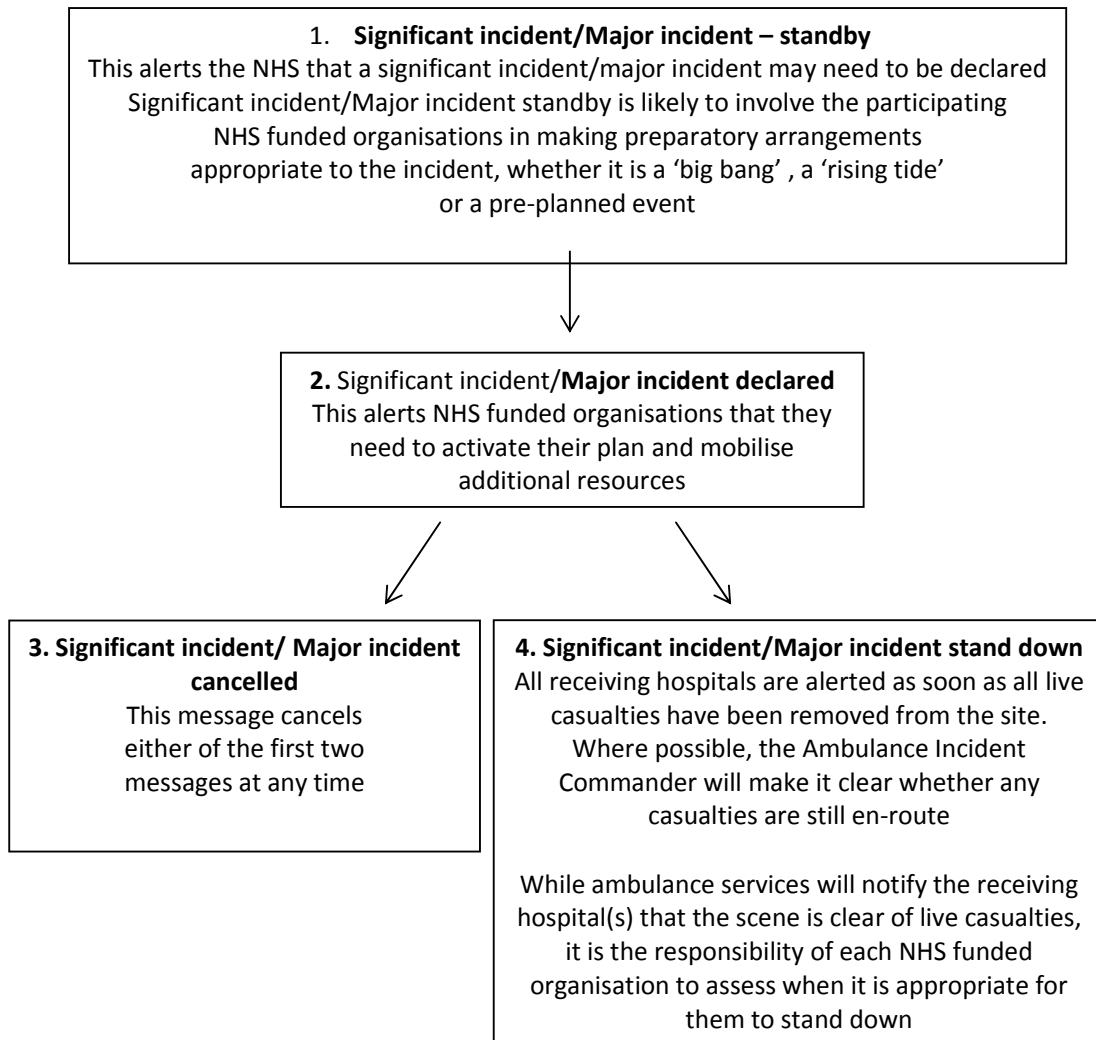


event, for example, infectious disease outbreak, power cuts, covert radiation leakage. In such cases the ambulance services may be involved but may not be the natural 'alerting' NHS organisation.

- a. in the event of a rising tide event, and/or a widespread incident, the communication cascade mechanism used should ensure referral via the NHS CB at area team or Regional level. The NHS CB will take responsibility for implementing Command and Control mechanisms and also the appropriate deployment of NHS resources; and
- b. NHS funded organisations should use the standard alerting messages whenever possible.

### Standard Messages Used by NHS Organisations

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



### **‘For Information v For Action’**

- 12.5 When communicating in an incident or emergency it is important that both the sender and the receiver are clear about intent of the message.
- 12.6 Messages in an incident or emergency should contain the prefix – ‘for information’ or ‘for action’ this will ensure that there is no ambiguity in the intent of the message.

### **Escalation and De-escalation Throughout the NHS**

- 12.7 The level of the response may need to be escalated or de-escalated for a number of reasons. Agreement for this process involving any NHS funded organisation needs to be made in conjunction with Health Gold Command so this can be co-ordinated across all NHS organisations. These may include:

<b>Criteria for Escalation</b>	<b>Criteria for De-escalation</b>
<ul style="list-style-type: none"><li>• increase in geographic area or population affected (Pandemic, Flooding etc.)</li><li>• the need for additional NHS external or internal resources</li><li>• increased severity of the incident</li><li>• increased demands from government departments, the service or from partner agencies or other responders</li><li>• heightened public or media interest</li></ul>	<ul style="list-style-type: none"><li>• reduction in incident resource requirements</li><li>• reduced severity of the incident</li><li>• reduced demands from the NHS partner agencies or other government departments</li><li>• reduced public or media interest</li><li>• decrease in geographic area or communities affected</li></ul>

### **Command and Control Arrangements**

- 12.8 During times of severe pressure and when responding to significant incidents and emergencies, NHS organisations need a structure which provides:
- a. clear leadership;
  - b. accountable decision making; and
  - c. accurate, up to date and far-reaching communication.

- 12.9 This structured approach to incident management under pressure is commonly known as 'command and control'.
- 12.10 The '[\*NHS Commissioning Board Command and Control Framework for the NHS during significant incidents and emergencies \(2013\)\*](#)', sets out the national NHS command and control structure for responding to local, regional and national periods of pressure, emergencies, significant incidents or major incidents. The principles are applicable to all NHS funded organisations.
- 12.11 The following is a summary of some of the key aspects of the NHS CB Command and Control Framework:
- a. all Civil Contingency Act (2004) (CCA) category one responder organisations follow the nationally recognised 'operational, tactical, strategic' command framework which corresponds to the emergency services' 'bronze, silver, gold' structure as explained below;
  - b. operational (bronze) command refers to those responsible for managing the main working elements of the response to an incident. They will act on tactical commands;
  - c. tactical (silver) command is responsible for directly managing their organisation's and/or health economy response to an incident. They develop the tactical plan which will achieve the objectives set by strategic command;
  - d. strategic (gold) command has overall command of the organisation or sector's resources. They are responsible for liaising with partners to develop the strategy and policies and allocate the funding which will deal with the incident. They delegate tactical decisions to their tactical commanders; and
  - e. multi-agency command: If a significant incident or emergency is large or widespread, it may be necessary to coordinate the response of several organisations. Multi-agency strategic coordination is undertaken through a Strategic Coordinating Group (SCG). The geographical responsibility of an SCG follows that of the Local Resilience Forum (LRF). The NHS is usually represented at the SCG by an NHS CB area team and Ambulance Service senior manager.

### **NHS Command and Control**

- 12.12 Incidents can take many forms, therefore the responses need to be appropriate and proportionate to the incident. Most incidents will be dealt with by individual NHS organisations or health economies without the need for others to be involved. However, some incidents may require a wider NHS or multi-agency response, within the context of the NHS it is likely that a CCG would be acting in an operational/tactical capacity. NHS Commissioning Board area teams provide leadership across a geographical area. If an incident requires a wider NHS or multi-agency response, this coordination and leadership is provided by an area team director.

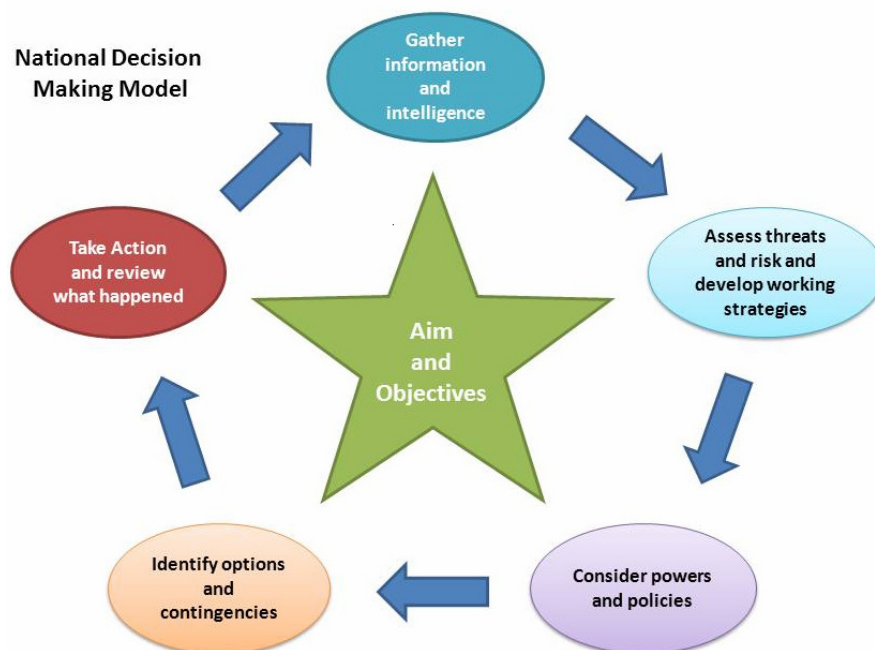
- 12.13 Local organisations must inform their commissioners and area team on-call about any internal incidents, responses to local emergencies or cases of extreme pressure.
- 12.14 NHS Commissioning Board regional teams: If an incident affects two or more areas, the NHS response will normally be led by the area team first affected and responding to it. If the NHS CB regional team has to take command of all NHS resources across the region, the team's on-call director will if necessary provide leadership and direction across the region.
- 12.15 NHS CB National team: In extreme situations such as pandemic influenza, a national fuel shortage or extreme weather, the NHS CB national team may take command of all NHS resources across England.
- 12.16 On-call Staff: Each NHS organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. They must therefore have an appropriate out-of-hours on-call system.

### Incident Coordination Centre (ICC)

- 12.17 Each NHS organisation has the responsibility to provide a suitable environment for managing a significant incident or emergency. This is known as an Incident Coordination Centre as described in the NHS CB Command and Control Framework (2013). It provides a functional space for making decisions and collecting and sharing information quickly and efficiently.
- 12.18 The area team Incident Coordination Centre (ICC) will serve as a focal point for all liaisons between NHS and partner organisations. It must be located within respective area team localities and have the appropriately trained staff to provide the relevant information to the SCG and Health Gold representative.

### Decision Making Framework

- 12.19 The National Decision Making Model identifies best practice to support all decision makers within NHS organisations.



- 12.20 An assessment of the potential consequences arising from a particular decision should be assessed against the mnemonic STEEPLE, which lists seven factors all decision makers should take into account when determining operational / incident-related decisions. The decision and rationale should be recorded within a written policy or decision log as part of the audit trail of the incident. These are:
- a. Social;
  - b. Technological;
  - c. Economic;
  - d. Ethical;
  - e. Political;
  - f. Legal; and
  - g. Environmental.

### Internal and External Communications

- 12.21 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 on NHS services. It is also imperative that communications messages are circulated within responding NHS organisations to ensure that there is an equally informed internal workforce, this may include a number of various media methods such as TV, Radio and Social media.
- 12.22 The CCA gives distinct legal duties to responders:
- a. in planning terms, warning and informing the public of the likely risks and threats that NHS organisations are preparing to address and examples of the types of responses planned;
  - b. in responding, communications arrangements should be appropriate to the message being released and the type of audience; and
  - c. the [Ten Step Cycle](#)<sup>12</sup> of communications is laid out in the CCA and can be used by communications managers in planning effective communications.
- 12.23 Based on these principles, the response of NHS funded organisations will be focussed on the right people, receiving the right message(s) at the right time.
- 12.24 Media liaison and handling will be an integral part of planning a response to any significant incident or emergency. Media Protocols and joint Media Liaison groups should be in place to ensure consistency of messages provided to the media. Integrated emergency plans, including business continuity plans, should generally provide for the identification of those officers with

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<sup>12</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/60906/10\\_step\\_cycle.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60906/10_step_cycle.pdf)

responsibility for media liaison, as well as identifying the media liaison roles of those with specific duties during an incident (including Chief Executives, On-Call Directors and Managers, as well as Communications Managers). Communication lines, with appropriate control rooms and centres, including the DH Media Centre, should be identified in plans.

12.25 Almost any significant incident or emergency will generate media interest, on a national and even international scale. Media handling on both local and national levels must be seen as an integral part of emergency planning because:

- a. the media will be used as the main channel for communicating with the public. Organisations will be required to use the media for information dissemination at each stage of an incident;
- b. local media will play a key role in message dissemination where an incident is localised; and
- c. the national media reach millions of people and it is therefore important to ensure they have accurate and timely information.

12.26 NHS funded organisations must be clear who is responsible for leading the media response for that organisation and how they should link into multi-agency communication groups and strategies in their LRF area. Those designated must be fully involved in the planning and preparation for dealing with significant incidents.

12.27 To plan and prepare for good media liaison, NHS organisations need:

- a. a call out procedure which includes a Communications Lead for those organisations among the first to be contacted;
- b. to ensure appropriate on call staff to have their mobile phones protected with the Mobile Telephone Privilege Access Scheme (MTPAS) via their LRF;
- c. detailed media handling policies and procedures with which on-call staff are familiar;
- d. to ensure plans are linked into any local multi-agency press briefing arrangements, which may be run by police or local authorities, including Joint Media Forums and the agreement of Joint Media Protocols;
- e. to have in place arrangements to call for extra support, at short notice, for the Communications Lead. For example, networks of Communications Leads might be established across NHS organisations to enable capacity to be boosted at short notice and to provide cover;
- f. to agree with other NHS agencies locally the procedure for co-ordinating information in an emergency and for the designation of a lead organisation and lead officer;
- g. to plan for facilities which can be made available at short notice, such as rooms for the media, telephone lines, IT, etc;

- h. to prepare simple, easily digestible information using a common recognised information picture (CRIP) about NHS organisations that might include size, staff numbers, specialties, names and positions/responsibilities of key people to hand out to media in the event of a significant incident and to supplement this with prepared messages appropriate to local risks in specific areas – for example on radiation hazards, HAZMAT and COMAH facilities or other local situations that may occur;
- i. to ensure that a daily schedule (battle rhythm) is agreed Nationally, Regionally and Locally to guarantee a top down bottom up approach is maintained;
- j. to ensure all Communications Leads, designated spokespersons and others who might have to fulfil the role of spokesperson, have appropriate training and development opportunities to enable them to fulfil their role;
- k. to make Communications Leads aware of previously identified regional spokespeople (for example, from the PHE or other relevant body depending on the nature of the incident); and
- l. to ensure Communication Leads have access to all National and Worldwide news networks.

### **Logging and Record Keeping**

12.28 NHS Organisations must have a cadre of Loggists as described in the NHS CB Core Standards for EPRR (2013) when called upon to support the management any incident or event. Loggists are an integral part in any incident response team. It is essential that those tasked with the responsibility of producing logs do so to best practice standards and understand the importance of logs, not only in the decision-making process during the incident, but also their evidential value and the rationale of a robust audit trail.

### **Scientific and Technical Advice Cell**

12.29 Guidance developed in 2006 led to the establishment of the Scientific and Technical Advice Cell (STAC) to provide expert guidance in an incident.

12.30 The importance of providing clear and consistent public health and health protection messages and advice is both widely accepted and readily sought by police commanders and other organisations. The STAC will access comprehensive and authoritative advice from a wide range of sources, including the NHS and Public Health England and other key scientific and technical sources to support and advise the SCG in directing the response to an incident. The range of relevant specialists needed to ensure comprehensive and authoritative advice will vary depending on the nature of the incident.

- 12.31 It is recommended that the chair of the STAC decides who is best placed to attend the SCG to provide a single point of specialist advice. Those invited to attend the STAC will need to be determined at the time, and will be dependent on the type of incident. In most cases it is expected that the person who will fulfil the role of the STAC chair will be easily identified.
- 12.32 The STAC chair will normally be a Director of Public Health or other senior public health consultant from PHE with specialist skills in incident command. The STAC chairs function is to:
- a. co-ordinate the necessary science advice including health, public health, and health protection advice to input into the strategic management of the incident;
  - b. agree clear public health messages to be given to the public and incident responders, especially health care professionals, via the SCG; and
  - c. manage the development, and provision, of a STAC which will usually be held at the Strategic Coordination Centre.
- 12.33 Membership of the STAC will be dependent on the type of incident but may include people with expertise in microbiology, epidemiology, toxicology, Health Protection, including Consultants in Communicable Disease Control, Environmental Health and representatives of the Environment Agency, the Food Standards Agency, a particular water company or water companies and the Defence Science Technology Laboratories (DSTL).
- 12.34 Practical arrangements for the STAC may have to include video- and tele-conferencing resources as, whilst it is desirable to bring all these agencies together in one location to advise the SCG, it may be impractical especially as some of the specialist practitioners may be few in number and only based at a national level.
- 12.35 The Regional Director of Public Health England must agree the arrangements in their area to ensure that there is appropriate Public Health leadership of a STAC.
- 12.36 At national level, in an emergency where scientific or technical advice is required to aid the emergency response, the Government may decide that a Scientific Advisory Group in Emergencies (SAGE) is required; this decision can either be made by the Lead Government Department (LGD) or the Cabinet Office in consultation with the Government Office for Science. SAGE is usually chaired by the Government Chief Scientific Adviser (GCSA). Each SAGE is emergency-specific and the main role of a SAGE is to ensure that there is a sufficient evidence base for incident-related decision making and to provide timely and coordinated advice.



## 13. Recovery

- 13.1 Recovery from any significant incident or emergency is imperative and requires a combined co-ordinated approach, from either the affected organisations internal departments or multi-agency, this will be dependent on the type and scale of the affecting incident.
- 13.2 The National [Emergency Response and Recovery Guidance](#) (2012)<sup>13</sup> defines recovery as:
- “The process of rebuilding, restoring and rehabilitating the community following an emergency, but it is more than simply the replacement of what has been destroyed and the rehabilitation of those affected.”
- 13.3 It can often be a complex process, involving many different elements of an organisation apart from those involved in the operational response. It can also be an elongated process and likely be subject to scrutiny – both from within the organisation, and externally from the public and media. It may also offer opportunities for service redesign and changes to operational practice.
- 13.4 The recovery phase should begin at the earliest opportunity following the start of an emergency; and should run in parallel with the response. As previously stated, it may last much longer than the response phase, and should not end until all disruption has been rectified, demands on services have returned to normal levels, and the physical and psychosocial needs of those involved have been met.
- 13.5 The nature of the incident will very much direct the structure and form of the recovery ‘cell’ – both in terms of the larger wide scale multi-agency focus, and also from within the organisation itself.
- 13.6 The scope for recovery activities, identified in the [National Recovery Guidance \(2008\)](#) can be very broad and through advanced planning, recovery capability can be built around four key themes:
- a. Humanitarian – physical and psychosocial impacts;
  - b. Economic – economic and business continuity;
  - c. Environmental – effects on the communities; and
  - d. Infrastructure – loss of NHS facilities, resources etc.

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<sup>13</sup> <https://www.gov.uk/government/publications/emergency-response-and-recovery>

## Debriefing

- 13.7 In order to learn from any incident, it is important to capture as much detail about the incident as soon as it is practicably possible, a series of debriefs post incident are seen as good practice. The purpose of the debrief is to identify issues that need to be addressed. It is recommended that they are attended by all staff that have been a part of the response in order to review processes and systems based on what went well, what did not go so well and what needs to be changed. The process of debrief will provide a support mechanism, by using trained staff to facilitate, identify staff welfare needs i.e. those at risk from stress which is a critical element of the debrief process.
- a. **Hot debrief:** Immediately after the incident or period of duty if incident is protracted with responders (at each location);
  - b. **Organisational debrief:** within two weeks post incident;
  - c. **Multi-agency debrief:** within one month of incident where there has been multi-agency involvement; and
  - d. **Post incident reports:** within six weeks of incident. These should be supported by action plans and recommendations in order to update any relevant plans and outline any training and further exercising required. These must be reinforced by achievable time frames.
- 13.8 NHS organisations must have a common platform for capturing debrief lessons and a process for sharing information e.g. ambulance services nationally use the Lessons Identified Debrief (LID) Programme. This provides a consistent secure method of quick time information sharing.

## Psychosocial

- 13.9 It is essential to understand the psychosocial resilience in order to be able to plan to meet the needs of staff. Psychosocial resilience is a multi-dimensional construct. It is *“the capacity of individuals, families, communities, systems and institutions to anticipate, withstand and/or judiciously engage with catastrophic events and/or experiences, actively making meaning out of adversity, with the goal of maintaining ‘normal’ function without fundamentally losing their identity”*
- 13.10 Psychosocial resilience is not about avoiding short-term distress. It is about recognising:
- a. *how people adapt to, and recover realistically from adverse events and/or circumstances;*
  - b. *that the abilities of people to accept and use social support and the availability of it are two of the most important features of resilience; and*

c. *there is evidence that adequate support reduces the effects of exposure to challenging events and emergencies.*

13.11 NHS organisations and NHS funded organisations must ensure there are robust arrangements in place that support responding to the psychosocial needs of staff affected by significant incidents, emergencies, and disasters.

### **Staff Welfare**

13.12 NHS organisation and NHS funded organisations must ensure staff welfare in general. Welfare includes anything that is done for the comfort and improvement of our staff. Measures include monitoring working time and should be in line with the Working Time Regulations (1998) and subsequent amendments. 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.

## **14. Assurance**

- 14.1 The minimum core standards, which NHS funded organisations must meet, are set out in the NHS CB Core Standards for EPRR (as summarised in section 8). These standards are in accordance with the Civil Contingencies Act 2004, the Health and Social Care Act 2012, the NHS Commissioning Board planning framework ('Everyone Counts: Planning for Patients') and the NHS standard contract.
- 14.2 A process is required to provide assurance to the NHS Commissioning Board (NHS CB), and subsequently to the Department of Health (DH), that the NHS is able to maintain a safe and resilient system of patient care in accordance with the above requirements.
- 14.3 Assurance will be sought by the DH from the NHS CB, which will be provided, via the NHS CB director of NHS operations and delivery (corporate), through the NHS CB regional directors, their NHS CB area team directors, the LHRPs and from NHS funded providers.
- 14.4 NHS funded organisations will be asked to submit evidence of their conformity to the required EPRR standards via the completion of a pro-forma template and the provision of a 'statement of EPRR conformity'. Supporting activities may also be undertaken by NHS CB or commissioners of services.
- 14.5 This process will be assessed through impartial NHS CB area team peer to peer review meetings which will make recommendations as to corrective action required and suggest opportunities for improvement.
- 14.6 Finally, the assurance process will be supplemented by a series of on-going system command post exercises.
- 14.7 Separately, or through the LHRP, CCGs will also be assured of plans and organisational resilience.
- 14.8 Directors of Public Health will seek NHS EPRR assurance through the LHRP processes.

## **15. Freedom of Information**

- 15.1 This document is publicly available.

## **16. Equality & Diversity**

- 16.1 Investing in a diverse NHS workforce enables us to deliver a better service and improve patient care in the NHS. Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense.
- 16.2 When putting arrangements in place to reflect this suite of documents, organisations should be mindful of their obligations under the Equality Act 2010. The Equality Duty ensures that public bodies consider the needs of all individuals in shaping policy, delivering services, and in relation to their own employees. It encourages public bodies to understand how different people will be affected by their activities on different people so that policies and services are appropriate and accessible to all and meet different people's needs.

## 17. Glossary of Terms

Bronze	Operational level command
BCM	Business Continuity Management
BCMS	Business Continuity Management System
BCP	Business Continuity Plan
BS	British Standard
BSI	British Standard Institution
CBRN	Chemical, Biological, Radiological & Nuclear
CCA	Civil Contingencies Act 2004
CCG	Clinical Commissioning Groups
COBR	Cabinet Office Briefing Rooms
COMAH	Control of Major Accident Hazards (regulations)
CPX	Command Post eXercises
CRIP	Common Recognised Information Picture
CRR	Community Risk Register(s)
CT	Counter Terrorism
DA	Devolved Administrations
DCLG	Department for Communities and Local Government
DH	Department of Health
DPH	Director of Public Health
DSTL	Defence Science Technology Laboratories
EPRR	Emergency Preparedness, Resilience and Response
EU	European Union
FT	Foundation Trust
GCSA	Government Chief Scientific Adviser
Hazard	A situation that poses a level of threat to life, health, property, or environment.
HAZMAT	Hazardous Materials (and items)
ICC	Incident Co-ordination Centre
IRP	Incident Response Plan

ISO	International Standards Organisation
LA	Local Authority
LGD	Lead Government Department
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MTPAS	Mobile Telephone Privileged Access Scheme
NARU	National Ambulance Resilience Unit
NHS BT	National Health Service Blood and Transplant Service
NHS CB	National Health Service Commissioning Board
NHS D	National Health Service Direct
NHS Gold	Strategic NHS Commander available to attend the Local Strategic Coordination Group and commit NHS resources to support the response to an emergency
NOS	National Occupational Standards (Skills for Justice)
NRA	National Risk Assessment
NRE	National Resilience Extranet
NRR	National Risk Register
PAS	Publicly Available Specification
PHE	Public Health England
PHU	Public Health Unit
PNICC	Police National Information Co-ordination Centre
Provider level	A provider of NHS commissioned care
Public health	the science of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals
ResCG	Multi- Strategic Coordination Group Response Co-ordinating Group
SAGE	Scientific Advisory Group for Emergencies
SCG	Strategic Coordination Group
SCC	Strategic Coordination Centre
STAC	Scientific Technical Advice Cell

Silver	Tactical level command
Sub-national level	Level of the four Regional offices
TCG	Tactical Coordination Group
Threat	Intent to or incident that may inflict harm or loss on a(nother) person
VAS	Voluntary Aid Societies



## 18. References and Underpinning Materials

The [Civil Contingencies Act 2004](#)<sup>14</sup>;

The [Health and Social Care Act 2012](#)<sup>15</sup>;

NHS Commissioning Board planning framework (*'Everyone Counts: Planning for Patients'*)<sup>16</sup>;

[NHS standard contract](#)<sup>17</sup>;

NHS Commissioning Board [EPRR documents and supporting materials](#)<sup>18</sup>

[NHS Commissioning Board Business Continuity Management Framework \(service resilience\) \(2013\)](#)<sup>19</sup>;

[NHS Commissioning Board Command and Control Framework for the NHS during significant incidents and emergencies \(2013\)](#)<sup>20</sup>;

NHS Commissioning Board Model Incident Response Plan (national, regional and area team);

[NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response \(EPRR\)](#)<sup>21</sup>;

National Occupational Standards (NOS) for Civil Contingencies – [Skills for Justice](#)<sup>22</sup>;

[BSI PAS 2015](#) – Framework for Health Services Resilience<sup>23</sup>;

[ISO 22301](#) Societal Security - Business Continuity Management Systems – Requirements<sup>24</sup>.

The [role of accountable emergency officers](#)<sup>25</sup>

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<sup>14</sup> <http://www.legislation.gov.uk/ukpga/2004/36/contents>

<sup>15</sup> <http://www.legislation.gov.uk/ukpga/2012/7/enacted>

<sup>16</sup> <http://www.commissioningboard.nhs.uk/everyonecounts/>

<sup>17</sup> <http://www.commissioningboard.nhs.uk/nhs-standard-contract/>

<sup>18</sup> [www.commissioningboard.nhs.uk/eprr/](http://www.commissioningboard.nhs.uk/eprr/)

<sup>19</sup> <http://www.commissioningboard.nhs.uk/files/2013/01/bus-cont-frame.pdf>

<sup>20</sup> <http://www.commissioningboard.nhs.uk/files/2013/01/comm-control-frame.pdf>

<sup>21</sup> <http://www.commissioningboard.nhs.uk/files/2013/01/epr-core-standards.pdf>

<sup>22</sup> <http://skillsforjustice.com/NOS>

<sup>23</sup> <http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030201297>

<sup>24</sup> [http://www.iso.org/iso/catalogue\\_detail?csnumber=50038](http://www.iso.org/iso/catalogue_detail?csnumber=50038)

The [Business Continuity Institute](#)<sup>26</sup>

[Freedom of Information Act 2000](#)<sup>27</sup>

Competencies for [NHS Commissioning Board co-chairs](#)<sup>28</sup> of Local health resilience partnership (LHRPs)

Competencies for [Director of Public Health \(DPH\) co-chairs](#) of LHRPs<sup>29</sup>

[Cabinet Office National Recovery Guidance](#)<sup>30</sup>

*Superseded documents:*

*The NHS [Emergency Planning Guidance 2005](#) (the [underpinning materials](#) remain valid until the NHS CB published replacement guidance)<sup>31</sup>*

*[Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013](#)<sup>32</sup>*

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<sup>25</sup> <http://www.commissioningboard.nhs.uk/files/2012/12/epr-er-officer-role.pdf>

<sup>26</sup> <http://thebci.org/>

<sup>27</sup> <http://www.legislation.gov.uk/ukpga/2000/36/contents>

<sup>28</sup> <https://www.wp.dh.gov.uk/publications/files/2012/08/nhs-lhrp-co-chair-competencies-020812.pdf>

<sup>29</sup> <http://www.dh.gov.uk/health/2012/07/resilience-partnerships/>

<sup>30</sup> <http://www.cabinetoffice.gov.uk/content/national-recovery-guidance>

<sup>31</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4121072](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121072)

<sup>32</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_133353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133353)