**NHSCBA/13/04/12/5**

**BOARD PAPER - NHS COMMISSIONING BOARD AUTHORITY (NHS CBA)**

| **Title:** Emergency preparedness resilience and response (EPRR) Model and Implications for the NHS Commissioning Board Authority (NHS CBA). |
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| **Clearance:** Ian Dalton, Chief Operating Officer |
| **Purpose of Paper:**<br><br>A key role of the NHS Commissioning Board (NHS CB) is to ensure that the NHS in England is properly able to deal with potential threats to its operation and to take command of the NHS during emergency situations where this is necessary. The delivery of the EPRR model must be in place by 31 March 2013.<br><br>This paper provides the Board with information on a new health Emergency Preparedness Resilience and Response (EPRR) model for England and the proposed next steps to implement the model across the NHS. |
| **Key Issues and Recommendations:**<br><br>Recommend that the Board notes the content of this paper and the proposed next steps necessary for implementation. |
| **Actions Required by Board Members:**<br><br>The Board is asked to:<br><br>1. note the paper; and<br><br>2. agree next steps to enable the NHS CBA to start the implementation phase for EPRR for the NHS. |

**NHS Commissioning Board Authority**

**13 April 2012**

**Emergency Preparedness Resilience and Response (EPRR) Model and Implications for the NHS Commissioning Board Authority**

## Executive Summary

The role of the NHS CB is to ensure that the NHS in England is properly able to deal with potential threats to its operation and to take command of the NHS during emergency situations where this is necessary. The delivery of the EPRR model is one of our essential deliverables which must be in place by 31 March 2013.

1. This paper provides the Board with information on a new health EPRR model for England and the proposed next steps to implement the model across the NHS.

2. It is anticipated that the key elements of the multi-agency emergency planning operating model will be published by the Department of Health (DH) in early April 2012.

3. The model has the broad agreement of the three main stakeholders – DH, Health Protection Agency (HPA) and the NHS Chief Executive and meets the legislative requirements imposed for the future on the different new organisations by the Health and Social Care Act (HSCA) 2012 and the Civil Contingencies Act 2004 (see annex B for HSCA summary).

## Recommendation

4. To note the content of this paper which is underpinned by the EPRR Core Policy Document, as well as the proposed next steps necessary for implementation.

## EPRR model

5. A revised EPRR model is required to ensure resilience of the health care system post 31 March 2013.

6. Following extended engagement and consultation with many stakeholders, the DH EPRR Steering Group presented a revised EPRR model to ministers in November 2011.

7. The model has been designed around the following core principles:

    - it builds on existing mechanisms that bring together the local health economy to plan for, and respond to, disruptive challenges;

- wherever possible, incidents should be managed at the most appropriate level, (usually at local level);

- recognising the health economy is part of a wider resilience system, local health planning should be aligned with the multi-agency Local Resilience Fora (LRF); and

- during national emergencies, the NHS CB would need to be able to command NHS resources to coordinate a unified response.

8. An effective health response depends on the local health economy planning together, while working closely with the wider LRF / resilience community. To achieve this, Local Health Resilience Partnerships (LHRPs) will be established. The Secretary of State for Health (SofS) has decided that these will be co-chaired by a local NHS CB lead and a designated Director of Public Health (DPH) (annex C).

9. Many potential incidents that threaten disruption to patient services fall solely within the overview of the NHS (e.g. the impact of a significant impairment of the NHS supply chain). During such incidents, the NHS CB at the most appropriate level will be responsible for managing the incident to satisfactory conclusion.

10. Other incidents will necessarily involve direct threats to the public health and, as such, will need the input of specialist public health expertise. Some situations that start as low level public health incidents may, however, rapidly grow to the point at which their magnitude threatens the capacity of the local NHS to respond effectively without support from other parts of the health service. In such cases, the model needs to ensure that there is clarity over the leadership of all stages of the incident among all parties.

11. In January 2012, discussions took place between the NHS Chief Executive and SofS, which focussed on when an incident would be led by public health or by the NHS and all parties recognised the following points:

    - the vast majority of incidents are public health incidents which, due to the very localised scale of the incident(s), do not require NHS or wider LRF input (for example. a food poisoning outbreak affecting a small element of the population);

    - It is important that during an incident, information is shared quickly between public health and NHS professionals (the E-Coli outbreak in Europe, summer 2011 demonstrated the importance of this); and

    - DsPH require skills and understanding of when NHS leadership is required to respond effectively to significant or developing incidents that impact on the NHS.

12. It has been agreed that DsPH, with Public Health England (PHE) would lead the initial response to public health incidents at a local level in close collaboration with the appropriate NHS CB lead. The NHS CB lead will

determine, in light of the impact on NHS resources and with advice from the DsPH, at what point the lead role will transfer, if necessary, to the NHS.

13. Analysis published on 7 February 2012 identified the current spend for EPRR activity for 2010/11, currently within Primary Care Trusts (PCTs) as circa £12m. Current baseline spending assumptions are that this is all for responsibilities that will in future fall to Local Authorities (LAs) from 2012-13. As part of EPRR implementation, the NHS CBA will need to identify the full NHS spend on EPRR and the spread of costs. This work will need to build on the existing analysis and the roles and responsibilities for EPRR in the new structures.

**Next steps and actions required by Board members**

14. The agreed model gives a good grounding to enable movement from the design to the implementation phase, including detailed arrangements to underpin the operating model through testing and exercising.

15. Progress is now critically dependent upon setting up appropriate NHS CB governance arrangements and the appointment of staff. Therefore, the next key actions to ensure the Board is prepared to discharge its responsibilities from 1 April 2013 include:

- the Chief Operating Officer (COO) will establish an Implementation Steering Group to provide national leadership and oversight of implementing the policy across the NHS. Membership of the group will include NHS CBA Medical Director, regional leads, Director of NHS Operations and the Head of NHS Preparedness;

- the COO, together with regional leads, will identify and appoint key NHS CB personnel with EPRR responsibilities at national, region and area office level;

- the COO will continue to encourage multi-agency working to ensure all agencies are co-ordinated in making their own and joint preparations;

- the Director of NHS Operations will continue to support the COO during the transition phase and until a permanent team is recruited; and

- further work will be undertaken to identify the full NHS spend on EPRR and the spread of costs, building on the existing analysis and the roles and responsibilities for EPRR in the new structures.

Ian Dalton CBE
**Chief Operating Officer**
NHS Commissioning Board Authority
28 March 2012

**Annex B. Draft Health and Social Care Act 2012– Summary of Relevant Clauses**

1. Clause 30 of the new Health and Social Care Act 2012 requires Local Authorities and the Secretary of State (SofS) to appoint Directors of Public Health (DPH). It defines the responsibilities of the DPH, which include Local Authority functions in relation to planning for and responding to emergencies that present a risk to public health.

   Local Authority functions in relation to emergencies are set out under the Civil Contingencies Act 2004. As a Category 1 responder, Local Authorities have a duty to assess, plan and advise communities during an emergency.

2. Clause 46 of the Health and Social Care Act 2012 sets out the roles & responsibilities of the NHS Commissioning Board Authority (NHS CBA), Clinical Commissioning Groups (CCGs) and providers of NHS funded services in relation to assuring NHS emergency preparedness and response.

   It also requires the NHS CBA to take steps it considers appropriate to ensure that CCGs and providers of NHS services are properly prepared to cope with emergencies and to monitor their compliance.

   The clause also allows the NHS CBA to take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by CCGs and service providers. The Board's functions in the clause can be delegated to another person or organisation. The clause defines a relevant emergency as one that might affect the services arranged or provided – whether by increasing the need for the services or in any other way.

   Each NHS funded organisation will be required to appoint an individual who is responsible for the preparedness and response of that organisation.

3. Clause 47 updates and extends SofS' powers of direction during an emergency to cover the post reform health system. SofS will be able to use these broad powers of direction when he considers it appropriate because of an emergency.

   The clause gives SofS the power to direct the NHS CBA to exercise his functions under this clause.

**Annex C. The Local Health Resilience Partnership**

1. It is proposed that *Local Health Resilience Partnerships* (LHRPs) should be established to deliver national Emergency Preparedness Resilience and Response (EPRR) strategy in the context of local risks. These will bring together the health sector organisations involved in emergency preparedness and response at the Local Resilience Fora (LRF) level. They will be a forum for co-ordination, joint working, planning and response by all relevant health bodies and will in effect be a formalisation of arrangements that already exist in many local health economies to co-ordinate health sector input to emergency response.

2. The LHRPs footprint will need to map to the 39 LRFs. Membership of the LHRPs will consist of EPRR leads from health organisations in the area, Public Health England (PHE) and others as agreed locally, and will ensure effective planning, testing and response for emergencies. They will enable all health partners to input to the LRF and in turn provide the multi-agency LRFs with a clear, robust view of the health economy and the best way to support LRFs to plan for and respond to health threats.

3. The LHRP will be a strategic group supported by a task and finish working group as required to complete specific items of work that reflect locally identified risks to the community. Membership of these workstream groups would predominantly be drawn from emergency planning professionals in local health economy organisations.

# Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013

# Executive summary

The Health & Social Care Act will strengthen arrangements for emergency preparedness, resilience and response (EPRR) with the changes coming into effect in April 2013.

This document describes the principles that will underpin EPRR, and sets out the roles and functions of the Secretary of State for Health, the Department of Health, the NHS Commissioning Board, Public Health England, and Directors of Public Health 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.

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# Introduction

1. The Health and Social Care Act 2012 makes significant changes to the health system in England from April 2013. This paper sets out the arrangements for emergency preparedness, resilience and response. An equality impact statement is provided later in this document.

2. The Department of Health, public health, and local healthcare systems must provide a seamless and co-ordinated response to the challenge of natural hazards, accidents, outbreaks and the enduring threat of worldwide terrorism. This requires a robust, integrated system that enables health sector organisations to play their full part in the protection of the health of local communities and the nation during emergencies, through coordinated preparation and response across the whole sector. The arrangements should reinforce the relationships at local level with the UK's existing civil resilience structures and emergency responder communities, and also support effective responses to the whole range of incidents and outbreaks at sub-emergency level.

**Key principles**

3. The following key principles underpin the proposed arrangements for Emergency Preparedness, Resilience and Response (EPRR):

- In emergencies, the Secretary of State will have a direct line of sight to the front line through the NHS Commissioning Board (NHS CB) and Public Health England (PHE).
- The NHS CB and PHE will work together at all levels to ensure nationally consistent health emergency preparedness and response capability.
- Incidents will be dealt with at the most appropriate level (in most cases at local level with escalation occurring when necessary).
- In the event of an emergency or incident, NHS CB, at an appropriate level, will lead the NHS response to any emergency that has the potential to or impacts on the delivery of NHS services, or requires the services or assets of the NHS to be mobilised, taking scientific and technical advice from PHE.
- PHE will provide national leadership and co-ordination of the public health response to the emergency preparedness, resilience and response system.
- The local authority, and the Director of Public Health acting on its behalf, have a pivotal place in protecting the health of its population. They will be required to ensure plans are in place to protect the health of their geographical population from threats ranging from relatively minor outbreaks to full-scale emergencies.

- At Local Resilience Fora (LRF) level, the co-ordination of health system EPRR will be aligned with multi-sector emergency preparedness and response reflecting LRF boundaries.
- There will be a national co-ordination function for major (national) crises and incidents that will be led by the Department of Health, bringing together the NHS CB and PHE at national level.

**Roles and functions**

4. The Secretary of State will be ultimately accountable for emergency response, supported by the Chief Medical Officer (CMO) and the Department of Health and with a direct line of sight to the front line through the NHS CB and PHE.
5. The Health and Social Care Act 2012 updates and extends the Secretary of State's powers of direction during an emergency, giving him broad powers of direction when he considers it appropriate because of an emergency (relevant sections of the Act are highlighted at the end of this document).
6. The Department of Health, as the Department of State, supports the Secretary of State in the discharge of his responsibilities for assuring a 'whole system' accountable response. The Department will continue to have policy responsibility for EPRR across the health system in line with Cabinet Office requirements.
7. In fulfilling its responsibilities on behalf of the Secretary of State, the Department will:
   (a) represent the health sector in the development of UK government civil resilience and counter terrorism policy, with scientific and technical advice from PHE, and liaising with international organisations such as EU and the World Health Organisation;
   (b) identify EPRR policy requirements for the health sector, and incorporate them as appropriate in the NHS CB mandate, PHE operating plan, and equivalent documents for Arms Length Bodies where appropriate;
   (c) provide assurance to the Cabinet Office of health system preparedness for and contribution to the UK government's response to domestic and international emergencies, in line with the National Risk Assessment and as one of nine Critical National Infrastructure sectors;
   (d) ensure the co-ordination of the whole system response to high-end risks impacting on public health, the NHS and the wider healthcare system;
   (e) support the UK central government response to emergencies including ministerial support and briefing;
   (f) provide a data and information conduit between the NHS CB, PHE and the Cabinet Office for emergency preparedness, assurance and response
   (g) take other action as required on behalf of Secretary of State to ensure a national health emergency is managed.

8. The NHS Commissioning Board will be responsible for ensuring there is a comprehensive NHS EPRR system that operates at all levels, for assuring itself that the system is fit for purpose and for leading the mobilisation of the NHS in the event of an emergency or incident.

9. In fulfilling these responsibilities the NHS CB will:

   (a) set a risk based national EPRR implementation strategy for the NHS, taking account of both cross-government and NHS requirements;

   (b) put in place a consistent national EPRR assurance framework for all providers of NHS funded care;

   (c) ensure it has capability for National Health Service command, control, communication and co-ordination and leadership of all providers of NHS funded care;

   (d) commission and set the strategic direction for an exercise and training programme for NHS EPRR, taking account of Cabinet Office requirements;

   (e) work closely and in collaboration with PHE, and where appropriate develop joint health response plans at national, sub-national and local levels; and

   (f) ensure provision of high quality and timely data to the Secretary of State and PHE in both preparedness and response modes.

10. Public Health England will be responsible for providing public health EPRR leadership and scientific and technical advice at all levels, co-ordinating its activities closely with the NHS and Directors of Public Health. It will deliver specialist public health services to national and local government, the NHS and the public, working in partnership to protect the public against infectious diseases and minimise the health impact from hazards. PHE will also be responsible for assuring itself that its systems are fit for purpose to respond to incidents and emergencies.

11. In fulfilling these responsibilities PHE will:

a) provide national leadership and coordination of the public health elements of the emergency preparedness, resilience and response system.

b) provide health protection services, expertise and advice (as currently provided by the Health Protection Agency at national and local levels) and co-ordinate the PHE response to major incidents;

c) provide risk analysis and assessment of emerging diseases, extreme events, chemical, radiological and Chemical Biological Radiological Nuclear and Explosive (CBRNE) threats to inform the Department and other government departments and agencies and health and multi-agency EPRR preparedness and response;

d) ensure provision of high quality and timely data to the Secretary of State and NHS CB, local authorities and across Government, in both preparedness and response modes;

e) produce a consistent EPRR assurance framework for PHE and for health protection interventions commissioned by PHE;

f) provide a range of specialist public health services eg laboratory, analytical and expert advisory, system assessment and training services;

g) communicate with Devolved Administrations to coordinate investigation and management of cross-border incidents;

h) provide information internationally eg to WHO or ECDC and act as the National Focal Point under International Health Regulations;

i) provide guidance to professionals in health and local government and other sectors; and

j) communicate with the public providing information and advice relevant to PHE's responsibilities.

12. Directors of Public Health will be appointed by the local authority jointly with the Secretary of State for Health and will carry out the local authority's new public health functions, including carrying out those functions of their local authority that relate to planning for and responding to emergencies involving a risk to public health.

13. Upper tier local authorities will be given a duty to ensure plans to protect the health of their populations are in place, through providing public health advice on health protection plans. This would be provided for through a regulation-making power in the Health and Social Care Act 2012. These plans would include wider health protection issues such as sexually transmitted infections, screening and immunisation programmes as well as EPRR.

14. This local authority role in health protection planning is not a managerial, but a local public health leadership function. It will rest on the personal capability and skills of the local authority Director of Public Health and his or her team to identify any issues and advise appropriately. Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population, working with Public Health England which will provide specialist health protection services

15. Local authorities and Directors of Public Health will be expected to collaborate with NHS CB and PHE to plan and prepare for, and to contribute to responses to emergency situations. The plans should ensure 24/7 response capability for emergencies. When a public health incident emerges, the organisation that first becomes aware of it will need to notify other partners in the local health system at the outset, to ensure NHS and PHE organisations are engaged appropriately in delivering any response that may subsequently be required.

16. The EPRR arrangements will be underpinned by legal duties of cooperation, contractual arrangements, clear escalation routes and transparency. Clinical Commissioning Groups (CCGs) will have a duty of co-operation with local authorities; NHS funded providers can be required through contracts to share plans and appropriate information. DsPH can use their annual report and membership of the health and well-being board to raise concerns more formally and the Secretary of State can use his agreement with the NHS CB to ensure that Board takes appropriate account of the advice of DsPH.

**The delivery of EPRR at local service, Local Resilience Fora, sub-national and national levels**

17. The local response is the basic building block of response to any emergency. It is based around the delivery of individual providers' and agencies' responsibilities at the service level. These arrangements are underpinned by the statutory framework for EPRR set out in the Civil Contingencies Act 2004 (CCA)[1] focussed on multi-agency cooperation through Local Resilience Forums (LRF)[2]. These bring together senior representatives of the emergency services, local authority partners, NHS bodies and other responders to prepare for and respond to emergencies as part of national coordination arrangements.

18. The NHS CB[3] and PHE will each be responsible for ensuring that they are adequately prepared for and able to respond to a wide range of emergencies. They will also need to work closely together at all levels and with local authorities, and be able to coordinate emergency response at the LRF, sub-national and national levels.

**The Health Response at Service level**

19. As now, provider organisations will be expected to have the resilience to manage incidents that affect only them, with escalation where necessary following agreed protocols. Leadership of the response to any incident would depend on the nature of the incident, and the skills and experience of the individuals involved. Plans should be in place and should be followed in practice, with clear criteria for escalating an incident where the response requires this.

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[1] Under the CCA 2004, emergency response organisations are classified as Category 1 (primary responders) or Category 2 (supporting agencies), Specific obligations for EPRR are assigned to each category. Local authorities, acute trusts, ambulance trusts, the Health Protection Agency (HPA) and Primary Care Trusts (PCTs) are currently Category 1 providers, Strategic Health Authorities (SHAs) are Category 2 providers.

[2] LRFs are existing multi-agency partnerships, supported by the Department of Communities and Local Government (DCLG), to enable and build local resilience capability through planning and testing. There are currently 39 LRFs that map directly on to police areas; LRFs typically have 3 seats for health representatives, currently: Local NHS management (i.e. PCTs), ambulance services and public health (HPA).

[3] The term NHS CB refers to one organisation with operational functions at central, sector and local office levels

20. Under the terms of the Health and Social Care Act 2012, each provider of NHS funded care, where relevant, and PHE units will comply with relevant legal EPRR requirements including the Civil Contingencies Act 2004 and will ensure 24/7 response capability for emergencies. The Health and Social Care Act 2012 provides that the Secretary of State for Health (and thus Public Health England) and the NHS Commissioning Board will be Category 1 responders under the Civil Contingencies Act. CCGs will be Category 2 responders. The status of provider organisations remains unchanged.

21. Each provider of NHS funded care will also be required to ensure the identification of an accountable Emergency Officer to take executive responsibility and leadership at service level[4] . EPRR requirements will be specified within contracts and providers will be required to collaborate in local multi-agency EPRR activity and to facilitate assurance processes.

22. As outlined above, the Health and Social Care Act 2012 will give the DPH responsibility for carrying out the functions of the local authority in relation to planning for and responding to emergencies involving a risk to public health.

23. At this local level, PHE will ensure specific plans are in place to respond to public health emergencies, working closely with DsPH. Where appropriate locally these should be joint plans with NHS CB and other health sector organisations. They will also ensure specialist PHE public health and scientific input, including horizon scanning and relevant data are available to all members of the health community

**Leadership of the response to public health incidents and emergencies**

24. Most public health incidents are contained locally and do not require activation of LRF-level plans. All incidents have the potential to require NHS resources. The Director of Public Health, with Public Health England, will lead the initial response to public health incidents at the local level, in close collaboration with the NHS lead. The NHS will determine, in the light of the impact on NHS resources and with advice from the Director of Public Health, at what point the lead role will transfer, if required, to the NHS.

25. Depending on the scale and nature of the incident the necessary handling of the incident will be agreed between the NHS and public health at the most appropriate level.

26. The Health and Social Care Act 2012 provides that, under the NHS Act 2006, section 252A, the NHS CB will have a statutory responsibility to 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.

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[4] Identification of an accountable Emergency Officer by providers would be to meet the obligation set out within the Health and Social Care Act 2012 that each provider has an appropriate and named 'officer' within the organisation to act as the accountable person for emergency preparedness. It would be for the organisation to decide how it will meet this requirement.

**Health emergency preparedness & response at LRF level**

27. The Secretary of State is ultimately accountable for the health response to emergencies, supported by the Chief Medical Officer and the Department of Health and with a direct line of sight to the front line through the NHS CB and PHE.

28. The health sector needs to be able to play an effective and co-ordinated role in multi-agency planning and response to emergencies, through participating in existing Local Resilience Fora (LRFs) and Strategic Co-ordinating Groups (SCGs)[5].

29. Local Health Resilience Partnerships (LHRPs) will be established to deliver national EPRR strategy in the context of local risks. These will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. Building on the existing arrangements for health representation at the LRF, the LHRP will be a forum for co-ordination, joint working, planning and response by all relevant health bodies. The LHRP will in effect be a formalisation of arrangements that already exist in many local health economies to co-ordinate health sector input to the LRFs and emergency response.

30. The LHRPs' footprint will need to map to the 39 Local Resilience Fora (LRF). Membership of the LHRPs will consist of EPRR leads from health organisations in the area, Public Health England and others as agreed locally, and will ensure effective planning, testing and response for emergencies. They will enable all health partners to input to the LRF and in turn provide the multi-agency LRFs with a clear, robust view of the health economy and the best way to support LRFs to plan for and respond to health threats.

31. The NHS CB will identify an individual to lead NHS emergency preparedness and response at the LRF level[6], and provide necessary support to enable planning and response to emergencies that require NHS resources.

32. A lead Director of Public Health from a local authority within the LRF area will be agreed to coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area. PHE will provide the health protection services, expertise and advice currently provided at an LRF level by the Health Protection Agency.

33. The local NHS lead identified by the NHS CB and the lead Director of Public Health will act as co-chairs at the LHRP during emergency planning. The local

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[5] Where a major incident affecting a wider area and / or requiring multi-agency coordination occurs, a Strategic Coordination Group (SCG) may be convened. SCGs comprise senior officers from those providers and agencies who attend LRFs, as appropriate to the nature of the specific incident. The SCG reports to and may be directed by national civil contingency arrangements, including COBR where appropriate.

[6] At every level of the NHS Commissioning Board, the NHS lead for emergencies will have executive authority to act on behalf of the NHS CB during a major incident, including the ability to command other NHS organisations resources in the locality to respond to effectively.

NHS lead will represent the health sector on the LRF, as now, since most emergencies require readiness and input of NHS resources. The ambulance service, lead Director of Public Health and PHE will also attend as necessary.

34. LHRPs will be established with appropriate terms of governance to ensure that all local parties in EPRR have a responsibility to keep their colleagues and the Chairs of the LHRP informed of any potential or actual incidents, so that planned handling, leadership and any escalation process can be followed effectively.

35. The proposed LHRPs will provide local health command, control, communication and co-ordination of providers of NHS-funded care. It will seek EPRR assurance from service level providers and where necessary raise issues with the commissioning body. The LHRP will identify a team to facilitate local planning, assurance and response.

36. Further work will be undertaken to plan and pilot the resourcing and operation of LHRPs to ensure the existing arrangements for planning and responding to local risks along with existing resources appropriately reflect the changes in responsibilities.

**The Health Response at Sub-national level**

37. Sub-national coordination of EPRR will be necessary for both the NHS and PHE. As well as providing a means for the Secretary of State to exercise his responsibility from national to local levels, this will, as now, give:

    - support to the local response / recovery process and to monitor the wider impacts of an emergency;
    - support to response / recovery co-ordination where the emergency crosses boundaries (e.g.LRF/SCG or Devolved Administration boundaries), or is complex, requiring extensive resources and/or communications; and
    - assurance of the arrangements at LRF level.

38. At sub-national level, the NHS CB will ensure the delivery of the national NHS EPRR strategy. A senior lead from the NHS[7] will be identified in each of the four NHS CB sectors to provide EPRR leadership across all the Local Health Resilience Partnerships in that area. The NHS CB sectors will be responsible for liaison and collaboration with the DCLG Resilience Hubs on NHS issues. The EPRR structures will build on the ‘business as usual’ structures for the NHS CB and PHE, with no unnecessary additional bureaucracy.

39. The PHE sectors will ensure the delivery of national PHE EPRR strategy in their area. The PHE sectors and NHS CB sectors will develop and ensure the delivery of a joint health resilience strategy in their area. The senior PHE EPRR lead at sector level will work closely with the NHS lead at sector level to ensure the seamless integration of individual organisational resilience plans and where

[7] This role may form part of a wider portfolio of work.

appropriate develop joint sub-national preparedness and response plans. Consideration will be given at sub national level for the PHE and NHS CB sector EPRR teams to be co-located.

**The Health Response at National level**

40. The Department of Health will be responsible for providing assurance to the Cabinet Office of the health system's preparedness for emergencies.

41. The NHS CB Chief Operating Officer will be the executive lead responsible for EPRR at board level. The NHS CB centrally will also provide a link with national NHS bodies, for example, NHS Blood and Transplant, health care regulators etc.

42. Whilst we anticipate that key outcomes for EPRR will be set annually, the nature of the activity is such that arrangements will be required to ensure on-going and regular co-ordination and liaison between the Department of Health, the NHS CB and PHE to help ensure the operational delivery of a national health resilience strategy. It is proposed there will be regular, formal meetings between the NHS CB, PHE and Department of Health to ensure effective co-ordination and communication around EPRR issues.

**Next steps**

43. This new system has been designed in partnership with a wide range of stakeholders from across the health system and external partners through a series of workshops. There is broad agreement that these arrangements will support the delivery of health sector EPRR. Further work is underway with NHS, public health and other colleagues to develop operational guidance for the system-wide emergency preparedness, resilience and response model and to undertake system-wide exercises to provide assurance of readiness for the new arrangements.

# EPRR – Equality Impact Statement

This document describes changes being made in health Emergency Preparedness Resilience and Response to reflect the new health system that will be established by the Health and Social Care Act 2012. This will create appropriate structures and functions in the NHS CB, PHE and with Directors of Public Health in Local Authorities.

EPRR is an overarching policy with component policies that deliver it. All policy makers involved in preparing plans for emergency response will ensure equality assurance, including equality impact assessments in these underpinning policies, for example in Pandemic Flu Planning and Blast Injuries.

The Pandemic Flu Plan (one aspect of emergency preparedness plans) published by the Department of Health has an equality impact assessment published alongside.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125342.pdf

Co-ordination of EPRR at a national, sub-national and local level will be carried out in line with the aims of the Equality Act (2010) and the specific requirements of public sector organisations set out in the Public Sector Equality Duty. Each area that currently produces plans for Civil Contingencies and Emergencies also carry out an equality impact assessment process and this will continue as each area reviews or produces new plans. The requirements will be to assess the plan on the impact it may have on any minority group or section of society. The equality analysis should be based upon all the protected characteristics set out in the Equality Act (2010). These are:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex; and
- sexual orientation

# Health and Social Care Act 2012 – summary of relevant sections

1. Section 30 of the new Health and Social Care Act 2012 requires local authorities and the Secretary of State to appoint Directors of Public Health. It defines the responsibilities of the Directors of Public Health, which include local authority functions in relation to planning for and responding to emergencies that present a risk to public health.
2. Local authority functions in relation to emergencies are set out under the Civil Contingencies Act 2004. As a Category 1 responder, local authorities have a duty to assess, plan and advise communities during an emergency.
3. Section 46 of the Health and Social Care Act 2012 sets out the roles and responsibilities of the NHS Commissioning Board, clinical commissioning groups and providers of NHS funded services in relation to assuring NHS emergency preparedness and response.
4. It also requires the NHS CB to take steps it considers appropriate to ensure that clinical commissioning groups and providers of NHS services are properly prepared to cope with emergencies and to monitor their compliance.
5. The section also allows the NHS CB to take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by clinical commissioning groups and service providers. The Board's functions in the section can be delegated to another person or organisation. The section defines a relevant emergency as one that might affect the services arranged or provided – whether by increasing the need for the services or in any other way.
6. Each NHS funded organisation will be required to appoint an individual who is responsible for the preparedness and response of that organisation.
7. Section 47 updates and extends the Secretary of State for Health's powers of direction during an emergency to cover the post reform health system. The Secretary of State will be able to use these broad powers of direction when he considers it appropriate because of an emergency.
8. The section gives the Secretary of State the power to direct the NHS CB to exercise his functions under this section.

# Glossary of terms used

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| CBRNE | Chemical Biological Radiological Nuclear and Explosive |
| CCA | Civil Contingencies Act (2004) |
| CCGs | Clinical Commissioning Groups |
| CMO | Chief Medical Officer |
| DCLG | Department of Communities and Local Government |
| DPH | Director of Public Health |
| DsPH | Directors of Public Health |
| ECDC | European Centre for Disease Control |
| EPRR | Emergency preparedness, resilience and response |
| HPA | Health Protection Agency |
| LHRP | Local Health Resilience Partnership |
| LRF | Local Resilience Fora |
| NHS CB | NHS Commissioning Board |
| PCT | Primary Care Trust |
| PHE | Public Health England |
| SCG | Strategic Co-ordinating Groups |
| SHA | Strategic Health Authority |