NHS England Emergency Preparedness, Resilience and Response Framework

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Contact Details for further information	National EPRR Unit EPRR 4W42 Quarry House Leeds LS2 7UE http://www.england.nhs.uk/ourwork/eprr/

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NHS England Emergency Preparedness, Resilience and Response Framework

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All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the Guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency preparedness, resilience and response in the NHS in England.

The web version of the guidance is available at http://www.england.nhs.uk/ourwork/eprr/

This document will be reviewed annually.

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

1. Purpose of this document 6
2. Who is this document for 6
3. Applicable legislation and guidance 6
4. Background 7
4.1 Aim 7
4.2 Objectives 7
5. Transition and reconfiguration 7
6. Definitions 8
6.1 Emergency Preparedness 8
6.2 Resilience 8
6.3 Response 8
6.4 Emergency 8
6.5 Incident 8
6.5.1 Business Continuity Incident 8
6.5.2 Critical Incident 9
6.5.3 Major Incident 9
7. Incident levels 9
7.1 Types of incident 10
8 Statutory requirements & underpinning principles of EPRR 10
8.1 Statutory requirements under the CCA 2004 10
8.2 Statutory requirements applicable within the NHS Act 2006 (as amended) 11
8.3 Underpinning principles for NHS EPRR 13
8.4 Planning structures 13
8.5 NHS England Core Standards for EPRR and NHS Standard Contract(s) 15
8.6 Cooperation between local responders 15
8.7 Mutual aid 15
8.8 Information sharing 15
8.9 Legal framework, public inquiries, Coroners inquests and civil action 16
8.9.1 Logging and record keeping 16
9 Roles and responsibilities 16
9.1 Accountable Emergency Officers(AEOs) 17
9.2 Providers of NHS funded services 18
9.2.1 NHS ambulance services: Ambulance Tactical Advisor 18
9.2.2 Mental health and learning disability secure services 18
9.3 CCGs 19
9.4 Local Health Resilience Partnerships (LHRPs) 19
9.5 NHS England 20
9.5.1 NHS England regions 20
9.5.2 NHS England national 21
9.6 The Department of Health (DH) 21
9.7 Public Health England (PHE) 22
9.7.1 PHE local (Public Health England centres and locally delivered PHE services) 22
9.7.2 PHE regional 22
9.7.3 PHE national 22
9.8 Department of Communities & Local Government 22

9.9 Cabinet Office and Cabinet Office briefing rooms 23
10. Cycle of preparedness 23
10.1 Risk management 23
10.2 Planning 23
10.3 Training 24
10.4 Exercising 24
10.4.1 Communications exercise 24
10.4.2 Table top exercise 25
10.4.3 Live play exercise 25
10.4.4 Command post exercise 25
10.4.5 Lessons identified 25
11 Organisational resilience 26
12 Incident response 26
12.1 Alerting mechanism to be used in the event of an incident 27
12.2 Standard alerting messages 27
12.3 METHANE 28
12.4 Critical Incident 29
12.5 Internal and external communications 29
12.6 Escalation and de-escalation 30
12.7 Staff welfare 30
12.8 On-call staff 30
13 Concepts of command and control 31
13.1 Operational 31
13.2 Tactical 31
13.3 Strategic 32
14 NHS command and control 33
14.1 The NHS in England 33
14.2 NHS England regions 33
14.3 NHS England national 33
14.4 Incident coordination 33
14.5 Incident Coordination Centre 34
14.6 ICC functions 34
14.7 Decision making 34
14.8 Organisational ICC requirements 34
15 Recovery 35
15.1 Debriefing 35
16 Assurance 36
17 Freedom of Information 36
18 Equality and health inequalities analysis 36
19 Acronyms 37
Appendix One: Escalation and de-escalation 38

1. Purpose of this document

The purpose of this document is to provide the framework for all NHS funded organisations in England to help with meeting the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012 (NHS Act 2006 (as amended)) and the NHS Standard Contract. In essence, this document seeks to describe how the NHS in England will go about its duty to be properly prepared for dealing with emergencies.

It supersedes the following documents:

- Previous versions of this document
- NHS England Command and Control Framework for the NHS during significant incidents and emergencies
- NHS England The Role of Accountable Emergency Officers
- NHS England Model Job Description and Competencies for Emergency Preparedness Officers in NHS Provider Organisations

2. Who is this document for

This framework contains principles for effective emergency preparedness, resilience and response (EPRR).

It is strategic national guidance for all NHS funded organisations in England including:

a) NHS trusts and foundation trusts
b) Primary and community care organisations
c) Providers of NHS funded services
   The term ‘provider of NHS funded services’ includes any independent or third sectors that are contracted for health service provision across the health economy, as defined in the NHS Act 2006 (as amended) and the NHS Standard Contract General Conditions
d) Commissioning organisations including NHS England, clinical commissioning groups (CCGs) and organisations providing support to CCGs
e) NHS Property Services
f) NHS Supply Chain
g) NHS Blood and Transplant

All Accountable Emergency Officers (AEOs) and EPRR practitioners must be familiar with the principles of EPRR and be competent and confident of their roles and responsibilities in planning for and responding to incidents and emergencies.

3. Applicable legislation and guidance

This document should be read in the context of:

a) The CCA 2004 and associated Cabinet Office Guidance
b) The NHS Act 2006 (as amended)

c) The NHS Constitution
d) The requirements for EPRR as set out in the NHS Standard Contract(s)
e) NHS England EPRR guidance and supporting materials including:
   - NHS England Core Standards for Emergency Preparedness, Resilience and Response
   - NHS England Business Continuity Management Framework (service resilience)
   - Other guidance available at http://www.england.nhs.uk/ourwork/eprr/
f) National Occupational Standards for Civil Contingencies
g) BS ISO 22301 Societal security – Business continuity management systems

4. Background

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 or a terrorist act. This is underpinned by legislation contained in the CCA 2004 and the NHS Act 2006 (as amended).

This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

4.1 Aim

To enable the NHS in England to ensure effective arrangements are in place to deliver appropriate care to patients affected during an emergency (as defined by the CCA 2004) or incident.

4.2 Objectives

- To prepare for the common consequences of emergencies rather than for every individual emergency scenario
- To have flexible arrangements for responding to emergencies, which can be scalable and adaptable to work in a wide-range of specific scenarios
- To supplement this with specific planning and capability building for the most concerning risks in the National Risk Register (NRR)
- To ensure that plans are in place to recover from incidents and to provide appropriate support to affected communities

Governance for EPRR may be best achieved through the linkage of EPRR and Business Continuity to the organisation's Risk Management Framework. The identification and management of risks must be linked to the Community Risk Register (CRR) and the NRR, as appropriate.

5. Transition and reconfiguration

Commissioners and providers must give due consideration to potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and/or respond to an emergency. As a minimum there should be a formal modelling exercise to identify any

potential impact and clear evidence of mitigating actions planned or undertaken to ensure effective EPRR is maintained.

6. Definitions

6.1 Emergency Preparedness

The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.

6.2 Resilience

Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.

6.3 Response

Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders.

6.4 Emergency

Under Section 1 of the CCA 2004 an “emergency” means

“(a) *an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;*
(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;
(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom”.

6.5 Incident

For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

6.5.1 Business Continuity Incident

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation’s normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

6.5.2 Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

6.5.3 Major Incident

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency as in section 6.4.

7. Incident levels

As an event evolves it may be described in terms of its level as shown. For clarity these levels must be used by all organisations across the NHS when referring to incidents.

Incident level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

7.1 Types of incident

The following list provides commonly used classifications of types of incident. This list is not exhaustive and other classifications may be used as appropriate. The nature and scale of an incident will determine the appropriate Incident Level.

- **Business continuity/internal incidents** – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime
- **Big bang** – a serious transport accident, explosion, or series of smaller incidents
- **Rising tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action
- **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action
- **Headline news** – public or media alarm about an impending situation, reputation management issues
- **Chemical, biological, radiological, nuclear and explosives (CBRNE)** – CBRNE terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent
- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials
- **Cyber attacks** – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality
- **Mass casualty** – typically events with casualties in the 100s where the normal major incident response must be augmented with extraordinary measures

8 Statutory requirements & underpinning principles of EPRR

Under the NHS Constitution the NHS is there to help the public when they need it most, this is especially true during an incident or emergency. Extensive evidence shows that good planning and preparation for any incident saves lives and expedites recovery.

All NHS funded services must therefore ensure they have robust and well tested arrangements in place to respond to and recover from these situations.

8.1 Statutory requirements under the CCA 2004

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies).

Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency

- share information with other local responders to enhance co-ordination
- cooperate with other local responders to enhance co-ordination and efficiency

Category 1 responders for health are:

- Department of Health (DH) on behalf of Secretary of State for Health (SofS)
- NHS England
- Acute service providers
- Ambulance service providers
- Public Health England (PHE)
- Local authorities (Inc. Directors of Public Health (DsPH))

Category 2 responders are critical players in EPRR who are expected to work closely with partners. They are required to cooperate with and support other Category 1 and Category 2 responders. They are less likely to be involved in the heart of planning work, but will be heavily involved in incidents that affect their own sector. Category 2 responders have a lesser set of duties - co-operating and sharing relevant information with other Category 1 and 2 responders.

Category 2 responders for health are:

- CCGs

CCGs are expected to provide support to NHS England in relation to the coordination of their local health economy.

Primary care, including out of hours providers, community providers, mental health service providers, specialist providers, NHS Property Services and other NHS organisations (for example NHS Blood &Transplant, NHS Supply Chain and NHS 111) are not listed in the CCA 2004. However, DH and NHS England guidance expects them to plan for and respond to emergencies and incidents in a manner which is relevant, necessary and proportionate to the scale and services provided.

NHS England will represent the NHS at the Local Resilience Forum (LRF); NHS ambulance service providers will also be present as an emergency service.

NHS funded organisations can find specific Cabinet Office content on the CCA at https://www.gov.uk/guidance/preparation-and-planning-for-emergencies-responsibilities-of-responder-agencies-and-others.

It is essential that commissioners and providers ensure they have effective, coordinated structures in place to adequately plan, prepare and rehearse the tactical and operational response arrangements with their local partners.

8.2 Statutory requirements applicable within the NHS Act 2006 (as amended)

The NHS Act 2006 (as amended) requires NHS England to ensure that the NHS is properly prepared to deal with an emergency. CCGs, as local system leaders, should assure

themselves that their commissioned providers are compliant with relevant guidance and standards and they are ready to assist NHS England in coordinating the NHS response.

The key elements are contained in Section 252A of the NHS act 2006 (as amended) and are:

a) NHS England and each CCG must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency
b) NHS England must take steps as it considers appropriate for securing that each CCG and each relevant service provider is properly prepared for dealing with a relevant emergency
c) The steps taken by NHS England must include monitoring compliance by each CCG and service provider; and
d) NHS England must take such steps as it considers appropriate for facilitating a coordinated response to an emergency by the CCGs and relevant service providers for which it is a relevant emergency.

A “relevant emergency” is defined as:

- In relation to NHS England or a CCG: any emergency which might affect NHS England or the CCG (whether by increasing the need for the services that it may arrange or in any other way);
- In relation to a relevant service provider: any emergency which might affect the provider (whether by increasing the need for the services that it may provide or in any other way).

In the context of this framework a relevant emergency is any incident defined under sections six and seven.

A “relevant service provider” is defined as:

- Any body or person providing services in pursuance of service arrangements.

“Service arrangements” in relation to a relevant service provider are defined as:

- Arrangements made by NHS England or a CCG under or by virtue of section 3, 3A, 3B, 4 or 7A or Schedule 1.

These elements clearly establish the relationship between NHS England and CCGs. In essence NHS England would seek to work with and through the local CCGs to ensure the NHS response can be effectively managed at strategic and tactical levels delivering the service-wide aim and objectives.

The NHS in England will also have in place strategic forums for joint planning for health incidents: Local Health Resilience Partnerships (LHRP). These partnerships will support the health sector’s contribution to multi-agency planning through the LRF.

In addition under Section 253, directions may also be given to NHS bodies by the SofS in relation to an emergency.

8.3 Underpinning principles for NHS EPRR

a) **Preparedness and Anticipation** – the NHS needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.

b) **Continuity** – the response to incidents should be grounded within organisations' existing functions and their familiar ways of working – although inevitably, actions will need to be carried out at greater pace, on a larger scale and in more testing circumstances during response to an incident.

c) **Subsidiarity** – decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Local responders should be the building block of response for an incident of any scale.

d) **Communication** – good two way communications are critical to an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public

e) **Cooperation and Integration** – positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response. Active mutual aid across organisational, within the UK and international boundaries as appropriate (see section 8.7)

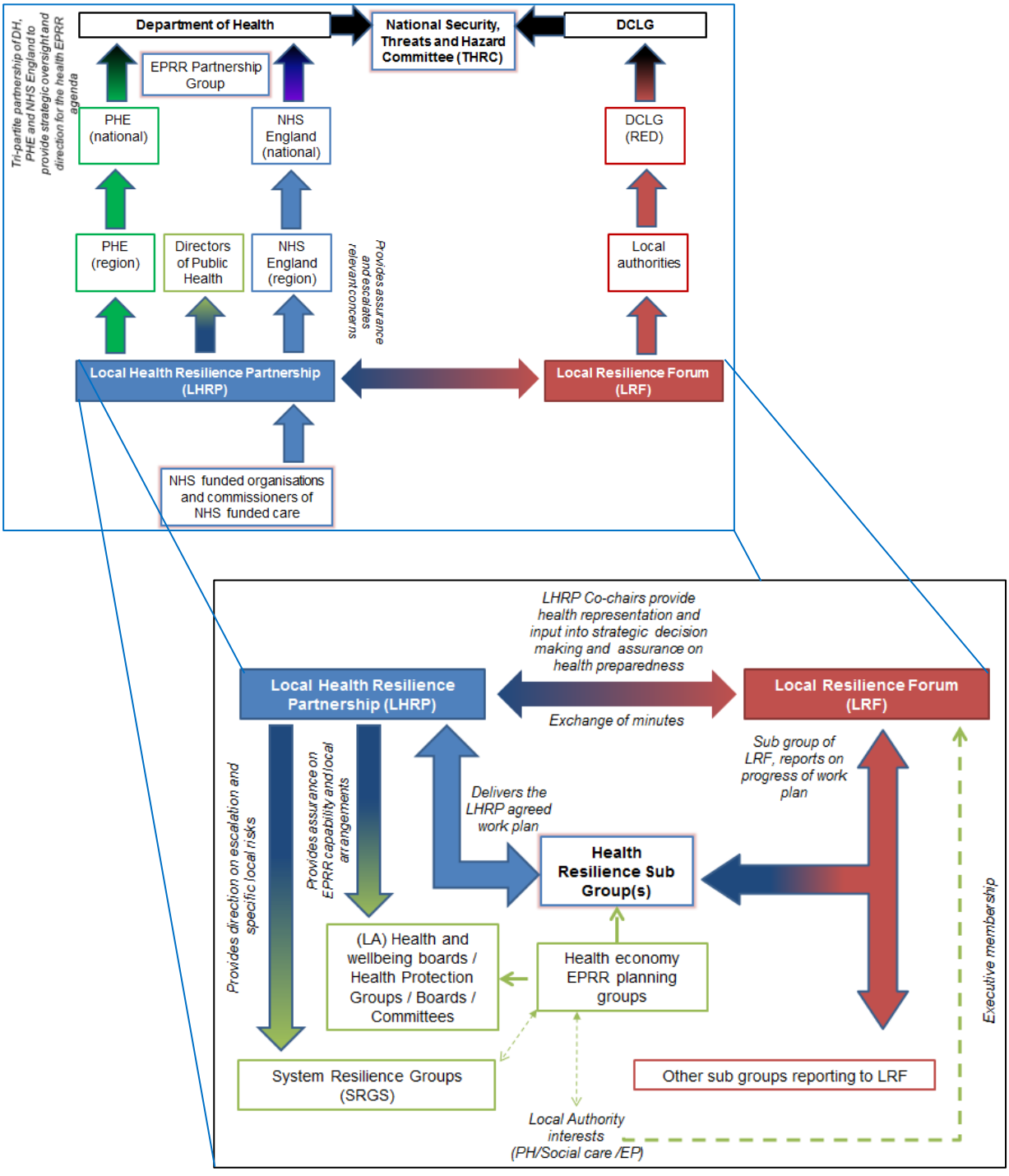
f) **Direction** – clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident in order to effectively prioritise and focus the response. A strong capacity in NHS England to oversee the health service working.

The underpinning principles apply to all commissioners and providers of NHS funded services.

8.4 Planning structures

Figure one shows the EPRR planning structure for the NHS in England and its interaction with key partner organisations

Figure One: **EPRR planning structure for the NHS in England**
Source: NHS England, Yorkshire & Humber.



Health resilience sub-groups may exist at LHRP level and also at a local health economy level to undertake strategic and tactical EPRR work.

8.5 NHS England Core Standards for EPRR and NHS Standard Contract(s)

The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the current NHS England Core Standards for EPRR (Core Standards). These standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended).

The NHS Standard Contract Service Conditions require providers to comply with EPRR Guidance. Therefore commissioners must ensure providers are compliant with the requirements of the Core Standards as part of the annual national assurance process (see section 15).

NHS England will ensure that commissioners are compliant with the requirements of the Core Standards as part of the annual CCG assurance framework.

8.6 Cooperation between local responders

Under the CCA 2004, cooperation between local responder bodies is a legal duty.

It is important that the planning for incidents is coordinated within individual NHS organisations, between health organisations and at a multi-agency level with partner organisations. NHS England will undertake the coordination role for health services at the LRF level and will work with CCGs to coordinate across local health economies.

The Local Health Resilience Partnership (LHRP) and the health economy EPRR planning groups facilitate this work.

8.7 Mutual aid

Successful response to incidents has demonstrated that joint working can resolve very difficult problems that fall across organisational boundaries.

Mutual aid arrangements should exist between NHS funded organisations and also their partner organisations and these should be regularly reviewed and updated.

Clinical networks will retain a key role in coordinating their specialist capacity.

8.8 Information sharing

Under the CCA 2004 responders have a duty to share information with partner organisations. This is seen as a crucial element of civil protection work, underpinning all forms of cooperation.

NHS services should formally consider the information that will be required to plan for, and respond to, an emergency. They should determine what information can be made available in the context of the CCA 2004. The organisation's Information Governance policies and procedures should cover the requirements of EPRR.

Further guidance can be obtained from the *Data Protection and Sharing Guidance for Emergency Planners and Responders* here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60970/dataprotection.pdf.

8.9 Legal framework, public inquiries, Coroners inquests and civil action

The day to day management of people and patients in the NHS is subject to legal frameworks, duty of care, candour and moral obligation. This does not change when responding to an incident however these events can lead to greater public and legal scrutiny.

8.9.1 Logging and record keeping

NHS funded organisations must have appropriately trained and competent loggists to support the management of an incident. Loggists are an integral part in any incident management team. It is essential that all those tasked with logging do so to best practice standards and understand the importance of logs in the decision making process, in evaluation and identifying lessons and as evidence for any subsequent inquiries. Following an incident a number of internal investigations or legal challenges may be made. These may include Coroners inquests, public inquiries, criminal investigations and civil action.

When planning for and responding to an incident it is essential that any decisions made or 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 documentation, therefore robust and auditable systems for documentation and decision making must be maintained. The organisation's Document Retention policies and procedures should cover the requirements of EPRR.

9 Roles and responsibilities

This section outlines the EPRR roles and responsibilities of:

a) Accountable Emergency Officers
b) Providers of NHS funded services
    a. NHS Ambulance Services
    b. Mental Health and Learning Disability Secure Services
c) Clinical commissioning groups
d) Local Health Resilience Partnerships
e) NHS England
f) Department of Health
g) Public Health England
h) Department of Communities & Local Government (DCLG)

9.1 Accountable Emergency Officers(AEOs)

This section defines the role of AEOs for EPRR.

The NHS Act 2006 (as amended) places a duty on relevant service providers to appoint an individual to be responsible for discharging their duties under section 252A. This individual is known as the AEO.

NHS England expects all NHS funded organisations to have an AEO with regard to EPRR. Chief executives 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 will be able to delegate this responsibility to a named director, the AEO.

The AEO will be a Board level director responsible for EPRR. They will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the Board that strategies, systems, training, policies and procedures are in place to ensure an appropriate response for their organisation in the event of an incident.

AEOs will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response.

The AEO will be supported by a non-executive director or other appropriate Board member to endorse assurance to the Board that the organisation is meeting its obligations with respect to EPRR and relevant statutory duties under the CCA 2004 and the NHS Act 2006 (as amended). This will include assurance that the organisation has allocated sufficient experienced and qualified resource to meet these requirements.

Specifically the AEO will be responsible for:

- Ensuring that the organisation, and any sub-contractors, is compliant with the EPRR requirements as set out in the CCA 2004, the NHS Act 2006 (as amended) and the NHS Standard Contract, including the NHS England Emergency Preparedness, Resilience and Response Framework and the NHS England Core Standards for EPRR
- Ensuring that the organisation is properly prepared and resourced for dealing with an incident
- Ensuring that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this
- Ensuring that the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and partner organisations in the local area served
- Ensuring that the organisation complies with any requirements of NHS England, or agents of NHS England, in respect of monitoring compliance
- Providing NHS England with such information as it may require for the purpose of discharging its functions

- Ensuring that the organisation is appropriately represented by director level engagement with, and effectively contributes to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate

9.2 Providers of NHS funded services

Providers of NHS funded services are to:

- Support CCGs and NHS England, within their health economies, in discharging their EPRR functions and duties, locally and regionally, under the CCA 2004
- Have robust and effective structures in place to adequately plan, prepare and exercise the tactical and operational response arrangements both internally and with their local healthcare partners
- Ensure business continuity plans mitigate the impact of any emergency, so far as is reasonably practicable
- Ensure robust 24/7 communication “cascade and escalation” policies and procedures are in place, to inform CCGs and healthcare partners, as appropriate, of any incident impacting on service delivery
- Ensure that recovery planning is an integral part of its EPRR function
- Provide assurance that organisations are delivering their contractual obligations with respect to EPRR
- Ensure organisational planning and preparedness is based on current risk registers
- Provide appropriate director level representation at LHRP(s) and appropriate tactical and/or operational representation at local health economy planning groups in support of EPRR requirements

In addition to the general requirements under this framework the following specific requirements apply:

9.2.1 NHS ambulance services: Ambulance Tactical Advisor

- The ambulance service will ensure the provision of on-call ambulance tactical advisors who are subject matter experts, appropriately equipped and competent to give appropriate advice to the ambulance tactical commander and, if necessary, the ambulance strategic commander. Tactical advisors can also be called upon to give advice to ambulance staff and managers in support of risk assessing and responding to unusual incidents.
- This may require the ambulance tactical advisor to attend the scene of the incident or emergency, a tactical coordinating group (TCG) or a strategic coordinating group (SCG).

9.2.2 Mental health and learning disability secure services

- Providers of these services must have in place evacuation plans which provide for relocation of service users to alternative secure premises in the event of any incident and how that relocation is to be effected in such a way as to maintain public safety and confidence.

9.3 CCGs

The EPRR role and responsibilities of CCGs are to:

- Ensure contracts with all commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity
- Monitor compliance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable Core Standards
- Ensure robust escalation procedures are in place so that if a commissioned provider has an incident the provider can inform the CCG 24/7
- Ensure effective processes are in place for the CCG to properly prepare for and rehearse incident response arrangements with local partners and providers
- Be represented at the LHRP, either on their own behalf or through a nominated lead CCG representative
- Provide a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness
- Support NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents (Alert Level 2-4)
- Fulfil the duties of a Category 2 responder under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 (as amended).

9.4 Local Health Resilience Partnerships (LHRPs)

LHRPs provide strategic forums for joint EPRR planning across a geographic area and support the health sector's contribution to multi-agency planning through the LRF. These forums will be co-chaired by NHS England and local lead director of public health (DPH).

- LRFs lead the multi-agency planning for any incident. LHRPs coordinate EPRR across their operational area and provide health input into LRFs.
- LHRPs will ensure coordinated strategic planning for incidents impacting on health or continuity of patient services and effective engagement across LHRP and local health economies.
- The DPH co-chair will have a specific responsibility to provide public health expertise and coordinate public health input.
- The NHS England co-chair will provide local leadership on EPRR matters to all providers of NHS funded services and maintain engagement with CCGs to ensure resilience is commissioned effectively, reflecting local risks.
- The LHRP should consider, and contribute to, the CRR developed by the LRF. These assessments should inform the planning and strategy set by the LHRP

The LHRP will coordinate health input to NHS England, PHE and local government in ensuring that member organisations develop and maintain effective health planning arrangements for incidents. Specifically they must ensure:

- That the arrangements reflect strategic leadership roles, ensuring robust service and local health economy response at the tactical level to incidents
- Coordination and leadership across health organisations within local health economies is in place
- That there is opportunity for coordinated training & exercising

- That the health sector is integrated into appropriate wider EPRR plans and structures of civil resilience partner organisations with in the LRF area(s) covered by the LHRP

Accountability

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

Membership

- Members of LHRPs 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.
- Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.

Working groups

- Due to the strategic nature of the LHRP the co-chairs will determine the need for any specific working groups and/or local health economy sub-groups to reflect locally identified risks and to ensure effective tactical and operational planning/response arrangements.
- 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 LRF sub-groups and LHRPs to avoid any duplication.

Further information on the work of the LRFhttps://www.gov.uk/local-resilience-forums-contact-details

9.5 NHS England

The generic EPRR role and responsibilities of NHS England are:

- To set a risk based EPRR strategy for the NHS
- To ensure there is a comprehensive NHS EPRR system and assure itself and DH that the system is fit for purpose
- Lead the mobilisation of the NHS in the event of an emergency
- Work together with PHE and DH, where appropriate, to develop joint response arrangements
- Undertake its responsibilities as a Category 1 responder under the CCA 2004

9.5.1 NHS England regions

At a regional level NHS England will:

- Ensure that each LHRP and LRF has director level representation
- Ensure integration of plans across the region to deliver a unified NHS response to incidents, including ensuring the provision of surge capacity
- Maintain capacity and capability to coordinate the regional NHS response to an incident 24/7
- Work with relevant partners through the LHRP & LRF structures
- Seek assurance through the local LHRP and commissioners that the Core Standards are met and that each local health economy can effectively respond to and recover from incidents
- Discharge the local NHS England EPRR duties as a Category 1 responder under the CCA 2004

9.5.2 NHS England national

At a national level NHS England will:

- Support the AEO to discharge EPRR duties
- Participate in national multi-agency planning processes including risk assessment, exercising and assurance
- Provide leadership and coordination to the NHS and national information on behalf of the NHS during periods of national incidents
- Provide assurance to DH of the ability of the NHS to respond to incidents including assurance of capacity and capability to meet National Risk Assessment (NRA) requirements as they affect the health service
- Provide support to DH in their role to UK central government response to emergencies
- Action any requests from NHS organisations for military assistance

9.6 The Department of Health (DH)

The EPRR role of DH is to:

- Identify EPRR policy requirements for the health sector and communicate these, as appropriate, to NHS England, PHE and other relevant organisations
- Provide assurance to ministers, the 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 NRA
- As the lead government department for health, ensure that plans are in place for identified risks to health in the NRA
- Ensure the coordination of the whole system response to high-end risks impacting on public health, the NHS and the wider healthcare system
- Support the UK central government response to emergencies including ministerial support and briefing, informed by data and reports provided by NHS England and PHE
- Take other action as required on behalf of the SofS to ensure a national emergency is appropriately managed
- Work with devolved administrations and internationally for planning and responding to relevant emergencies

9.7 Public Health England (PHE)

9.7.1 PHE local (Public Health England centres and locally delivered PHE services)

At a local level PHE will:

- Ensure that PHE has plans for emergencies in place across the local area
- Support the LHRPs, coordinating with local government partners
- Provide assurance of the ability of PHE to respond in emergencies
- Provide a representative to the LHRP, as required, and to represent PHE on the LRF

9.7.2 PHE regional

At a regional level PHE will:

- Ensure the delivery of the national EPRR strategy across their region
- Provide strategic EPRR advice and support to PHE centres
- Ensure integration of PHE emergency plans to deliver a unified public health response across more than one LHRP
- Maintain PHE's capacity and capability to coordinate regional public health responses to emergencies 24/7

9.7.3 PHE national

At a national level PHE will:

- Ensure there is a comprehensive EPRR system that operates for public health at all levels and provides assurance that the system is fit for purpose
- Work together with the NHS at all levels and where appropriate develop joint response plans
- Provide specialist expert public health services and input to national and local planning for emergencies
- Undertake at all levels, its responsibilities on behalf of SoS as a Category 1 responder.

9.8 Department of Communities & Local Government

The Department of Communities and Local Government (DCLG) provides the platform for multi-LRF co-operation and planning in emergency preparedness. The function of the sub-national tier is to improve co-ordination and communication between central government and local responders, and other organisations. DCLG should ensure that areas are prepared to respond to events which would affect most or all of the area or which could overwhelm any locality.

DCLG Resilience & Emergencies Division (RED) works directly with LRFs, supporting collaboration and co-operation in planning for wide-area high-impact events affecting more than one locality. RED would provide the Government Liaison Officer in a response where appropriate to facilitate this communication function.

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 Multi-SCG

Response Coordinating Group (ResCG) in order to bring together appropriate representatives from local SCG.

9.9 Cabinet Office and Cabinet Office briefing rooms

The general role of the Cabinet Office is to make government work better. As part of its on-going work the Cabinet Office engages with central, local and regional partners to prepare for emergencies and to coordinate the central government response to major disruptive challenges, including:

- maintaining in a state of readiness in all the central crisis management facilities; and
- deciding whether, when and where the central response mechanism should be activated.

The UK central Government response to an emergency is underpinned through the use of the Cabinet Office briefing rooms (COBR) which is the physical location from which the central response is activated, monitored and coordinated. Ministers and senior officials, as appropriate, from relevant UK government departments and agencies along with representatives from other organisations, as necessary, are brought together in COBR to ensure a shared situational awareness and to facilitate effective and timely decision making.

10. Cycle of preparedness

10.1 Risk management

Risk management is covered within the CCA 2004 and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.

Within each LRF NHS funded organisations have responsibility in the context of multi-agency planning to contribute to the CRR. NHS funded organisations will therefore need to undertake risk assessment exercises appropriate to their facilities and services.

Risk assessment undertaken at a regional or national level should be informed by local risk assessments.

An agreed methodology for risk assessment is available on the Cabinet Office website: https://www.gov.uk/risk-assessment-how-the-risk-of-emergencies-in-the-uk-is-assessed

10.2 Planning

Incident response plans (IRPs) should contain a framework for response. There should be sufficient background information so that responders can make informed decisions. They should include a command and control framework to manage the response and sufficient operational procedures to enable responders to manage an incident.

NHS ambulance services should also refer to the *National Ambulance Service Guidance for Preparing an Emergency Plan* published by the National Ambulance Resilience Unit (NARU) http://naru.org.uk/wp-content/uploads/2013/02/NARU-AACE-PEP-GUIDANCE-v8Fas.pdf.

10.3 Training

Training staff that have a response role for incidents is of fundamental importance. NHS organisations are familiar to responding to routine everyday challenges by following usual business practices, yet very few respond to incidents on a frequent basis. If staff are to respond to an incident in a safe and effective manner they require the tools and skills to do so in line with their assigned role.

Training should be focussed on the specific roles and requirements assigned to the individual, aligned to a Training Needs Analysis (TNA) and ensure training objectives and outcomes are met and recorded. In addition to covering all aspects of the response role, training should also highlight wider organisational and multi-agency response structures, as appropriate to the role.

Standards for NHS incident training are contained within the Skills for Justice National Occupational Standards (NOS) framework and should be referred to when identifying staff training needs; please see http://nos.ukces.org.uk/Pages/results.aspx?u=http%3A%2F%2Fnos%2Eukces%2Eorg%2Euk&k=civil%20contingencies.

Training needs to be an on-going process to ensure skills are maintained; it is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning.

10.4 Exercising

Plans developed to allow organisations to respond efficiently and effectively must be tested regularly using a variety of processes, such as table top and live play exercises. Roles within the plan, not individuals, are exercised to ensure they are fit for purpose and encapsulate all necessary functions and actions to be carried out in an incident. The outcome (log) of testing and exercising must identify and record whether it worked and what needs changing. The log must also identify what has changed. This information provides an audit tool that lessons have been identified and action taken and is key evidence during any inquiry process.

Through the exercising process individuals have the opportunity to practice their skills and increase their confidence, knowledge and skill base in preparation for responding in a live incident.
Organisations should consider exercising with partner agencies and contracted services where the identified risks and the involvement of partner organisations is appropriate.
Learning from exercises must be cultivated into developing a method that supports personal and organisational goals and is part of an annual plan validation and maintenance programme.

Each NHS funded organisation is required to undertake the following:

10.4.1 Communications exercise

Minimum frequency – every six months

These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They should include testing telephone, email, paging and

other communications methods in use. The communications exercise should be conducted both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced.

10.4.2 Table top exercise

Minimum frequency – every 12 months

The table top exercise brings together relevant staff, and partners as required, to discuss the response, or specific element of a response, to an incident. They work through a particular scenario and can provide validation to a new or revised plan. Participants are able to interact and gain knowledge of their own, and partner organisations' roles and responsibilities.

10.4.3 Live play exercise

Minimum frequency – every three years

The live play exercise is a live test of arrangements and includes the operational and practical elements of an incident response. For example simulated casualties being brought to an emergency department or the setting up of a mass countermeasure centre, hostage situation or mass evacuation.

If an organisation activates its plan for response to a live incident this replaces the need to run an exercise, providing lessons are identified and logged and an action plan developed.

Under interoperability there is an expectation that NHS funded organisations will actively participate with exercises run by multi-agency partners, including the LRF, where relevant to health.

10.4.4 Command post exercise

Minimum frequency – every 3 years

The command post exercise (CPX) tests the operational element of command and control and requires the setting up of the Incident Coordination Centre (ICC). It provides a practical test of equipment, facilities and processes and provides familiarity to those undertaking roles within the ICC. It can be incorporated into other types of exercise, such as the communications exercise or live play exercises.

In conjunction with local CPXs NHS funded organisations should also test their links with their multi-agency partners to test communication arrangements and information flows.

If an organisation activates their ICC in response to a live incident this replaces the need to run an exercise, providing lessons are identified and logged and an action plan developed.

The functionality of equipment in an ICC should be tested as a minimum of every three months

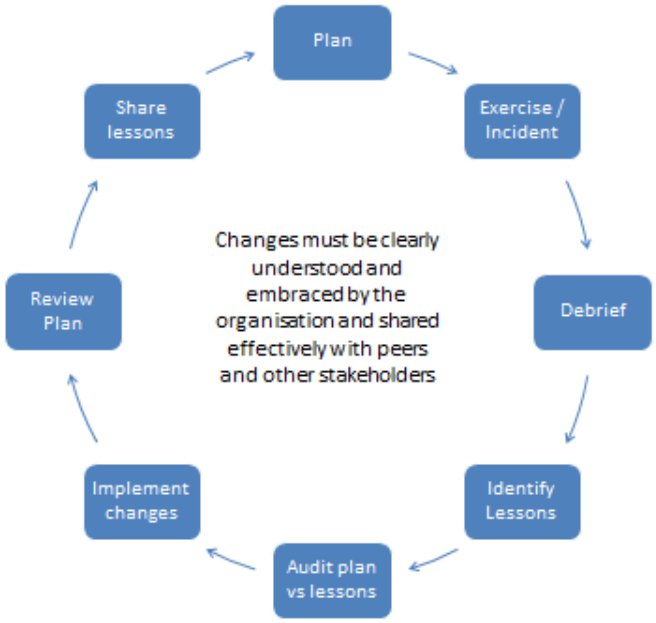
10.4.5 Lessons identified

NHS funded organisations are required to share information of lessons identified through exercising or incident response across the wider NHS through a common process

coordinated through the LHRP. Relevant information must also be shared with partner organisations. Working collaboratively will improve organisational cohesion and ensure patients and the public are safeguarded during an incident.

The national business continuity guidance offers a useful model for a learning cycle that can be adopted for EPRR purposes.

Figure Two**: The learning cycle**



(Adapted from Chapter 6 (Business Continuity Management) of *Emergency Preparedness*, Revised Version)

11 Organisational resilience

Business continuity management (BCM) is an essential tool in establishing an organisation's resilience to maintain their business prioritised activities. BCM gives organisations a framework for identifying and managing risks that could disrupt normal services.

While 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 the incident response plan. It is critical that both plans are integrated and complementary of each other and there is early recognition of the resource implications.

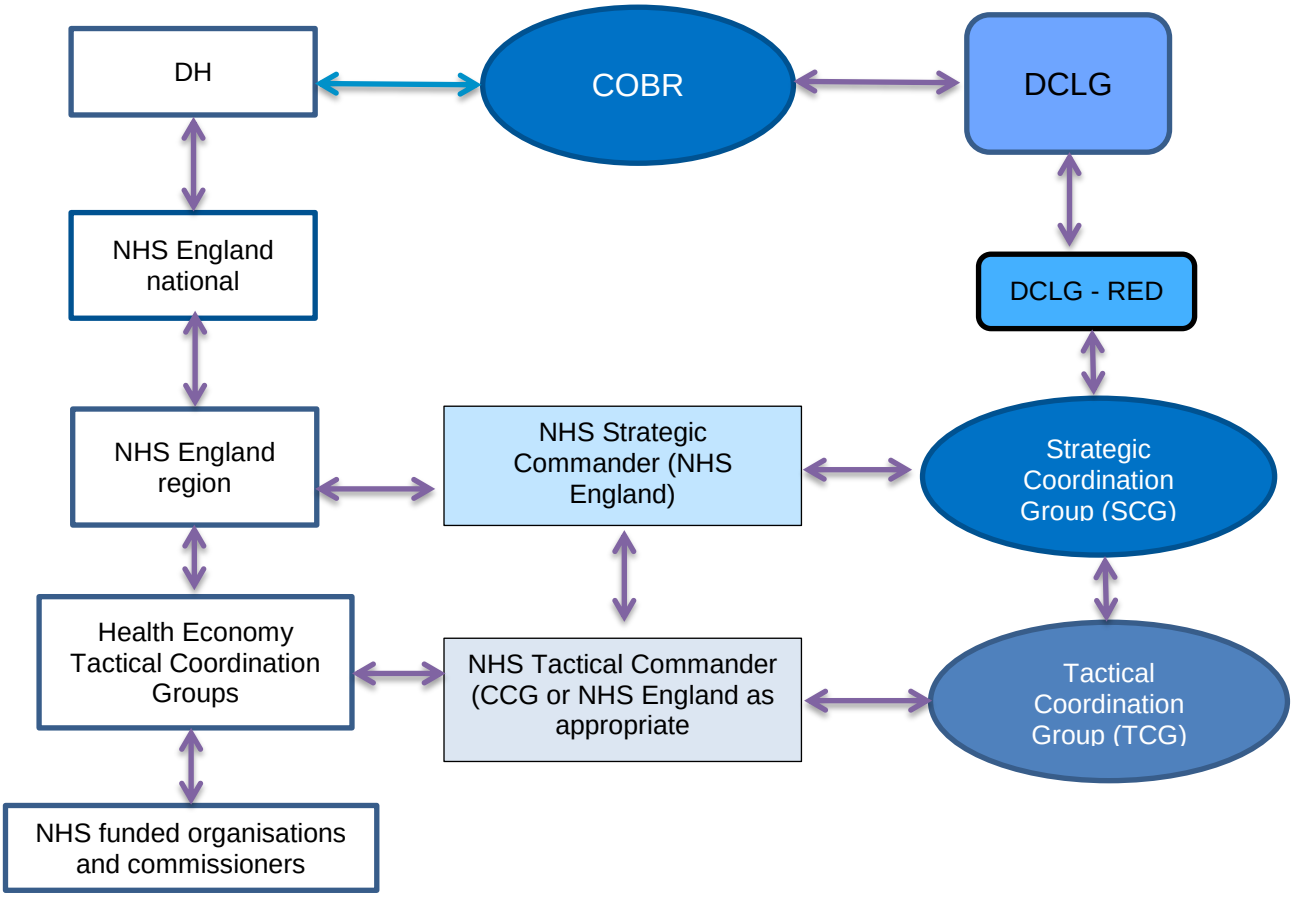
Detailed information on business continuity management is available in the NHS England Business Continuity Management Framework: http://www.england.nhs.uk/ourwork/eprr/

12 Incident response

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

Figure three shows the NHS England EPRR response structure and its interaction with key partner organisations

Figure three**: EPRR response structure for the NHS in England**



12.1 Alerting mechanism to be used in the event of an incident

While emergencies are often triggered by 'big bang' events and alerts are cascaded by NHS ambulance services there are other potential circumstances where an NHS incident occurs, for example infectious disease outbreaks. In such cases the ambulance service may or may not be involved and may not be the alerting mechanism for the health sector.

In the event of such an incident the communication cascade mechanism should be via local commissioners who should ensure they also alert the NHS England regional team. In some instances such alerts may also come directly from NHS England.

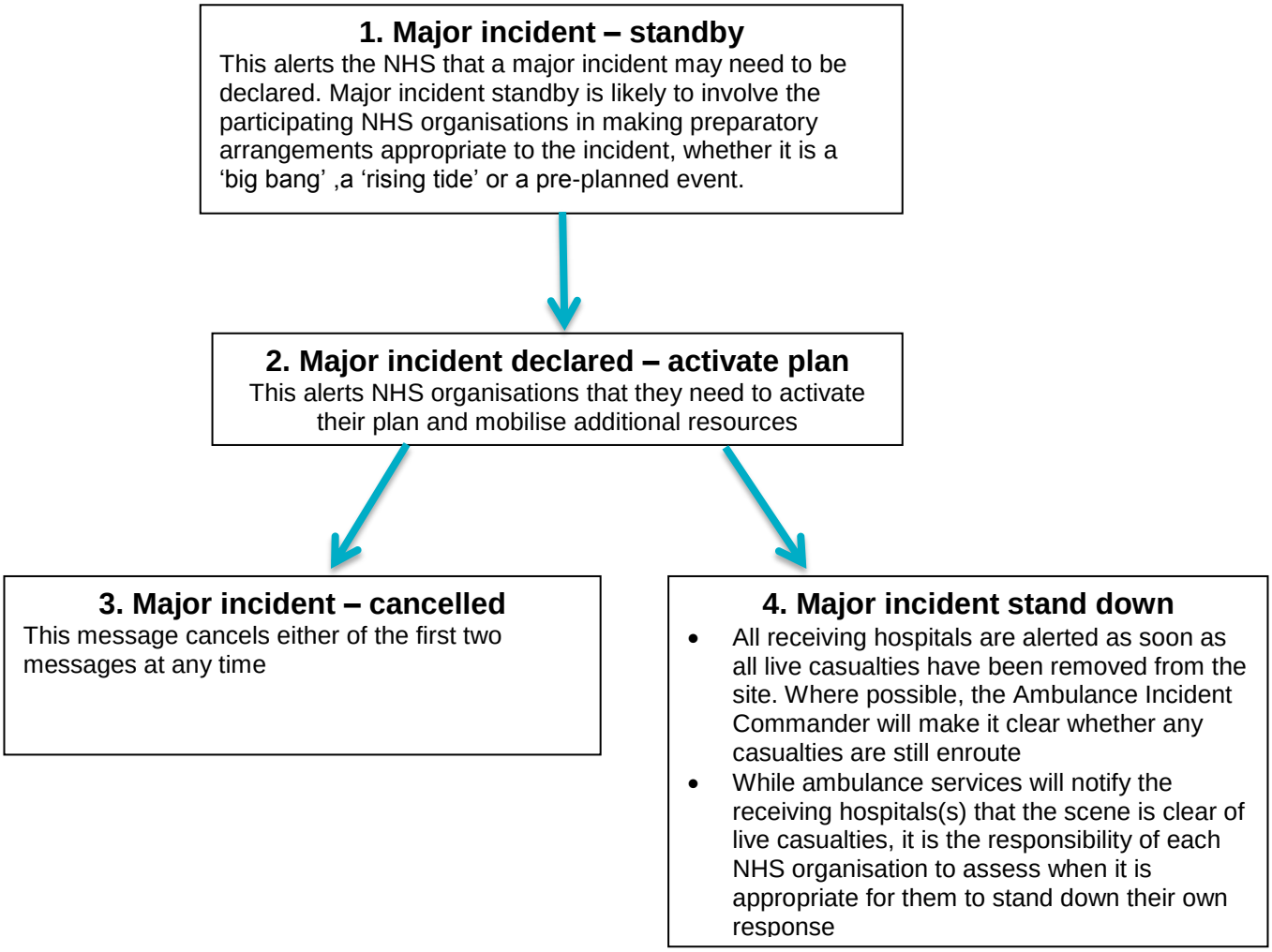
NHS England will assist CCGs in implementing command and control mechanisms and the deployment of appropriate NHS resources should the response extend beyond the operational area of a single CCG.

Health services should use standard alerting messages at all times.

12.2 Standard alerting messages

To avoid confusion about when to implement plans it is essential to use standard messages.

Standard messages



12.3 METHANE

The Joint Emergency Services Interoperability Principles (JESIP) identifies METHANE as the preferred model to share information to promote a shared situational awareness.

Major incident declared?
Exact location
Type of incident
Hazards present or suspected
Access - routes that are safe to use
Number, type, severity of casualties
Emergency services present and those required

(source JESIP, 2015)

12.4 Critical Incident

Any organisation declaring a critical incident should adopt the following format;

“Critical Incident declared by (*organisation*)”

	SBAR report
Situation	describe situation/incident that has occurred
Background	explain history and impact of incident on services / patient safety
Assessment	confirm your understanding of the issues involved
Recommendation	explain what you need, clarify expectations and what you would like to happen
	Ask receiver to repeat information to ensure understanding

“SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety” (*NHS Institute for Innovation and Improvement)*

Please note: A Critical Incident is principally an internal escalation response to increased system pressures/ disruption to services that are or will have a detrimental impact on the organisation’s ability to deliver safe patient care.

12.5 Internal and external communications

Effective communications form an essential part of any incident response. Effective communications ensure that patients and the wider public are well informed about NHS services in their local area and what is expected of them. Retaining public confidence is dependant on the organisation’s ability to manage the situation and ensureNHS staff are aware and informed.

Effective communication with staff and the public about an incident will minimise its wider impacts and increase the confidence in the NHS response. This involves identifying specific audiences and the appropriate communication tools and messages to achieve this. NHS England needs to work closely with providers of NHS funded services to ensure that patients, staff and the wider public receive accurate information that is timely, reliable and easily understood.

Any incident is likely to generate significant media interest. A large and diverse 24/7 media, alongside the growth in social media has meant that information about incidents and events is now more readily available to staff and the public and coverage is likely to evolve faster than ever before. This coverage needs to be managed as effectively as possible as speculation can quickly become presented as fact and mislead key audiences. This can reduce effective management of the wider incident, and so the NHS must work with partners to respond to media interest quickly and effectively

NHS England communications leads will ensure effective engagement with LRF communication structures and processes

Communications specialists in NHS organisations will need to ensure that they can deliver;

- Joined up communication – a managed and coordinated communication and media response across responding NHS bodies and aligned to the multi-agency response, DH and PHE, where appropriate, via NHS England Communications teams
- Accurate and timely statements to staff and media - NHS England and provider organisations should provide regular statements to both the public and staff providing situational updates and reliable, useable information about accessing services and facilities and other aspects of the incident response
- Ensure that websites and other digital channels are kept up to date – many people will use digital media resources to find out about any incident or the response to it and it is essential that websites and other NHS digital media are regularly updated and contain clear, accurate, consistent and reliable information about the situation. This should include ensuring that any press statements are placed on the relevant organisations' website and are disseminated more widely using social media sites such as Twitter and Facebook
- Support designated spokespeople - the modern media landscape means there is a round-the-clock demand for information during the course of an incident. Responder organisations will need a cadre of trained and informed spokespeople to take part as required

12.6 Escalation and de-escalation

The level of the response may need to be escalated or de-escalated for a number of reasons. Agreement for this process needs to be made in conjunction with health strategic commanders so it can be coordinated across all organisations.
Appendix One shows the criteria that may trigger an escalation and/or de-escalation.

12.7 Staff welfare

NHS funded organisations must ensure staff welfare in general which includes anything done for the comfort and improvement of our staff. Incident managers and directors 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 mindful of their own and their teams levels of stress and fatigue and that effective arrangements are in place to minimise the potential impact. Arrangements may include rest breaks and shift systems for protracted incidents.

12.8 On-call staff

Each NHS organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. Incidents, emergencies and peaks in demand can occur at any time of day or night, so each organisation must have an appropriate out-of-hours on-call system. A director should always be available to make strategic decisions for the organisation; other staff may also be on-call to provide support. Staff should be appropriately trained noting the National Occupational Standard relevant to their role within the organisational response.

13 Concepts of command and control

The following is based on and adapted from *Emergency Response and Recovery* (Cabinet Office, 2013) which can be found here: https://www.gov.uk/guidance/emergency-response-and-recovery.

The management of emergency response and recovery is undertaken at one or more of three ascending levels: Operational, Tactical and Strategic. This is based around the concepts of command, control and coordination which are defined as follows:

- Command is the exercise of vested authority that is associated with a role or rank within an organisation (the NHS), to give direction in order to achieve defined objectives.
- Control is the application of authority, combined with the capability to manage resources, in order to achieve defined objectives.
- Coordination is the integration of multi-agency efforts and available capabilities, which may be interdependent, in order to achieve defined objectives. The coordination function will be exercised through control arrangements, and requires that command of individual organisations' personnel and assets is appropriately exercised in pursuit of the defined objectives.

The levels are defined by their differing functions rather than specific rank, grade or status.

13.1 Operational

Operational is the level at which the management of immediate 'hands on' work is undertaken. Operational commanders will concentrate their effort and resources on the specific tasks within their geographical or functional area of responsibility.

Individual organisations retain command authority over their own resources and personnel but each organisation must liaise and coordinate with all other organisations involved, ensuring a coherent and integrated effort. This may require the temporary transfer of personnel or assets under the control of another organisation.

These arrangements will usually be able to deal with most events or situations but if greater planning, coordination or resources are required an additional tier of management may be necessary. The operational commander will consider whether a tactical level is required and advise accordingly.

13.2 Tactical

The purpose of the tactical level is to ensure that the actions taken by the operational level are coordinated, coherent and integrated in order to achieve maximum effectiveness, efficiency and desired outcomes.

Where formal coordination is required at tactical level then a TCG may be convened with multi-agency partners within the area of operations. The tactical commanders will:

- Determine priorities for allocating available resources
- Plan and coordinate how and when tasks will be undertaken
- Obtain additional resources if required
- Assess significant risks and use this to inform tasking of operational commanders

- Ensure the health and safety of the public and personnel

The tactical commanders must ensure that the operational commanders have the means, direction and coordination to deliver successful outcomes.

The NHS tactical commander at the TCG will be identified and agreed by NHS England in consultation with the CCG. They will ensure that all NHS service providers are coordinated through health economy tactical coordination groups.

Where it becomes clear that resources, expertise or coordination are required beyond the capacity of the tactical level it may be necessary to invoke the strategic level of management to take overall command and set the strategic direction.

13.3 Strategic

The purpose of the strategic level is to consider the incident in its wider context; determine longer-term and wider impacts and risks with strategic implications; define and communicate the overarching strategy and objectives for the response; establish the framework, policy and parameters for lower level tiers; and monitor the context, risks, impacts and progress towards defined objectives.

Where an event or situation has a particularly significant impact; substantial resource implications, or lasts for an extended duration it may be necessary to convene a multi-agency coordinating group at the strategic level bringing together the strategic commanders from relevant organisations. This group is known as the SCG.

The SCG does not have the collective authority to issue commands to individual responder agencies; each will retain its own command authority, defined responsibilities and will exercise control of its own operations in the normal way. The NHS strategic commander at the SCG will be identified and agreed by NHS England in consultation with the CCG(s) and empowered to make executive decisions on behalf of the NHS. In addition the NHS ambulance service(s) will be present in their role as an emergency service.

The purpose of the SCG is to take overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which lower tier command and coordinating groups will work. The SCG will:

- Determine and promulgate a clear strategic aim and objectives and review them regularly
- Establish a policy framework for the overall management of the event or situation
- Prioritise the requirements of the tactical tier and allocate personnel and resources accordingly
- Formulate and implement media-handling and public communication plans
- Direct planning and operations beyond the immediate response in order to facilitate the recovery process

For incidents across multiple SCG areas then NHS England regional and national teams, as appropriate, will undertake command, control and coordination of the NHS and will be responsible for appropriate representation to regional and central coordination structures and groups.

14 NHS command and control

Response arrangements need to be flexible to match individual situations, many of which can be dealt with by individual organisations at the operational or tactical level.

14.1 The NHS in England

Responses at Alert Level 1 or 2 may be managed by an individual organisation or local health economy through the CCGs in liaison with the regional team. For a response at Alert Level 1 managed by an individual organisation the local/lead commissioner must be informed through their on call arrangements.

All actions that are, or would be undertaken at lower alert levels will need to be maintained in addition to any actions arising from a higher alert level. For example, An incident identified as Level 3 will require all actions identified at Level 1, 2 and 3 to be maintained.

14.2 NHS England regions

NHS England regions provide leadership across a geographical area. If a response requires a wider NHS or multi-agency response then the respective regional team will provide command, control and coordination for the NHS.

Responses at Alert Level 3 will require the regional office to take command, control and coordination of the NHS across their region. Tactical command will remain with local responding organisations, as appropriate.

Responses at Alert Level 4 will require national NHS England command, control and coordination of the NHS across England. Tactical command will remain with local responding organisations, as appropriate.

14.3 NHS England national

For responses at Alert Level 4 and in certain situations such as pandemic influenza, national fuel shortage or extensive extreme weather events, NHS England (national) may take command of all NHS resources across England. In this situation direction from the national team will be actioned through the regional teams.

14.4 Incident coordination

Incident coordination is the function that brings together organisations and resources to ensure effective response to and recovery from incidents. The coordination function can be conducted by a person or a team.

Any command, control and coordination system has to be sustainable to operate 24 hours a day, 7 days a week in order to deliver the strategic objectives and over a protracted period of time where necessary.

14.5 Incident Coordination Centre

The ICC supports the Incident Management Team (IMT) to provide an enhanced level of operational support. It is widely recognised that the efficiency and effectiveness of an ICC is greatly improved through the utilisation of a formal structure. Benefits of this include:

- **Unity of effort** – all team members operate under a common list of objectives
- **Accountability** – each individual has a specific role for which they are responsible
- **Eliminates redundancy** – clearly established division of labour eliminates duplication of effort

All organisations need to have in place suitable and sufficient arrangements to effectively manage the response to an incident. Arrangements for the ICC need to be flexible and scalable to cope with a range of incident scales and hours of operation required.

14.6 ICC functions

While the specific activities undertaken by the ICC will be dictated by the unique demands of the situation, there are five broad tasks typical of ICCs:

- **Coordination** – matching capabilities to demands
- **Policy making** – decisions pertaining to the response
- **Operations** – managing as required to directly meet the demands of the incident
- **Information gathering** – determining the nature and extent of the incident ensuring shared situational awareness
- **Dispersing public information** – informing the community, news media and partner organisations

The ICC will provide a focal point for coordination of the response and the gathering, processing, archiving and dissemination of information across the NHS and externally, as required. ICC plans should also include arrangements for the management of visitors.

14.7 Decision making

Decision making, especially during an incident, is often complex and decisions are open to challenge. Decision makers will be supported in all instances where they can demonstrate that their decisions were assessed and managed reasonably in the circumstances existing at a particular point in time. Use of decision support models and processes assist in providing this evidence, particularly in conjunction with decision logs.

The Joint Decision Model (JDM) (http://www.jesip.org.uk/joint-decision-model/) is suitable for all decisions and has been adopted by JESIP in the joint doctrine to practically support decision makers working under difficult circumstances. It is organised around the three primary considerations: situation, direction, action.

It is expected that decision makers will use their judgment and experience in deciding what additional questions to ask and considerations to take into account to reach a decision. The JDM is to support the decision making process in achieving the desired outcomes.

14.8 Organisational ICC requirements

Each organisation needs the ability to establish an ICC and maintain a state of organisational readiness. Large organisations with multiple sites may need a facility at each location where tactical and operational functions can be coordinated supported by a separate strategic facility for overall command and control.

There should be sufficient resilience within the organisation to ensure that there is an alternative ICC available for use in the event the primary ICC is unavailable.

An ICC must be resilient to loss of utilities, including telecommunications, and to external hazards such as flooding.

The ICC should have an activation plan with action cards for key staff working within it. Sufficient resources should be made available to coordinate an incident over an extended period of time.

ICC equipment should be tested every three months as a minimum to ensure functionality.

15 Recovery

Recovery from any incident is imperative and requires a coordinated approach from the affected organisation(s) and multi-agency partners, depending upon the type and scale of the incident.

The national Emergency Response and Recovery Guidance provides detailed advice for organisations; https://www.gov.uk/emergency-response-and-recovery. It may also offer opportunities for service redesign and changes to operational practice.

The recovery phase should begin at the earliest opportunity following the start of an incident and should be run in parallel with the response. The recovery phase does 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.

Guidance on psychosocial issues can be found at – http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_103562

15.1 Debriefing

In order to identify lessons from any incident it is important to capture as much detail about the incident and the experiences of those involved as soon as is reasonably practicable. A series of debriefs post incident is seen as good practice.

The purpose of a debrief is to identify issues that need to be addressed. It is essential that they are attended by all staff that had a part in the response in order to review what went well, what did not go well and what needs to be changed. The process of de-brief should provide a support mechanism and identify staff welfare needs.

Organisations should ensure they use appropriately trained staff to facilitate.

Debriefs should be held as follows:

a) Hot debrief – immediately after the incident or period of duty
b) Cold/Structured/Organisational debrief – within two weeks post incident
c) Multi-agency debrief – within four weeks of the close of the incident
d) Post incident reports – within six weeks of the close of the incident

The post incident reports should be supported by action plans, with timescales and accountable owners, and recommendations in order to update any relevant plans or procedures and identify any training or exercising required.

There should be a mechanism for sharing lessons identified across both the local health economy, through the LHRP, and across the wider NHS.

16 Assurance

The minimum requirements which NHS funded organisations must meet are set out in the Core Standards. These standards are in accordance with the CCA 2004, the NHS Act 2006 (as amended) and the Cabinet Office *Expectations and Indicators of Good Practice set for Category 1 and 2 Responders*. The latest version of the Core Standards can be found at http://www.england.nhs.uk/ourwork/eprr/gf/#core.

All NHS funded organisations will be asked to provide evidence of their compliance and for their Board to issue a *Statement of EPRR Conformity* to their commissioners. NHS England will ensure that CCG compliance forms part of the annual CCG Assurance Framework.

NHS England will, in collaboration with LHRPs ensure that an annual assurance program will be undertaken that will inform the national report to the DH and SoS.

17 Freedom of Information

This document is publically available.

18 Equality and health inequalities analysis

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

Guidance on the equality and health inequalities legal duties can be found at https://www.england.nhs.uk/wp-content/uploads/2014/12/hlth-inqual-guid-comms.pdf

19 Acronyms

Without a common understanding of what specific terms and phrases mean, multi-agency working will always carry the risk of potentially serious misunderstandings, the consequences of which could be extremely severe. Since 2007 the Cabinet Office has been working with a wide range of partners to build and maintain a single point of reference for civil protection terminology as one of the underpinning elements of interoperable communications and coherent multi-agency working.
The latest version of this lexicon can be found here:
https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

Appendix One: Escalation and de-escalation