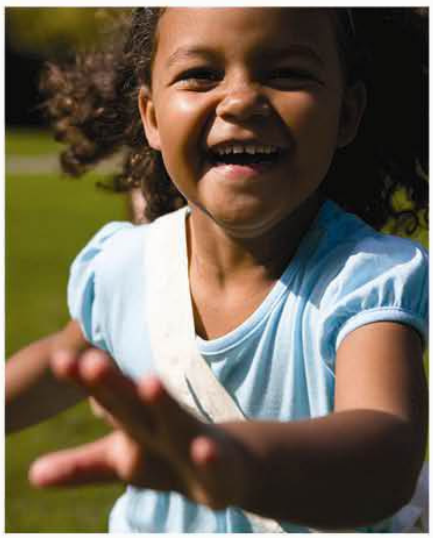
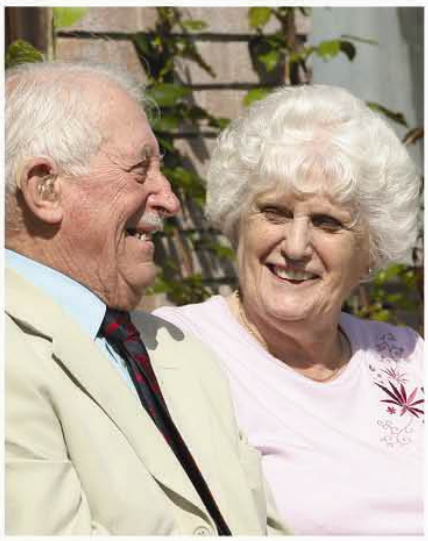
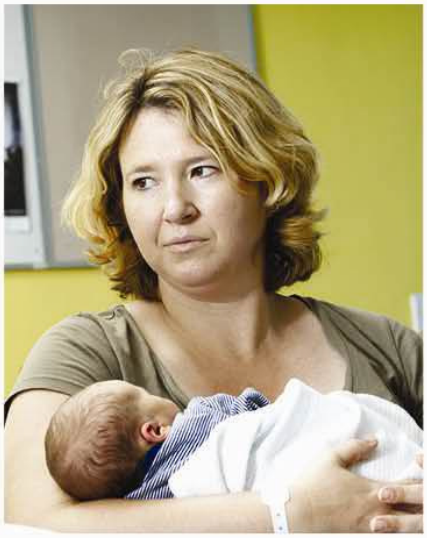
NHS Commissioning Board

# NHS Commissioning Board frequently asked questions (FAQs) on the future arrangements for health Emergency Preparedness, Resilience and Response (EPRR)







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# NHS CB EPRR FAQs for the NHS

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| **Date** | 7 January 2013 |
| **Audience** | NHS Commissioning Board area team directors. |
| **Copy** | ▪ Clinical commissioning groups,<br>▪ Co-chairs of local health resilience partnerships (LHRPs),<br>▪ NHS Commissioning Board regional directors of operations,<br>▪ NHS Commissioning Board regional emergency planning leads,<br>▪ SHA emergency planning leads. |
| **Description** | **This document should be read in conjunction with the letter published 31 October 2012[1] and supporting materials.** |
| **Cross Reference and Links** | [1] http://www.commissioningboard.nhs.uk/eprr/<br>[2] http://www.commissioningboard.nhs.uk/2012/08/02/emerg-prepared/ |
| **Action Required** | **Area team directors have been requested to implement the new health EPRR arrangements and establish LHRPs within their local area[2].** |
| **Timing** | To be used in the deployment of the new health EPRR arrangements within their local area by April 2013. |
| **Contact Details** | NHSCB.EPRR@nhs.net<br>NHS Operations, Quarry House, Leeds, LS2 7UE |

# Key EPRR FAQs

**Qs 1-6 produced specifically for CCGs but relevant to wider audience.**

## Q1. What is EPRR?

**A1.** The acronym EPRR stands for "Emergency Preparedness Resilience and Response". EPRR is defined by a series of statutory responsibilities under the Civil Contingencies Act (2004). This requires NHS-funded organisations to maintain a robust capability to plan for, and respond to, incidents or emergencies that could impact on health or services to patients.

Until 31 March 2013, it remains the statutory responsibility of all PCT and Cluster SHA Chief Executives to oversee and maintain Health EPRR capability across their geographical areas of responsibility. The PCT (or SHA) leads the health input to the multi-agency Local Resilience Forum (LRF) in planning for emergencies or major incidents that could impact on health or health services and across other agencies. Ambulance services whilst part of the NHS, also attend the LRF as one of the three emergency services.

PCTs (and in large scale incidents, SHAs) coordinate the response to significant incidents and emergencies in their areas. In serious or protracted incidents this may require control of NHS resources.

There will be a transition from existing commissioning organisations to the new NHS CB structures, as detailed below. Providers of NHS-funded healthcare services continue to be responsible for the resilience of their organisations and for having appropriate incident response plans in place.

From 1 April 2013, the NHS CB Area Team will take on the overall leadership of the local NHS in terms of planning and response.

An identified area team director and a local director of public health (DPH) will co chair a new planning body – the Local Health Resilience Partnership (LHRP) and will be members of the LRF. Clinical commissioning groups (CCGs) will be involved in planning through the LHRPs.

The NHS lead will determine, in light of the impact on NHS resources and in discussion with the DPH, the point at which the lead role in response to an emergency will transfer (if required) to the NHS. The NHS CB will then take appropriate steps to lead and ensure a co-ordinated response to an emergency by NHS-funded service providers at a local level.

## Q2. What are the principal roles of health sector organisations in the new EPRR System?

**A2.** See the summary of the principal roles of health sector organisations, which was published on 26 July 2012:
http://www.dh.gov.uk/health/2012/07/resilience-partnerships/

## Q3. What is an LHRP?

**A3.** An LHRP is a "Local Health Resilience Partnership". 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 Local Resilience Fora (LRFs). They are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations. Members of the LHRP will be executive representatives, who are able to authorise plans and commit resources on behalf of their organisations. They will be able to provide strategic direction for health EPRR in their area.

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.

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 health planning groups for their local areas

LRFs lead the multi-agency EPRR planning for any major incident or emergency, whether or not they relate to, or impact on, health. LHRPs co-ordinate EPRR across the health system and provide health input to LRFs.

LHRPs will ensure co-ordinated planning for emergencies impacting on health or continuity of patient services and effective engagement across local health organisations. LHRP Co-chairs will be the key links with: LRF chairs; DPH colleagues, Public Health England (PHE); Health sector EPRR leads; LA Chief Executives and EPRR teams; other senior EP leads for local agencies. The DPH Co-chair will have a specific responsibility to provide public health expertise and co-ordinate public health in put.

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.

## Q4. How will LHRPs be constituted?

**A4.** Model terms of reference for LHRPs and a model "concept of operations" for LHRPs, were published on 26 July 2012[1]. These provide a consistent framework for EPRR across the country while recognising the need to reflect local requirements and to build on the strong relationships that already exist between health and multi-agency partners.

The model terms of reference set out the expected membership of LHRPs. It is expected that CCGs will be represented on all LHRPs – but it will be for *local determination* whether some or all CCGs need to be represented in a given local geography.

## Q5. What will be the CCGs' role in EP?

**A5.** CCGs will be Category 2 responders. Category 2 responder organisations are "co-operating bodies that are placed under slightly lesser obligations under the Civil Contingencies Act (2004) than Category 1 responders.

As such they have a role in both 1) planning and prevention and 2) responding to emergencies.

**1) Planning and prevention**
Generically, their roles will be to co-operate and share relevant information with category 1 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. Further information can be found at: http://www.cabinetoffice.gov.uk/content/civil-contingencies-act

Corporately, CCGs will support the NHS CB in discharging its EPRR functions and duties locally, ensuring representation on the LHRP.

As commissioners, CCGs will be required to 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

[1] http://www.dh.gov.uk/health/2012/07/resilience-partnerships/

Should providers fail to maintain their 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 mobilse relevant providers during significant and widespread incidents (see Response below).

They will also be expected to develop, test and update their own business continuity plans to ensure they are able to maintain business resilience during any disruptive event or incident.

**2) Response**
As Category 2 Responders under the CCA, CCGs must respond to reasonable requests to assist and co-operate.

This will include supporting 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 all applicable providers that support primary care services should the need arise

CCGs are responsible for maintaining service delivery across their local health economy to prevent business as usual pressures and minor incidents within individal providers from becoming significant incidents or emergencies. This could include the management of commissioned providers to effectively coordinate increases in activity across their health economy. CCGs need a process that enables them to escalate significant incidents and emergencies to the NHS CB area team as applicable.

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 nuclear, chemical or biological
- Where there is a significant issue of geographic remoteness, which may compromise a NHS CB area team to act alone as a Category 1 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.

## Q6. Will CCGs be involved in on-call rotas for Emergency Response?

**A6.** In certain circumstances, it is the responsibility of the NHS CB at national, regional and local levels, to implement the appropriate emergency 24/7 on-call arrangements to lead the NHS response to an emergency, as applicable.

It is for local determination and agreement whether or not CCG or CCG members are included on the NHS CB area team rota or have a role during the initial response to incidents, considering: the local geography; the number of executives on the roster; and the emergency planning expertise, which may have transferred into CCGs.

However, robust escalation procedures must be put in place such that if an NHS-funded provider has a problem (rather than an immediate major incident), the locally-agreed route for escalation (whether out of hours or during normal business hours) is available via the CCGs and that would almost certainly involve CCGs establishing their own on-call rotas.

As previously stated, should providers fail to maintain their performance levels, CCGs need to provide their commissioned providers with a route of escalation on a 24/7 basis such that business as usual pressures and minor incidents can be prevented from escalating into significant incidents or emergencies.

## Q7. What training will I need and who will provide this?

**A7.** All staff on emergency on-call rotas would need to have the relevant capability (training and exercising).

Executives responsible for EP (ie Business Continuity Management) in CCGs and those (if any) on NHS CB area team emergency response on-call rosters will need to undertake “Strategic Leadership in a Crisis” training.

This is currently provided under the DH “EPRR training and exercising programme”. There will be no changes to this programme before April 2013, by which time a decision on future funding and provision will need to have been made. NHS CB will also need to decide, in light of any such decision, what funding and provision may be needed in future.

It is also recommended that key director level response staff are trained in the legal aspects of decision making (or ‘*Surviving Public Enquiries*’), which is also provided under the existing DH programme, or equivalent courses for which there are several providers used currently by the NHS.

Specific local response training in defined areas (such as nuclear, petrochemical, biological storage, etc) will be dependent on issues identified in specific community risk registers. There is no national (Department of Health) training programme for this so this will need to be sourced locally in conjunction with NHS CB area teams

It is the intention to provide on-line training and communications support toolkits to enable local development of bespoke support packs. These will not include media training for senior executives as this is a wider organisational requirement.

It will be a requirement of the LHRP, through their co-chairs, to arrange suitable programmes for those staff asked to respond in their locality.

## Q8. When will the system change and when will we take on our new responsibilities?

**A8.** The formal handover of statutory responsibilities for new system will be on 1 April 2013.

Sir David Nicholson wrote to NHS Leaders on 13 August 2012, http://www.dh.gov.uk/health/2012/08/transition-health-system/
His letter stated that the responsibility for NHS emergency preparedness remains with all PCT Cluster and Cluster SHA Chief Executives until 31 March 2013 but the NHS CBA needs to commence operational handover in October 2012. Neil McKay subsequently wrote to NHS leaders on 12 September setting out further guidance on transferring responsibilities.

Therefore:

PCTs may discharge their EPRR responsibilities to competent area teams prior to April 2013, subject to:

a. The adoption of an agreed assurance process to demonstrate due diligence and to gain assurance that the area team is competent in its ability to assume EPRR responsibilities on behalf of the PCT
b. Having a Memorandum of Understanding (MOU) or equivalent in place between the PCT and the area team, which clearly identifies all responsibilities being transferred.
c. Having an MOU or equivalent in place between the area team and all applicable providers of NHS-funded care to enable the area team to call upon such relevant resources as may be necessary from any one or all of those providers in response to a major incident.

## Q9. Where can I find out additional information on EPRR?

**A9.** From your local emergency planning leads or via the following websites:

http://publications.dh.gov.uk/2012/08/02/eprr-arrangements/

http://www.dh.gov.uk/health/2012/07/resilience-partnerships/

http://www.commissioningboard.nhs.uk/eprr/

Should you require any further information, please contact your applicable SHA EPL (or your local NHS EP lead).

As people are appointed to the NHS Commissioning Board EPRR roles their details will be updated on the EPRR section of the NHS CB website, which is currently under development.

# FAQs regarding DPH roles

### Q10. Is an MoU being agreed between local authorities for the lead DPH to fulfil the co-chair role?

**A10.** The DPH co-chair has a role to ensure that the public health aspects of EPRR are appropriately integrated into the business of the LHRP, working with their PHE centre director and DPH colleagues in the LRF area. This should be supported by a formal memorandum of understanding (MOU) between the relevant Local Authorities in order to underpin the Lead DPH's (i.e. the LHRP Co-chair's) authority to act on behalf of the others. If this process is to be mandated then it would be for the PHE Transition Team, working with their local Government colleagues in DH and DCLG to determine. This issue has been passed onto DH colleagues for resolution.

### Q11. Will there be another MOU or agreement between LAs and DH regarding the DPH role, to include indemnification, liability, authority to act, etc?

**A11.** As above, there may well be a need for an MOU between LAs in order to ensure LA Chief Executives can give authority and/or indemnification to enable the DPH Co-chair authority to act.

But there is no requirement for an MOU between DH and LAs on this as each DPH will act with the authority of his/her LA Chief Executive in accordance with the organisation's statutory responsibilities. Only where the "lead" DPH is acting on behalf of other LAs/DsPH in the LHRP Co-chair role will an MOU be relevant.

### Q12. Can Directors of Public Health/LA elected members say what goes in an NHS EP Plan, e.g. for an acute or ambulance trust?

**A12.** Under the new EPRR model, Local Authorities (LAs) will be required to promote the preparation of appropriate local health protection arrangements. The Director of Public Health (DPH) role on behalf of the LA is a professional advisory one, providing advice, scrutiny and challenge in relation to NHS emergency plans. It will not be for the DsPH or LAs to instruct the NHS what to do or how to do it but their role will be one of (constructive) challenge around the appropriateness of local plans in relation to emergency preparedness resilience and response.

Similarly, Overview and Scrutiny Committees (OSCs) and/or Health and Well-being Boards (HWBs) will have a challenge role rather than a formal "holding to account" role - as is the case now.

For further information on the health protection advisory role of LAs, please see The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2012 which come into force on 1 April 2013 and are available at:
http://www.legislation.gov.uk/ukdsi/2012/9780111531679

## Q13. Are any existing PCT EPRR staff transferring with the DsPH into Local Authorities?

**A13.** Potentially, but not automatically – as reflected in the Ian Dalton letter to the service. This will be for local determination in accordance with the relevant HR transition policies and in discussion with area team directors.

## Q14. What is the future role of the DsPH with respect to EPRR?

**A14.** As stated in the EPRR model policy document, published in April 2012 and subsequent guidance published on 26 July 2012[2], the DsPH role in EPRR will be:

a. to co-chair the LHRP (a lead DPH will undertake this role where the LHRP covers more than one Local Authority)

b. to provide leadership for the public health system within their LA area

c. on behalf of LAs, to provide information and advice with a view to promoting the preparation of appropriate local health protection arrangements

d. to work closely with PHE to provide initial leadership for the response to public health incidents and emergencies within their LA area

e. to maintain oversight of population health and ensure effective communication with local communities

[2] http://www.dh.gov.uk/health/2012/07/resilience-partnerships/

# FAQs regarding LHRPs

### Q15. How are the DsPH Co-chairs of LHRPs going to be appointed?

**A15.** This is for determination by the relevant LA Chief Executives in discussion with their DsPH.

### Q16. Will Local Authorities (social care) be represented on LHRPs?

**A16.** Although the exact membership and make-up of LHRPs will be for local determination, LAs will be represented on LHRPs by DsPH.

### Q17. The April 2012 EPRR policy document states that LHRPs are being established to deliver national EPRR strategy in the context of local risks. Who sets the national EPRR Strategy?

**A17.** The Department of Health (DH) sets national health EPRR strategy based the Cabinet Office (CO) National Risk Assessment (NRA). The NHS CB and PHE will then be 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.

### Q18. In the policy document, what is meant by [LHRPs will] "facilitate the production of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning"?

**A18.** 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 major emergencies and major incidents. Specifically, they must ensure:

a. That the plans reflect strategic leadership roles, ensuring robust service and local level response to emergencies.

b. Coordination between health organisations is included within the plans.

c. That there is opportunity for co-ordinated exercising of local and service level plans in accordance with Department of Health (DH) policy and the CCA 2004.

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.

## Q19. Is there secretariat support and who funds the LHRP?

**A19.** It is expected that NHS CB area teams will provide the secretariat support for LHRPs and NHS CB will fund that secretariat function. However, the membership attendance at LHRPs will be funded by the individual organisations. I.e. costs will "lie where they fall".

## Q20. Who is going to do the "doing"? i.e. who will organise training locally, write local plans, review plans and exercising, etc?

**A20.** LHRPs will be responsible for coordination of this but it is expected that the NHS CB area team emergency planning officers (EPOs) will be leading this aspect of EPRR work, with input from other local organisations.

## Q21. It was an expectation that LHRPs would be co-terminous with LRFs. How will this work in some areas where 2 LRFs or more are co-terminous with one LHRP or vice versa and which LHRP would have primacy in terms of representation?

**A21.** Whilst it is recognised that the original intention was for LHRP boundaries to be fully co-terminous with LRF boundaries, it has not been possible in all cases to meet all local requirements and at the same time maintain absolute co-terminosity. Where there are exceptions, it is for local determination by the NHS CB area team director and LRF chairs to agree more complex boundary issues.

## Q22. How much input will the LRFs have into the local determination process as to the future of existing (LRF) health sub-groups?

**A22.** 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-group (or equivalent) and LHRPs mindful of the need to avoid any duplication. The LHRPs will be the principal health planning groups for their local areas.

## Q23. What authority and competence will the LHRP have to assess and assure the response of the health sector in emergencies?

**A23.** Individual members of the LHRP are authorised by their employing organisations to act in accordance with their organisational governance arrangements and their statutory status and responsibilities. NHS Co-chairs' competency will be assessed as part of the NHS CB process for appointing the NHS Co-chair and they will be accountable to the NHS CB Regional Directors.
Similarly, DPH Co-chairs have professional competency requirements within their current and future roles and they will be accountable to LA Chief Executives.

The specific competencies required of the NHS LHRP co-chair are set out in: https://www.wp.dh.gov.uk/publications/files/2012/08/nhs-lhrp-co-chair-competencies-020812.pdf

The DPH LHRP co-chair competencies are set out in the appendix to the following document: http://www.dh.gov.uk/health/2012/07/resilience-partnerships/

## Q24. "The LHRP has a pivotal role in facilitating planning but does not have a collective role the delivery of emergency response". If the LHRP does not have a collective role in the delivery of response how can it achieve the assurance requirement described above?

**A24.** 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.

# FAQs regarding NHS funded provider organisations

### Q25. At what levels will collaboration with multi-agency partners take place to facilitate inclusive planning and response? and how will that be represented to the LHRP?

**A25.** It is for provider organisations to identify appropriate representation on the LHRP. Providers must identify an Accountable Emergency Officer (AEO) to take executive responsibility and who will assume a leadership role at service level in any emergency.

### Q26. What is meant by NHS-funded provider organisations ensuring "preparedness to maintain critical services in periods of disruption"?

**A26.** This covers all the following requirements:

a. Having Business Continuity Plans in place

b. Providing the resilience to manage emergencies and incidents that affect only them as individual organisations, with escalation as necessary

c. Maintenance of services in emergency response.

d. Working with appropriate networks (in particular trauma networks, critical care networks and burns networks to support a comprehensive response to incidents across more than one NHS provider.

### Q27. What is meant by provider organisations "facilitating NHS EPRR assurance, including business continuity"?

**A27.** The new system presents few changes for frontline providers and their statutory responsibilities. They will be expected both to provide assurance and to participate in wider system assurance activities, which will contribute to assurance processes across the NHS and health EPRR system.

# FAQs re NHS CB - General

## Q28. What is meant by "*at all levels,* ensure there is a comprehensive NHS EPRR system and assure itself that the system is fit for purpose"?

**A28.** The NHS Commissioning Board will be a single organisation charged with delivering sections 46 and 47 of the Health and Social Care Act in relation to EPRR. The word "levels" refers to the fact that the CB will have a National office, four CB Regions and 27 Area Teams, which will relate to particular geographies. This logic applies also to the mobilisation of the NHS in the event of an emergency or major incident.

## Q29. What other national documents are under development?

**A29.** Further to the publication of supporting materials on 26 July 2012[3] and 2 August 2012[4], the following supporting information was published on 31 October 2012[5]

1. An EPRR PowerPoint presentation, complete with speaking notes.
2. The EPRR transitional assurance process by which the Department of Health will seek assurance from the NHS CB and subsequently how the NHS CB will seek assurance from the NHS.
3. Area Team Director EPRR Implementation Check-List.
4. Template Memorandum of Understandings to facilitate both the safe transfer of EPRR responsibilities between SHA / PCT Clusters and the NHS CB and to enable area teams to call upon such relevant provider resources as may be necessary in response to a major incident.
5. A roadmap of DH and Cabinet Office EPRR published guidance documents.
6. Model competencies for members of NHS CB emergency on-call rotas.

The following supporting and guidance materials are under development:

1. Template specification for incident coordination centres.
2. NHS CB National incident response plan (covering Central, Regional and area team levels).
3. From October 2012, a series of off-the-self testing packages will be made available to support organisations in testing their EPRR capabilities: Burns; Hospital Evacuation; Significant Communicable Disease and Mass Casualty / Trauma.
4. Emergency Planning framework (which will be applicable from 1 April 2013):
   - Command & Control (to replace the 2007 guidance)
   - Emergency Planning Framework (to replace the 2005 guidance).
   - Business Continuity (to clearly signpost to ISO22301 and PAS 2015).

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[3] http://www.dh.gov.uk/health/2012/07/resilience-partnerships/

[4] http://publications.dh.gov.uk/2012/08/02/eprr-arrangements/

[5] http://www.commissioningboard.nhs.uk/ourwork/gov/eprr/

# FAQs regarding NHS CB Area Teams

### Q30. Is there going to be a standard template for an area team emergency response plan?

**A30.** It is anticipated that the NHS CB will produce a national incident response plan (NIRP) with framework plans for regional and local response. These regional and local response plans will need to reflect specific regional or local risks as identified in Community Risk Registers.

### Q31. What if my area team director has not been appointed yet?

**A31.** The appointment process for the remaining 4 area team directors has been published. For those area teams where the process has not be completed, the Regional Director will appoint an interim lead to assure that the EP programme is protected. This lead role could be undertaken by an existing CEO of a PCT or by using the offices of an adjacent area team director.

### Q32. Area teams will be responsible for ensuring the local roll-out of LHRPs, coordinating with PHE and local government partners. What is meant by "local roll-out"?

**A32.** The area team will be responsible for setting up, managing the secretariat and supporting the LHRP(s) in their area.

### Q33. What is the future staffing for EPRR in the area teams going to look like by grade and who is determining this staffing structure?

**A33.** The staffing structure was determined following discussions with EPRR specialists and Regional Directors. Each area team will appoint a Lead for EPRR at Band 8c with support posts shared across the Area Team Operations and Delivery Directorate, demonstrating the need for a range of skills for postholders.

# FAQs re NHS CB - Regions

**Q34. NHS CB Regions are identified as being accountable for the establishment of LHRPs across the region, coordinating with PHE and Local Government. Why are the Regions accountable for the establishment and not the NHS CB area teams?**

**A34.** This is a way of describing the oversight role that CB Regions will have for all the area teams in their geographical patches. So area teams will be accountable for establishing LHRPs (with PHE and Local Government) but CB Regions will be accountable for ensuring this happens throughout their region.

**Q35. Can you explain the future geography i.e. how old regions are different from new regions for the NHS CB despite being called the same?**

**A35.** The word "regions" has been reintroduced to identify what was originally being referred to as the "sub-national" level. For the NHS CB, "regions" refers to one of the four geographical NHS Commissioning Board Regions that have now been defined. These are: North, Midlands & East, London, and South. The actual geographies concerned are the same as the current SHA Clusters.

# FAQs re NHS CB - National

**Q36. The April 2012 EPRR Policy document states that the NHS Commissioning Board National Support Centre will support the response to incidents that affect two or more NHS regions. Do you really mean that the National Centre will only support a response that affects two or more regions?**

**A36.** The NHS CB will respond and provide support as appropriate and when requested. As the NHS CB is a single organisation, whether the response required is at national, regional or local level will be determined on a case-by-case basis but, in all cases, it will be as a single organisation operating under the established principle of subsidiarity.

# FAQs re Public Health England/Local Authority roles

### Q37. What is the provider role of PHE actually going to look like with respect to EPRR?

**A37.** This is a matter for DH EPRR and the PHE Transition Team and has been referred to them.

### Q38. What are the HPA Health Emergency Planning staff going to be doing in the future?

**A38.** This is a matter for DH EPRR and the PHE Transition Team and, as such, it has been referred to them.

### Q39.Who is ensuring that Local Authorities understand that Health emergency planning is different from Local Authority emergency planning and that Health EPRR is different from Public Health EPRR?

**A39.** This is a matter for DH EPRR and the PHE Transition Team and, as such, it has been referred to them.

### Q40. STAC training- what is the future of this and who will deliver this in the future?

**A40.** This will be for DH EPRR Policy Branch to determine but it is envisaged that all such technical advice during an incident will be routed via Public Health England.

# Other FAQs

## Q41. How are national resources, such as radiation monitoring equipment, to be accessed in the future?

**A41.** This is a matter for the relevant DH Policy Branch (Health Protection) and has been referred to them.

## Q42. What is "assurance" going to look like in the future?

**A42.** The transition assurance model has been agreed in principle by the NHS CB and will be published shortly. It is anticipated that future assurance will take the form of assurance pro-formas linked to minimum standards in the published guidance – see also answer to Q27 - and in line with the National Capability Survey (NCS). As these processes are finalised by the NHS CB, more detailed information on future assurance will be published, most likely in the New Year.

## Q43. NHS Organisations are being asked to take part in the National Capability Survey (NCS) this autumn through a time of significant structural change. How will the results of this be used nationally.

**A43**. The National Capability Survey is a Cabinet Office survey undertaken by designated Category 1 and Category 2 responders (CCA 2004) including NHS Organisations. The Department of Health (EPRR and NHS Operations) will review the findings of the 2012 NCS and the implications for the new EPRR system.

## Q44. Do all members of the LHRP require security clearance?

**Answer:** No not all members of the LHRP require security clearance but the Co-Chairs of the LHRP should be cleared to SC (Security Clearance) Level and this should be through the Department of Health Security Vetting Officer or NHS Regional Sponsor and not through external organisations. Where postholders have clearance from an external agency a copy of this will provided to the Regional Lead for EPRR but any security clearance after 1st February be 2013 must be through Department of Health.

# Glossary of EPRR acronyms

| | | |
|---|---|---|
| AEO | - | Accountable Emergency Officer |
| BCP | - | Business Continuity Plan |
| C3 | - | Command, Communications and Coordination |
| C4 | - | Command, Control, Communications and Coordination |
| CB | - | (NHS) Commissioning Board (from 1.4.13) |
| CBA | - | (NHS) Commissioning Board Authority (to 31.3.13) |
| CBRN | - | Chemical, Biological, Radiological and Nuclear |
| CCA | - | Civil Contingencies Act (2004) |
| CCG | - | Clinical Commissioning Group |
| CCM(C) | - | Crisis and Consequence Management (Centre) |
| CMO | - | Chief Medical Officer |
| COBR | - | Cabinet Office Briefing Room |
| COMAH | - | Control of Major Accident Hazards |
| CONOPs | - | Concept of Operations |
| COO | - | Chief Operating Officer |
| CPX | - | Command Post Exercise |
| CQC | - | Care Quality Commission |
| CSU | - | Commissioning Support Unit |
| CT | - | Counter Terrorism |
| DA | - | Devolved Administration |
| DCLG | - | Department for Communities and Local Government |
| DH | - | Department of Health |
| DPH/DsPH | - | Director of Public Health/Directors of Public Health |
| ECOSA | - | Emergency Coordination of Scientific Advice |
| EPRR | - | Emergency Preparedness, Resilience and Response |
| EPL | - | Emergency Preparedness/Planning Lead |
| EPO | - | Emergency Planning Officer |
| EP | - | Emergency preparedness/Emergency planning |
| ERD | - | Emergency Response Department (HPA) |

| | | |
|---|---|---|
| HPA | - | Health Protection Agency |
| HPU | - | Health Protection Unit |
| HWB | - | Health and Well-being Board |
| LA | - | Local Authority |
| LGA | - | Local Government Association |
| LHRP | - | Local Health Resilience Partnership |
| LMC | - | Local Medical Committee |
| LRF | - | Local Resilience Forum |
| MD | - | Medical Director |
| MOU | - | Memorandum of Understanding |
| NHS | - | National Health Service |
| NHSBT | - | NHS Blood and Transplant |
| NHSD | - | NHS Direct |
| NIRP | - | National Incident Response Plan |
| NRA | - | National Risk Assessment |
| NRPA | - | National Risk Planning Assumptions |
| OSC | - | Overview and Scrutiny Committee (LA) |
| PCT | - | Primary Care Trust |
| PHE | - | Public Health England |
| PMO | - | Programme Management Office (NHS CBA) |
| RCCC | - | Regional Civil Contingencies Committee |
| RO | - | Regional Office |
| SAGE | - | Scientific Advice to Government in Emergencies |
| SCG | - | Strategic Coordinating Group (Gold Command) |
| SHA | - | Strategic Health Authority |
| SITREP | - | Situation Report |
| SOP | - | Standard Operating Procedure |
| SofS | - | Secretary of State |
| SRO | - | Senior Responsible Officer |
| STAC | - | Scientific and Technical Advisory Cell |
| TOTO | - | Top of the Office |