NHS Commissioning Board

NHSCB8/11/12/3

BOARD PAPER - NHS COMMISSIONING BOARD

Title: Emergency preparedness

Clearance: Ian Dalton, Chief Operating Officer / Deputy Chief Executive

Purpose of Paper:

To provide an update following the April Board meeting and September briefing note on:

- progress towards implementation of the new emergency preparedness resilience and response (EPRR) model;
- the risks to delivery; and
- NHS CB transitional assurance process.

Key Issues and Recommendations:

The Board is asked to:

- note the work programme in place to deliver the new NHS EPRR structure by 1 April 2013;
- note the risks that exist in delivering this programme to time and the mitigating actions that have been put into place; and
- endorse the process for assurance around EPRR implementation.

Actions Required by Board Members:

- The Board is asked to note the progress to date, note prospects and endorse the proposed readiness assurance approach.

Emergency preparedness

Executive summary

1. The NHS needs to be able to plan for - and respond to - a wide range of incidents and emergencies that could impact on health or patient care. These could take the form of a range of events ranging from the impact of extreme weather conditions on the NHS, responding to a major disruption to the NHS supply chain, pressure caused by an outbreak of an infectious disease such as pandemic influenza to the healthcare consequences of events such as major transport accidents. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS funded care, to show that they are prepared for such incidents while maintaining services to patients. This programme of work is referred to in the health community as emergency preparedness resilience and response (EPRR).

2. New arrangements for local health EPRR will commence from 1 April 2013 as part of the changes the Health and Social Care Act 2012 is introducing to the health system in England. The latest position on preparation and implementation is set out below.

3. Good progress is being made against the programme plan, however risks remain due to the challenging timescales and the absence of some key local area team (LAT) appointments. Partnership working is fundamental to the process and local engagement activity is already underway.

4. A readiness assurance process is being established to assure the Board that the new arrangements can be effectively implemented across the country from 1 April 2013.

Links to the Board's mission statement

5. The proposals in this paper have a direct link to each of the four components of the mission statement.

    a. **Why we exist:** the paper addresses ways in which the NHS CB can improve and safeguard the quality of lives for patients and the wider public. It will do this on a fair and equal basis and within available resources.

    b. **How we work**: each of the proposals in the paper has a direct impact on patient and public safety. Our proposals explicitly prioritise the safety and interests of patients and communities and are dependent on strong partnership working.

c. **What we do:** the proposals relate directly to how we plan for civil emergencies and make sure the NHS is resilient. They set out next steps in the systems transition to new arrangements for EPRR.

d. **Our success:** the paper describes the next stage in the process of redesigning the EPRR system. Our success will be measured through our state of preparedness, resilience and response, but also through the extent to which we work effectively with delivery partners at local and national level.

Progress to date

6. The role of the NHS Commissioning Board (NHS CB) is to ensure that the NHS in England is properly prepared to be able to deal with potential disruptive threats to its operation and to take command of the NHS, where necessary, during emergency situations. By April 2013 the right people, processes and systems will need to be in place at each level of the system. Specifically:

- on-call rotas will need to be in place with members identified in regions and LATs;
- competencies will need to have been tested and training requirements met where necessary for all prospective members of rotas;
- regional and local incident coordination centres will need to have been established in each region and LAT;
- the assurance process will need to have been completed (see below) with statements of readiness in place and formal confirmation that all parts of the NHS have robust systems in place; and
- local health resilience partnerships (LHRPs) will need to be in place across England.

7. LHRPs will be the key local strategic groups for health EPRR and will link with the existing 38 multi-agency Local Resilience Fora (LRFs). Across the country, the establishment of the LHRPs will also be covered by the broader transition assurance process. Membership will comprise all local health partners, co-chaired by the lead director locally for the NHS CB and a Director of Public Health.

8. A series of regional workshops has commenced (North and Midlands & East regions have been completed), hosted by NHS CB regional directors. These have been designed to ensure strong, consistent messages, both on arrangements for transition and the design of the new system. A template

health EPRR presentation and speaking notes have been developed for local adaptation. The presentation and EPRR frequently asked questions (FAQs) have been published on the NHS CB website and used in the regional workshops.

9. These have been issued alongside a number of other documents setting out the new arrangements for health EPRR to support the roll-out and establishment of LHRPs. The newly-published documents also link to previous information and guidance as described below:

- Information regarding the post-April 2013 arrangements for health EPRR was published on 3 April 2012[1].
- A key feature of the new arrangements is the formation of LHRPs and a resource pack to support their establishment was published on 26 July 2012[2].
- On 2 August 2012, further guidance was issued to support the maintenance of current resilience arrangements during transition[3].
- Final details of the arrangements and process for implementation of the new health EPRR system[4] was cascaded to the NHS on 31 October 2012, specifically:
    - the assurance process for implementation of the new EPRR arrangements.
    - the process for operational handover to the NHS CB, including the provision of template memorandums of understanding to facilitate the safe transfer of EPRR responsibilities between cluster SHA/PCTs and the NHS CB and to enable LATs to call upon such relevant provider resources as may be necessary in response to a significant incident or emergency.
    - competencies and training for members of emergency on-call rotas; and
    - establishment of the NHS CB command and control arrangements.

10. Interviews have been completed and appointments are being made to six senior NHS CB EPRR posts that will lead the implementation EPRR process – two corporate posts within the NHS CB national support centre and one in each of the four NHS CB regional offices.. These individuals will play a key role in implementing the new EPRR system across the country.

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[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133353

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

[3] http://www.dh.gov.uk/health/2012/08/eprr-arrangements/

[4] http://www.commissioningboard.nhs.uk/eprr

NHS CB transitional assurance process for EPRR

11. An assurance process has been developed and endorsed by the DH EPRR transition programme board and approved by the NHS EPRR implementation steering group. This will provide assurance to the Board, and in turn to the Department of Health, that the revised model of EPRR is in place and able to maintain a safe and resilient system of patient care from 1 April 2013.

12. A tracking matrix (the headings of which are in annex A) has been developed to monitor progress towards full implementation of the revised EPRR arrangements and, particularly:

    - the appointment and provision of NHS LHRP co-chairs by 30 November 2012; and
    - the establishment of NHS CB LAT and regional emergency on-call rosters by 17 December 2012.

13. Regional directors have been asked to provide a progress update against these objectives and it is anticipated that further progress reports will be requested in mid December 2012 and again in early February 2013. Progress towards regional milestones will be refreshed regularly, with issues and risks reviewed through weekly discussions with regional EPRR leads.

14. The Department of Health (DH) will seek assurance from the NHS CB that the revised model of EPRR is in place and able to maintain a safe and resilient system of patient care from 1 April 2013. This assurance will need to be provided by the Board on the basis of advice from the Chief Operating Office/Deputy Chief Executive. The NHS CB Director of NHS Operations and Delivery (Corporate) will seek assurance from regional directors, who in turn will seek assurance from their LATs to ensure this advice is based on an understanding of the readiness of each part of the country.

15. As implementation progresses, the LAT directors will be asked to complete a pro-forma template and provide a formal 'statement of readiness' on the capability of the NHS CB safely to undertake its EPRR responsibilities. They will also need to confirm that LHRPs have been established effectively. This statement will assure the Board that the revised command, control, co-ordination and communication arrangements are in place.

16. The evidence provided as part of this process will itself be assessed through an objective LAT peer review process. This will provide constructive challenge and make recommendations on further action that may be required, while potentially also identifying opportunities for further improving and strengthening the national system.

17. These processes will be supplemented by a series of regional exercises when each of the NHS CB regions, along with Public Health England and Directors of Public Health, will test capabilities to respond to a health emergency and refine operational planning. These exercises will be held between November and February, with a combined exercise for London and the South, reflecting the geography in and around London and shape of the two regions.

18. In summary therefore, assurance to the Board will be based on evidence gathered through three processes:

- statements of readiness and completed templates from each region, LAT and LHRP,
- a peer review process between LATs, providing an opportunity for constructive challenge and shared learning; and
- regional command post exercises.

This evidence will be brought together in a final statement, signed by all local NHS partners and confirming that robust systems are in place.

19. Discussions are also underway on governance and partnership arrangements following transition and into 2013/14. It is proposed that any partnership agreement with DH should be firmly embedded in the broader partnership framework between the NHS CB and the Department.

Risk and mitigation

20. On a monthly basis, EPRR implementation risks, and their mitigation, are reported in detail to the programme management office of the NHS CB. The key risks can be summarised as:

- Timescales for implementation
- Recruitment to key posts
- Relatively short lead-in time for any remedial action following testing
- System resilience during transition
- Potential for reduced focus on this agenda due to competing priorities

21. Timescales and recruitment are the primary risks to implementation. Effective delivery of the model will be dependent on the timely and effective transfer of roles and responsibilities to existing and emerging health organisations.

22. A range of mitigating actions are in place as follows:

- Recruitment to EPRR posts is being fast-tracked wherever possible. Where LAT Directors are not in post ongoing leadership is being provided, as required, by PCT Cluster chief executives.

- The proposed assurance process has been communicated to regions, with a focus on making early progress in the less complex LHRPs. This will allow a greater concentration of focus on those areas where the challenges are greatest.

- A weekly review process has been put in place between the corporate team and the regions, supported by a tracker document setting out progress and supporting the maintenance of up to date lines of communication on known or emerging issues.

- Clear communications have been sent through the system, highlighting the need to maintain capacity and expertise in the system during the transitional period.

- Discussions are ongoing with DH and other partners on the system-wide exercises to ensure that they reflect the fact that they are testing a system in transition. The objective of these discussions is to ensure that the exercises are both suitably challenging and also set up in a way that is likely to provide points of learning and development.

- A comprehensive review of guidance has been undertaken, ensuring that national EPRR guidance is up to date and relevant to the new arrangements.

Next steps

23. The NHS EPRR implementation programme will continue to support regions and LATs in the delivery of the new EPRR model and will continually monitor progress and risks to delivery to ensure progress.

24. Through its assurance process, regular reports will be provided to the EPRR steering group and to the Board.

25. The following documents will be developed during November and December 2012:

    - The NHS CB corporate incident response plan.
    - 2013 command and control guidance for the new system, to replace the 2007 guidance.
    - 2013 emergency planning framework, to replace the 2005 guidance.

- Guidance on resilience planning to clearly signpost to the framework for health services resilience and international standards on business continuity (ISO22301 [previously BSI 25999] and PAS 2015).

Actions requested of board members

26. The Board is asked to note the progress to date, note the risks associated with the work programme and mitigating actions being taken.

27. It is asked to support the fast-tracking of these appointments wherever possible, particularly in LATs.

28. The Board is asked to endorse the assurance process for EPRR implementation.

Ian Dalton CBE
Deputy Chief Executive/Chief Operating Officer
October 2012

NHS Commissioning Board

annex A: Headings of the EPRR Assurance Tracking Matrix

NHS CB regional (milestones for each of the four regions)

Appointments			Competency & Training				Command & Control				Assurance		
Regional Director Appointed	EPRR Lead Appointed	On-Call Rota Members Selected	Competency Assessment Completed	Strategic Leadership in a Crisis	Surviving Public Enquiries	Risk Assessment (training)	On-Call Rota Implemented	Handover date agreed with SHA	Incident coordination centre mgmn't plan approved	Incident Coordination Centre (ICC) Established	Local Testing Conducted	Command Post Exercise Conducted	Statement of Readiness Submitted

NHS CB local area teams (LATs) (milestones for each of the 27 LATs)

Appointments			Competency & Training				Command & Control				System Alignment		Assurance				
LAT Director	EPRR Lead	On-Call Rota Members Selected[1]	Competency Assessment & training identified[1]	Strategic Leadership in a Crisis	Surviving Public Enquiries[2]	Risk Assessment (training)[2]	On-Call Rota Implemented	Handover date agreed with PCT	Incident coordination centre mgmn't plan approved	Incident Coordination Centre (ICC) Established	CCGs aware of responsibilities	Multi-Agency Partners informed of changes	Local Testing Conducted	Command Post Exercise Conducted[2]	Completion of Assurance Proforma	Independent Assessment of Readiness	Statement of Readiness Submitted

Note:
1. Milestone set-out in the letter dated 2 August 2012
2. As a minimum, the LAT Director should be trained in surviving public enquiries
3. Not all LATs will participate in CPXs

Local health resilience partnerships (LHRPs) (milestones for each of the LHRPs)

Appointments			Competency & Training		LHRP Set-up					System Alignment				Assurance	
LAT Appointed to LRF[1]	NHS CBA Co-Chair[1]	DsPH Co-Chair Appointed	Competency Assessment Completed	Training Provided as required	Co-chairs Meet	Membership Identified	1st LHRP Meeting	Terms of Reference Approved	CONOPs established	Multi-Agency Partners informed of changes	Agreement in-place with LRF health sub-groups[1]	Provider Accountable Officers identified	Members' incident response plans Aligned	Completion of Assurance Proforma	Statement of Readiness Submitted