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# NHS Emergency Preparedness Resilience and Response Framework

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# 1. Purpose and context

This Framework describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. It provides the framework and principles for effective Emergency Preparedness, Resilience and Response (**EPRR**), to help all **NHS-funded Organisations** in England meet the requirements of the Civil Contingencies Act 2004 (**CCA 2004**), the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract.

This Framework reflects the changes introduced from the Health and Care Act 2022 and the formation of Integrated Care Boards (ICBs). A summary of the changes are:

- Clinical Commissioning Groups (**CCGs**) as of 1 July 2022 dissolved and Integrated Care Boards (**ICBs**) established
- The CCA 2004 and the NHS Act 2006 will be updated to set out the duties of ICBs in relation to emergency planning
- NHS England and NHS Improvement will formally be merged into one organisation, called NHS England [1].

# 2. Who is this document for?

This guidance is issued under section 2 and 252A of the NHS Act 2006. It is strategic national guidance for NHS-funded Organisations in England including but not limited to:

- NHS Trusts, Foundation Trusts and Care Trusts
- providers of NHS-funded primary care
- independent and third sector providers of NHS-funded services (whether under a contract with an NHS commissioner or otherwise)
- NHS commissioning organisations, including NHS England and ICBs

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

[1] From 1 April 2019, NHS England and NHS Improvement have worked together to better support the NHS to deliver improved care for patients. They work under a single operating model to deliver all aspects of the existing organisations' functions with shared governance, systems and processes, organisation structures and capabilities, culture and behaviours and financial set up.

responsibilities in planning for and responding to incidents and emergencies.

Whilst this document is intended for ICBs and providers, other Arm's Length Bodies (ALBs) providing NHS services may wish to use this guidance to help inform good resilience planning. This will be a decision for each ALB organisation.

# 3. Applicable legislation and guidance

This Framework should be read in the context of:

- CCA 2004, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (**2005 Regulations**) and associated Cabinet Office guidance
- NHS Act 2006
- Health and Care Act 2022
- the NHS Constitution
- the requirements for EPRR as set out in the NHS Standard Contract(s)
- NHS England EPRR guidance and supporting materials including:
  – NHS Core Standards for Emergency Preparedness, Resilience and Response
  – other guidance available on the NHS England website
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (**MOS**)
- ISO 22301:2019 Security and resilience – Business continuity management systems
- Integrated Care Systems/ Integrated Care Boards
- National Risk Register
- Equality and health inequalities legal duties

All references to legislation include any amendments made to that legislation.

# 4. Background

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the CCA 2004, the NHS Act 2006 and the Health and Care Act 2022.

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

## 4.1 Aim of the framework

To enable the NHS in England to ensure effective arrangements are in place to deliver appropriate care to patients affected by an emergency or incident.

## 4.2 Objectives of the framework

- To prepare for the common consequences of incidents and emergencies rather than for every individual emergency scenario.
- To have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios.
- To supplement this with specific planning and capability building for the most concerning risks as identified as part of the wider UK resilience.
- To ensure that plans are in place to recover and learn from incidents and emergencies and to provide appropriate support to affected communities.

Governance for EPRR is 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 National Risk Register (**NRR**) and the National Security Risk Assessment (NSRA), as appropriate.

## 4.3 Summary of key changes

Below is a summary of the key changes since the last published version of the Framework (version 2, 2015):

- Changed to reflect that the Emergency Preparedness Resilience and Response functions of Public Health England (PHE) now sit with the United Kingdom Health Security Agency (UKHSA) (throughout text)

- Addition of the Health and Care Act 2022 (throughout text)

- Addition of ICBs (throughout text)

- Removal of CCGs (throughout text)

- Addition of context section (1)

- Addition of Cabinet Office (JESIP) definition of Major Incident (6.5)

- Amendment to definition of Level 3 Incident (7)

- Update to definition of Mass Casualty Incident (7.1)

- Update to definition of Cyber Security Incident (7.1)

- Planning structures diagram updated (8.4)

- Amended link to Cabinet Office guidance (8.8)

- Suggested record keeping requirements added (8.9.1)

- Amendment to AEO support requirements from non-executive directors (9.1)

- Incident Coordination Centre (**ICC**) equipment test added to exercise requirements (10.4.5)

- Update to incident response structure for the NHS in England (12)

- Addition of expectation around regard for promoting equality and addressing health inequalities. (18)

# 5. Service reconfiguration

Commissioners and providers must give due consideration to the potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and/or respond to an incident or 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 incidents and emergencies.

## 6.2 Resilience

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

## 6.3 Response

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

## 6.4 Incidents

For the NHS, incidents are defined as:

**Business Continuity Incident** – an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

**Critical Incident** – any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.
A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

**Major Incident** – The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder

agency. [2]

In the NHS this will cover 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 under Section 8.1.4.

A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multi-agency support to a lead responder.

The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally.

The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

Each will impact on service delivery within the NHS, and this may undermine public confidence and require contingency plans to be implemented. When making the decision to declare an incident the person making the decision should be clear on what the declaration of an incident will achieve. NHS organisations and NHS-funded organisations should be confident in judging the severity of an incident and determining if declaration is warranted.

## 6.5 Classifications of types of Major Incident

The following list provides commonly used classifications for types of Major Incidents. This list is not exhaustive and other classifications may be used as appropriate to describe the nature of the incident.

- **Rapid onset** – develops quickly, and usually with immediate effects, thereby limiting the time available to consider response options (in contrast to rising tide) e.g. 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

[2] “Emergency responder agency” includes any category 1 and category 2 responder as defined in the CCA 2004 and associated guidance.

nuclear release developing elsewhere and needing preparatory action.

- **Headline news** - public or media alarm about an impending situation, significant reputation management issues, e.g. an unpopular patient treatment plan which gathers significant publicity.

- **Chemical, biological, radiological, nuclear and explosives –** CBRNe terrorism is the actual or threatened dispersal of CBRNe materials (one or several, or in combination with explosives), with deliberate criminal, malicious or murderous intent.

- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials.

- **Cyber security incident** – a breach of a system's security policy to disrupt its integrity or availability or the unauthorised access or attempted access to a system.

- **Mass casualty** – an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage.

## 6.6 Organisations

- **NHS-funded Organisation** – organisations who receive direct or indirect funding from NHS England.

- **Provider of NHS-funded services** means NHS trusts, foundation trusts and care trusts and any independent or third-sector providers that are contracted for the delivery of services to support the health service, as defined in the NHS Act 2006

- **Integrated Care Board (ICB)** – each Integrated Care System (ICS) has an ICB bringing together the NHS locally to improve population health and establish shared strategic priorities within the NHS.

- **NHS England**[3] – all parts of the organisation, but specifically NHS England regional teams, and specialist central teams e.g. Estates, Specialised Commissioning etc)

[3] NHS England as a category 1 responder under the Civil Contingencies 2004 has a duty to follow this guidance.

# 7. NHS incident response levels

An incident is described in terms of the level of response required. This level may change as the incident evolves (see Figure 1).

Incident response levels describe at which level coordination takes place. For clarity, these levels must be used by all organisations across the NHS when referring to incidents. **They are specific to the NHS in England and are not interchangeable with other organisations' incident response levels.** Guidance to assist with escalation and de-escalation is provided in the Appendix.

All incidents and emergencies resulting in the activation of UK Central Government response arrangements will be managed as Level 4 incidents.

Further explanation about operational, tactical and strategic command can be found at Sections 13.1 to 13.3.

| | |
|---|---|
| **Level 1** | An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans |
| **Level 2** | An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region |
| **Level 3** | An incident that requires a number of NHS-funded organisations within an NHS England region to respond.<br>NHS England to coordinate the NHS response in collaboration with the ICB.<br>Support **may** be provided by the NHS England Incident Management Team (National). |
| **Level 4** | An incident that requires NHS England national command and control to lead the NHS response.<br>NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level.<br>NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level. |

*Figure 1: NHS incident response levels*

# 8. Statutory requirements and underpinning principles of EPRR

Under the NHS Constitution the NHS is there to help the public when they need it; 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 organisations must therefore ensure robust and well-tested arrangements are in place to respond to and recover from these situations.

## 8.1 Statutory requirements under the CCA 2004 and 2005 Regulations

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

### 8.1.1 Category 1 responders

Category 1 responders are those organisations at the core of an 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 coordination
- co-operate with other local responders to enhance coordination and efficiency
- provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only)

Category 1 responders with responsibility for health or public health are:

- The Secretary of State for Health and Social Care (**SofS**) in relation to the SofS duty to protect public health under the NHS Act 2006. In practice, the SofS delegates their role to the United Kingdom Health Security Agency (UKHSA), so that in practice the UKHSA operates as though the UKHSA itself is a category 1 responder.
- NHS England
- ICBs
- NHS trusts and NHS foundation trusts with the function of providing:
  - ambulance services or
  - hospital accommodation and services in relation to accidents or emergencies
- local authorities (including directors of public health (**DsPH**))
- Port health authorities

### 8.1.2 Category 2 responders

Category 2 responders such as utility providers and transport providers, are critical partners in EPRR that are required to co-operate 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 which affect their sector. Category 2 responders have a lesser set of duties, which are to co-operate and share relevant information with other Category 1 and 2 responders.

### 8.1.3 Others

NHS-funded organisations that are not NHS trusts or foundation trusts (e.g. primary care contractors, out-of-hours providers, independent sector and third sector providers) are not listed in the CCA 2004. However, NHS England and the Department of Health and Social Care (**DHSC**) expect them to plan for and respond to emergencies and incidents in a manner which is relevant, necessary and proportionate to the scale and the services they provide. Also, note that NHS-funded organisations not listed as Category 1 or Category 2 responders under the CCA 2004 may still have EPRR obligations under the NHS Act 2006 and/or their contracts with the NHS (see further below).

Under the 2005 Regulations, each local area must have a Local Resilience Forum (LRF). ICBs will represent the NHS at the LRF; NHS England, NHS Trusts and Foundation Trusts providing emergency ambulance services or accident and emergency hospital services are also LRF members.

The NHS in England will also have in place strategic forums for joint planning for health incidents: these are known as local health resilience partnerships (LHRP). These partnerships will support the health sector's contribution to multi-agency planning through the LRF. See section 9.5 for further detail.

**It is essential that NHS-funded organisations ensure they have effective, co-ordinated structures in place to adequately plan, prepare and rehearse the strategic, tactical and operational response arrangements with local partners.**

### 8.1.4 Meaning of "emergency"

Under section 1(1) of the CCA 2004 an 'emergency' is defined as:

"(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; or

(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".

## 8.2 Statutory requirements under the NHS Act 2006

The NHS Act 2006 requires NHS England and the ICB to ensure that the NHS is properly prepared to deal with an emergency. ICBs 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 contained in section 252A of the NHS Act 2006 are:

a) NHS England and each ICB 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 ICB and each '**relevant service provider**' (definition set out below) is properly prepared for dealing with a relevant emergency.

c) The steps taken by NHS England must include monitoring compliance by each ICB and service provider.

d) NHS England must take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by ICBs and relevant service providers for which it is a '**relevant emergency**' (definition set out below).

e) NHS England may arrange for any body or person to exercise any functions of NHS England under subsections a) to d) and any functions it has, by virtue of being a Category 1 responder under CCA 2004.

A '**relevant emergency**' is defined as:

- **In relation to NHS England or ICB:** Any emergency which might affect NHS England or the ICB (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).

This definition of "relevant emergency" should be used when considering the scope of legal obligations under the NHS Act 2006. However, in practice, generally NHS organisations should use the terminology set out at sections 6.5 (incident) and 8.1.4 (emergency) unless otherwise stated.

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 under the 2006 Act for the provision of services.

These elements clearly establish the relationship between NHS England and ICBs. NHS England would seek to work with and through ICBs to ensure the NHS response can be effectively managed at strategic and tactical levels to deliver the service-wide aims and objectives.

In addition, under section 253, the SofS may also give directions to NHS bodies in relation to an emergency.

## 8.3 Underpinning principles for NHS EPRR

These underpinning principles apply to all commissioners and NHS-funded organisations.

a) **Preparedness and anticipation** – the NHS needs to anticipate and manage the consequences of incidents and emergencies by identifying risks and understanding direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared. This includes 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. Actions will need to be faster, on a larger scale and in more testing circumstances during a 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 blocks of response for an incident of any scale.

d) **Communication** – good two-way communication is critical to any 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. This includes active mutual aid across organisations, within the UK and across 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.

## 8.4 Planning structures

Figure 2 below shows the EPRR planning structure for the NHS in England and the interactions with key partner organisations.

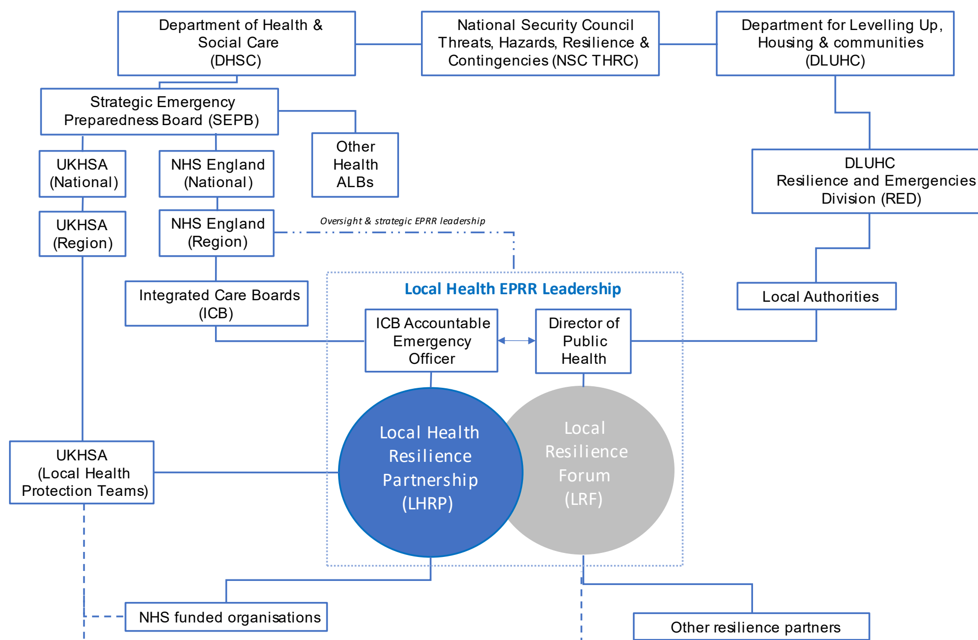


*Figure 2: EPRR planning structure for the NHS in England*

* LHRPs will be co-chaired by the ICB AEO and a Director of Public Health. NHS England will be a member of each LHRP[4]

Health resilience sub-groups may exist at LHRP level and at an ICS level to undertake strategic and tactical EPRR work.

## 8.5 NHS Core Standards for EPRR and the NHS Standard Contract

The minimum requirements that commissioners and NHS-funded organisations must meet are set out in the current NHS Core Standards for Emergency Preparedness, Resilience and Response (**Core Standards**). These Core Standards are in accordance with the CCA 2004, 2005 Regulations and the NHS Act 2006.

The NHS Standard Contract Service Conditions[5] require Providers of NHS-funded services to comply with EPRR guidance. Therefore, commissioners must ensure

[4] see 9.4 for NHS England (London) arrangements

[5] See NHS Standard Contract, Service Conditions SC30

Providers of NHS-funded services are compliant with the requirements of the Core Standards as part of the annual national assurance process (see Section 17).

Details of the annual assurance process are available here.

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

## 8.6 Co-operation between local responders

Under the CCA 2004 and 2005 Regulations, co-operation between local responder bodies is a legal duty. In addition, the NHS Act 2006 sets out a duty on NHS bodies to co-operate with each other in discharging their functions.

It is important that the planning for incidents is co-ordinated within and between individual health organisations and at a multi-agency level with partner organisations. NHS England and ICBs will co-ordinate health services at the LRF level, and ICBs will ensure co-ordination across local ICSs.

The LHRP and local EPRR planning groups facilitate this partnership working.

## 8.7 Mutual aid

The successful response to incidents has demonstrated that joint working can resolve very difficult problems which fall across organisational boundaries.
Mutual aid arrangements should exist between NHS-funded organisations, and between NHS-funded organisations and partner organisations. 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 and 2005 Regulations responders have a duty to share information with partner organisations. This is a crucial element of civil protection work; it underpins all forms of co-operation.

NHS-funded organisations should formally consider the information 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. An organisation’s information governance policies and procedures should cover the requirements of EPRR.

Cabinet Office Data Sharing Guidance 2019 is available on the Civil Contingencies Secretariat page of Resilience Direct.

## 8.9 Record keeping

The day-to-day management of people and patients in the NHS is subject to legal obligations such as duties of care, candour and confidentiality as well as professional obligations. This does not change when responding to an incident. However, these events can lead to greater public and legal scrutiny. This may include coroners' inquests, public inquiries, criminal investigations and civil action. When planning for and responding to an incident, all decisions made or actions taken must be recorded and stored in a way that can be retrieved later to provide evidence.

### 8.9.1 Logging and record keeping

NHS-funded organisations must have appropriately trained and competent Loggists to support recording of decisions made in the management of an incident. Loggists are an integral part of any incident management team. All those tasked with logging must do so to best practice standards and understand the importance of logs in the decision-making process, evaluation and identifying lessons, and as evidence for any subsequent inquiries.

Following an incident, internal investigations, external scrutiny and/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, all decisions made or actions taken must be recorded and stored in a way that can be retrieved later 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. For example, NHS England uses the categories and retention periods shown in Table 1 for EPRR-related records.

| Category | Examples | Minimum retention period | Final action |
| --- | --- | --- | --- |
| Incidents (declared) | Decision logbook, on-call logbook, incident-related documents including plans and organisational structures<br>Paper and electronic records | 30 years | Review, archive or destroy under confidential conditions |
| Exercise | Paper and electronic records | 10 years | Review, archive or destroy under confidential conditions |

| Category | Examples | Minimum retention period | Final action |
|---|---|---|---|
| On-call (routine – non-Major Incident) | Decision log, on-call log, handover records<br>Paper and electronic records | 10 years | Review, archive or destroy under confidential conditions |
| EPRR | Incident response plans, guidance, standard operating procedures, core standards for assurance<br>Electronic records | 30 years | Review, archive or destroy under confidential conditions |
| EPRR | Information sharing protocols, memorandum of understanding, service-level agreements<br>Paper and electronic records | 10 years | Review, archive or destroy under confidential conditions |
| EPRR | LHRP and sub-group minutes, papers, action logs<br>Risk registers<br>Electronic records | 30 years | Review, archive or destroy under confidential conditions |

*Table 1: Records to be retained and retention periods*

# 9. Roles and responsibilities

This section outlines the EPRR roles and responsibilities of:

- accountable emergency officers (**AEOs**)
- Providers of NHS-funded services
- specific roles and responsibilities for:
  - NHS ambulance services
  - NHS mental health and learning disability secure services
  - ICBs
  - LHRPs
  - NHS England
  - DHSC
  - UKHSA
  - Department for Levelling Up, Housing & Communities (DLUHC)

## 9.1 Accountable emergency officers

The NHS Act 2006 places a duty on relevant service providers (defined at Section 8.2) to appoint an individual to be responsible for discharging the duties under section 252A(9), outlined below. This individual is known as the AEO.

NHS England expect all NHS-funded organisations to have an AEO with regard to EPRR. Chief executives may designate the responsibility for EPRR as a core part of their organisation's governance and its operational delivery programmes. Chief executives will be able to delegate this responsibility to a named director.

The AEO will be a board-level director (or equivalent in organisations without a board) 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 their organisation responds appropriately 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.

Specifically, the AEO will be responsible for ensuring that their organisation:

- itself and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and the Core Standards
- is properly prepared and resourced to deal with an incident
- itself and any sub-contractors it commissions have robust business continuity planning arrangements in place that align to ISO 22301 or subsequent guidance that may supersede this
- has a robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served
- complies with any requirements of NHS England, in respect of monitoring compliance
- provides NHS England with such information as it may require for the purpose of discharging its EPRR functions
- is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate.

The independence that Non-executive Directors (NEDs) bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. Therefore, EPRR should be included on appropriate committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually. Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

Whilst it is recognised that EPRR is a collective board level responsibility, a number of NEDs bring skills and experience in crisis and incident management. Where this is the case, additional support to the AEO from a suitably experienced NED is recommended. This will be a decision for local Chairs and Chief Executive Officers (CEOs).

## 9.2 Providers of NHS-funded services

To meet their obligations under the Civil Contingencies Act 2004, NHS Act 2006 and the NHS Standard Contract providers of NHS-funded services are required to:

- support ICBs within their ICS and NHS England in discharging their EPRR functions and duties, locally and regionally
- 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 the ICB, NHS England, healthcare and multi-agency 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 any sub-contractors 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 ICS planning groups in support of EPRR requirements.

In addition to these general requirements under this Framework the following specific requirements apply.

### 9.2.1 NHS ambulance services

**Ambulance tactical adviser**

The NHS emergency ambulance service will ensure the provision of on-call ambulance Tactical Advisers who are subject matter experts. They will be appropriately equipped and competent to give appropriate advice to the ambulance Tactical Commander and, if necessary, the ambulance Strategic Commander. Tactical Advisers can also be called on to give advice to ambulance staff and managers in support of risk assessing and responding to unusual incidents.

The ambulance Tactical Adviser may be required to attend the scene of the incident or emergency, a tactical coordinating group (**TCG**) and/ or a strategic coordinating group (**SCG**).

**Medical support**

The NHS ambulance service must have in place arrangements for the provision of medical support in the event of a mass casualty incident.

### 9.2.2 Mental health and learning disability secure services

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

## 9.3 Integrated Care Boards

The ICB's role and responsibilities are to:

- fulfil the relevant duties under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 and the Health and Care Act 2022
- AEO to co-chair the LHRP and maintain the involvement and support of LHRP partners at strategic and tactical level
- ensure appropriate director level representation at the LRF
- establish a mechanism to provide NHS strategic and tactical leadership and support structures to effectively manage and coordinate the NHS response to, and recovery from, incidents and emergencies, 24/7. This will include representing the NHS at Strategic Coordinating Groups and Tactical Coordinating Groups

- support NHS England in discharging their EPRR functions and duties locally, including supporting ICS tactical coordination during incidents (level 2–4 incidents)
- ensure robust escalation procedures are in place to respond to disruption to delivery of patient services
- provide a route of escalation for resilience planning issues to the LHRP in respect of commissioned provider EPRR preparedness
- develop and maintain incident response arrangements in collaboration with all NHS-funded organisations and partner organisations
- ensure that there is an effective process for the identification, recording, implementation and sharing of lessons identified through response to incidents and emergencies and participation in exercises and debrief events
- provide annual assurance against the NHS EPRR Core Standards, including by monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with applicable Core Standards
- ensure contracts with all commissioned providers (including independent and third sector) contain relevant EPRR elements, including business continuity

Where the ICB or LRF covers more than one geographical location then agreement will be made locally in respect of representation for planning and response.

## 9.4 NHS England (London)

Due to the unique structure of resilience across the capital, NHS England (London) leads on NHS resilience matters across the region including the response. NHS England (London) as the lead organisation coordinates resilience planning, assurance and response with their ICBs, for example, via the London Local Health Resilience Partnership, and continues to represent the NHS at the London Resilience Forum.

## 9.5 Local Health Resilience Partnerships

LHRPs provide strategic forums for joint EPRR planning across a geographical area and support the health sector's contribution to multi-agency planning through the LRF.

The roles and responsibilities around LHRPs are as follows:

- LHRPs coordinate NHS EPRR across the LRF area and provide health input into LRFs and multi-agency planning for incidents

- LHRPs ensure coordinated strategic planning for incidents impacting on health or continuity of patient services and effective engagement across the LHRP and local ICSs
- the DPH co-chair has a specific responsibility to provide public health expertise and coordinate public health input
- the ICB co-chair provides local leadership on EPRR matters to all NHS-funded organisations and maintains engagement across the local health and social care system to ensure resilience is commissioned effectively, reflecting local risks
- the LHRP should consider, and contribute to, the Community Risk Register (CRR) developed by the LRF. These assessments should inform the planning and strategy set by the LHRP.

The LHRP will co-ordinate health input to NHS England, UKHSA 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 ICS response at the tactical level to incidents
- coordination and leadership across health organisations within local ICSs are in place
- there is opportunity for co-ordinated training and exercising and the sharing of lessons identified
- the health sector is integrated into appropriate wider EPRR plans and structures of civil resilience partner organisations within the LRF area(s) covered by the LHRP
- there is a mechanism for the peer review of EPRR assurance against the Core Standards.

### 9.5.1 Accountability

- LHRPs are not statutory organisations and accountability for EPRR remains with individual organisations.
- Each constituent organisation remains responsible and accountable for its effective response to incidents in line with its 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.

### 9.5.2 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.

### 9.5.3 Working groups

Due to the strategic nature of the LHRP, the co-chairs will determine the need for any specific working groups and/or ICS 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 LRF can be found here.

## 9.6 NHS England

NHS England's general EPRR role and responsibilities are to:

- set a risk based EPRR strategy for the NHS
- ensure there is a comprehensive NHS EPRR system and assure themselves and DHSC that the system is fit for purpose
- lead the mobilisation of the NHS in the event of an emergency, in line with the NHS incident response levels (section 7)
- work with UKHSA and DHSC, where appropriate, to develop joint response arrangements
- undertake its responsibilities as a Category 1 responder under the CCA 2004.

### 9.6.1 NHS England (Region)

At a regional level NHS England will:

- provide director level representation at the LHRP
- ensure that each LHRP is suitably co-chaired by the ICB

- as a category 1 responder, ensure suitable representation at the LRF(s)
- ensure integration of plans across the region to deliver a unified NHS response to incidents, including the provision of surge capacity
- maintain capacity and capability to coordinate the regional NHS response to an incident 24/7 through effective surge and escalation planning at ICB level
- work with relevant partners through the LHRP and LRF structures
- seek assurance through the local LHRP and commissioners that the Core Standards are met and that each ICS can effectively respond to and recover from incidents
- coordinate and locally endorse any requests from NHS organisations for military assistance
- provide support to the ICB, as required, to ensure any response to a Major Incident is effective
- discharge the local NHS England statutory EPRR duties as a Category 1 responder under the CCA 2004 (delegated function).

### 9.6.2 NHS England national team

At a national level NHS England will:

- support the NHS England AEO to discharge their 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 national incidents
- have available specialist clinical advice to the NHS on planning for and responding to an incident. This may also include the provision of a clinical support cell during the response to an incident
- provide assurance to DHSC of the NHS's ability to respond to incidents, including assurance of capacity and capability to meet wider UK resilience strategy requirements as they affect the health service
- support DHSC in its role in the UK central government response to emergencies
- action any requests from NHS organisations for military assistance

- support organisations during the response and recovery phases of an incident or emergency.

## 9.7 DHSC

DHSC's EPRR role is to:

- identify EPRR policy requirements for the health sector and communicate these, as appropriate, to NHS England, UKHSA and other relevant organisations
- provide assurance to Ministers, the Cabinet Office and other government departments of the health system's preparedness for and contribution to the UK central government's response to domestic and international emergencies, in line with the NSRA
- as the lead government department for health, ensure that plans are in place for identified risks to health in the NSRA
- 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 UKHSA
- take other action as required on behalf of the SofS ensure a national emergency is appropriately managed
- work with devolved administrations and internationally to plan and respond to relevant emergencies.

## 9.8 United Kingdom Health Security Agency (UKHSA)

At local, regional and national levels the UKHSA will deliver SofS responsibilities as a Category 1 responder.

### 9.8.1 UKHSA (locally delivered services)

At a local level UKHSA will:

- ensure that UKHSA has plans for incidents and emergencies in place across the local area
- support the LHRPs, coordinating with local government partners
- provide assurance of the ability of UKHSA to respond to incidents and emergencies

- provide a representative to the LHRP as required
- represent the SofS on the LRF.

### 9.8.2 UKHSA regional

At a regional level UKHSA will:

- ensure the delivery of the national EPRR strategy across its region
- provide strategic EPRR advice and support to UKHSA at a local level
- ensure integration of UKHSA emergency plans to deliver a unified public health response across more than one LHRP
- maintain UKHSA's capacity and capability to coordinate regional public health responses to emergencies 24/7.

### 9.8.3 UKHSA national

At national level UKHSA 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 NHS England at the national level and where appropriate develop joint response plans
- provide specialist expert public health services and input to national and local planning for emergencies.

## 9.9 Department for Levelling Up, Housing and Communities (DLUHC)

DLUHC provides the platform for multi-LRF co-operation and planning in emergency preparedness. The function of this sub-national tier is to improve coordination and communication between UK central government and local responders, and other organisations. DLUHC should ensure that areas are prepared to respond to events that would affect most or all of the area or could overwhelm any locality.

DLUHC Resilience and 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 provides the government liaison officer in a response where appropriate to facilitate this communication function.

DLUHC 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) to bring together appropriate representatives from local multi-agency Strategic Co-ordinating Groups.

## 9.10 Cabinet Office

Responsibilities of the Cabinet Office include co-ordinating the government's response to crises and managing the UK's cyber security. As part of its ongoing work, the Cabinet Office engages with central, local and regional partners to prepare for emergencies and to coordinate the UK central government response to major disruptive challenges, including:

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

The UK central government response to an emergency is underpinned by the Cabinet Office Briefing Rooms (**COBR**), which is the physical location from which the central response is activated, monitored and co-ordinated. 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.

All incidents and emergencies where the UK central government response is activated will be managed as Level 4 incidents.

# 10. Cycle of preparedness

## 10.1 Risk management

Risk management is covered within the CCA 2004 and the 2005 Regulations 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.

## 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.

## 10.3 Training

The training of staff who have a response role for incidents is of fundamental importance. NHS organisations are familiar with responding to routine everyday challenges by following usual business practices.  Notwithstanding COVID-19, very few staff members will 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 needs to be an ongoing process to ensure skills are maintained; it is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning.

Training should focus 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 **MOS**, which should be referred to when identifying staff training needs, as well as the Skills for Justice NOS framework.

## 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 functions and actions worked and what needs changing. The log must also identify what has changed as a result. This information provides an audit tool highlighting that lessons have been identified and action taken. It is key evidence for any inquiry.

Through the exercising process individuals can practise their skills and increase their confidence, knowledge and skill base in preparation for responding to a live incident.

Organisations should consider carrying out joint exercises with partner agencies and contracted services where the identified risks and the involvement of partner organisations is appropriate.

Learning from exercises is central to developing a method that supports personal and organisational goals and must be part of an annual plan validation and maintenance programme.

Each NHS-funded organisation is required to undertake the following:

### 10.4.1 Communications systems exercise

Minimum frequency – every six months.

These exercises test the organisation's ability 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 systems exercise should be conducted both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced.

Participation in a communications systems exercise initiated by another organisation does not remove the requirement for each organisation to undertake its own communications system exercise.

### 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 scenario and can help validate a new or revised plan. Participants can 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 counter-measure distribution 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 in exercises run by multi-agency partners, including the LRF, where relevant to health.

### 10.4.4 Command post exercise

Minimum frequency – every three 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 familiarity for those undertaking roles within the ICC. It can be incorporated into other types of exercise, such as the communications systems exercise or live play exercises.

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

If an organisation activates its 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.

### 10.4.4 ICC equipment test

Minimum frequency – every three months.

The functionality of equipment used in an ICC must be tested.

## 10.5 Lessons identified

NHS-funded organisations are required to share lessons identified through exercising or incident response across the wider NHS, using a common process coordinated by 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 (Figure 3) for a learning cycle that can be adopted for EPRR purposes.

*Figure 3: (Adapted from Chapter 6 Business Continuity Management of the Emergency Preparedness guidance issued by the Cabinet Office, revised March 2012)*

# 11. Organisational resilience

Business continuity management (**BCM**) is an essential tool in establishing an organisation's resilience to maintain its 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 business continuity arrangements and the IRP to be triggered. It is critical that both plans are integrated and complementary 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.

# 12. Incident response

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 co-ordinating the applicable response.

Provider organisations must inform their respective Integrated Care Boards who are required to maintain 24/7 on-call arrangements.

As the accountable organisation for maintaining resilience across the NHS, NHS England EPRR On-Call should be made aware of any incidents that have affected or are likely to affect an organisations ability to continue to delivery safe patient services. The usual route for notification is from ICBs to NHS England via regional on-call teams, so they can ensure appropriate support and coordination is put in place for the response but also consider the impact on service delivery from other multiple/concurrent incidents. Specific examples include when:

- a Business Continuity Incident or Critical Incident is declared by your organisation
- a Major Incident is declared by your organisation or a partner agency your organisation is supporting in the response
- your organisation's resources have become overwhelmed due to an incident and mutual aid is required
- an ambulance re-direction is required due to disruption at your hospital site
- due to overwhelming system pressure your organisation is unable to support the response to any potential Major Incident declarations in your area
- your organisation is the target of a threat involving chemical, biological, radiological, nuclear or explosive materials (**CBRNe**); or your organisation has activated its CBRNe response plans
- an emergency evacuation of some or all of your organisation's sites/premises is required or underway
- your organisation is supporting a large-scale community evacuation
- your organisation anticipates or is experiencing media interest relating to an incident or emergency to which your organisation is responding.

**In addition to alerting your ICB and/or NHS England EPRR On-Call, it is your organisation's duty to ensure that its partners and supporting organisations (e.g. community services, primary care services etc) are alerted to the declaration of any incidents.**

Figure 4 shows response structures for the NHS in England and its interaction with key partner organisations. Local NHS Strategic Command will lead the mobilisation of NHS-funded organisations to respond to a major incident in line with the priorities set by the Strategic Coordinating Group that has NHS membership, and at the Tactical Coordinating Group.

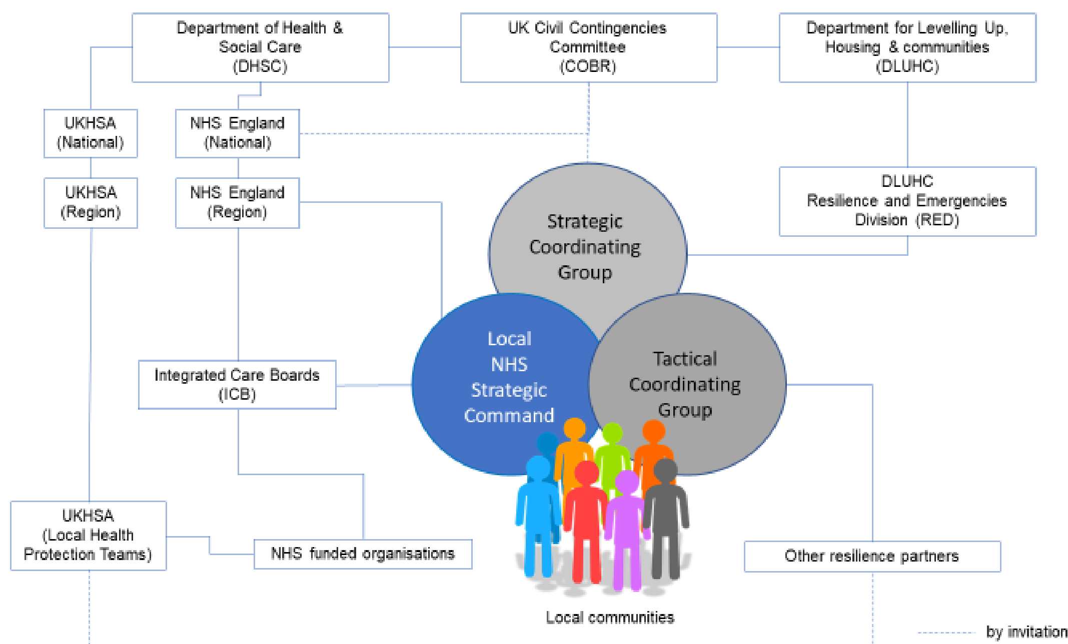


*Figure 4: Incident response structure for the NHS in England (*In London, this is the responsibility of NHS England (London) see 9.4). **n.b.** LRFs and LHRPs are not part of the response structure*

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

While incidents and emergencies are often triggered by 'rapid onset' events and alerts are cascaded by NHS ambulance services, there are other potential circumstances where an incident affecting the NHS occurs, e.g. infectious disease outbreaks. In such cases the NHS 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 ICBs 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 ICBs in implementing command and control mechanisms and the deployment of appropriate NHS resources.

Although the alert could come from an external partner, health services should always use standard alerting messages.

## 12.2 Standard alerting messages

To avoid confusion about when to implement plans it is essential that standard messages are used, as shown in Figure 5.

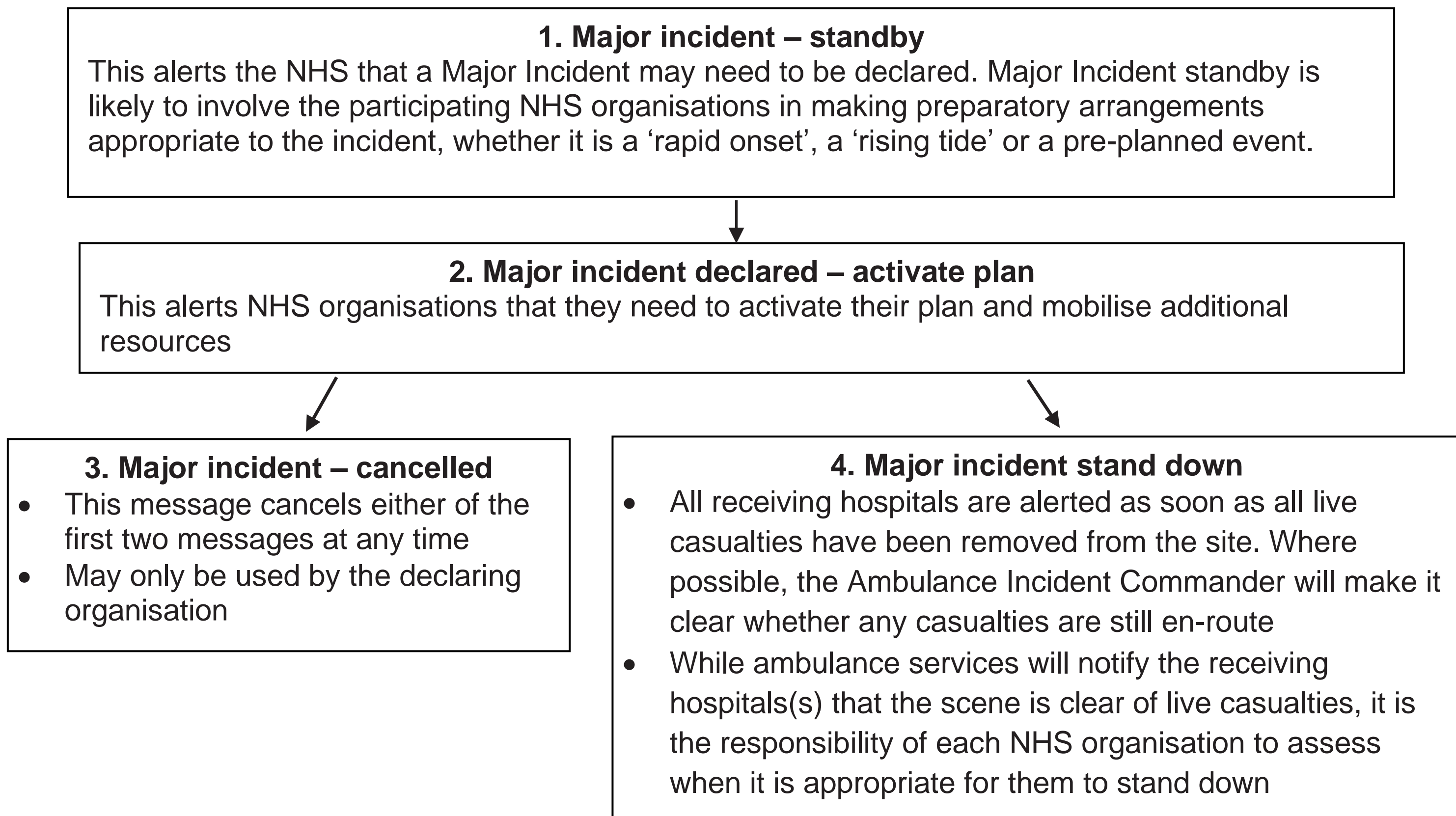


*Figure 5: Standard alerting messages*

## 12.3 METHANE

The JESIP identify METHANE as the preferred model for sharing information to promote a shared situational awareness.

**M**ajor incident – standby or declared?

**E**xact location

**T**ype of incident

**H**azards present or suspected

**A**ccess – routes that are safe to use

**N**umber, type, severity of casualties

**E**mergency services present and those required

This format should be used when sharing information across partner organisations. It can be adapted to be used in a variety of incident types. Figure 6 provides an example of how it could be applied to a cyber incident.

| | |
|---|---|
| **M** | **Does the attack affect two or more agencies and require full command and control**<br>**Are critical services impacted** |
| **E** | What network area is affected including potential spread and/or containment of the attack |
| **T** | Nature of the cyber attack (worm, zombie, Trojan etc.) |
| **H** | Data breach including financial loss<br>Business continuity and your ability to continue to deliver critical services<br>Threat and Risk to other partners |
| **A** | Single agency response plan along with their capabilities to resource the response/recovery, including skill sets<br>Request for mutual aid for additional resources and/or subject matter experts |
| **N** | Potential disruption to services delivered to vulnerable people |
| **E** | Incident has been reported to:<br>NHS Digital<br>Information Commissioners Office<br>National Cyber Security Centre<br>Shared services providers or partners joined through the network |

*Figure 6: METHANE for cyber incident*

## 12.4 Critical Incident

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 NHS-funded organisation's ability to deliver safe patient care.

Any organisation declaring a Critical Incident should adopt this format: 'Critical Incident declared by (*organisation*)'. This format could also be used for example when reporting a business continuity incident.

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):

| **SBAR report** | |
|---|---|
| **S**ituation | Describe situation/incident that has occurred |
| **B**ackground | Explain history and impact of incident on services/patient safety |
| **A**ssessment | Confirm your understanding of the issues involved |
| **R**ecommendation | Explain what you need, clarify expectations and what you would like to happen |
| **If the message is passed by voice message, ask the receiver to repeat information to ensure understanding** | |

## 12.5 Internal and external communications

Effective communications form an essential part of any incident response. They 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 depends on the organisation's ability to manage the situation and ensure NHS staff are aware and informed.

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

Any incident is likely to generate significant media interest at local, regional and potentially national levels. It is important to ensure that communications are co-ordinated to ensure that messaging is consistent across all organisations.

A large and diverse 24/7 media, alongside the growth in social media, has meant that information about incidents and events is now readily available and coverage is likely to evolve faster than ever before. This coverage needs to be managed as effectively as possible. Speculation can quickly become presented as fact, misleading key audiences. This can reduce effective management of the wider incident. It is therefore essential the NHS works with its partners to respond to media interest quickly and effectively.

NHS-funded organisations should make the NHS England (Region) communications teams aware of any communications activity related to an incident. NHS England (Region) communications teams will ensure effective engagement with national organisations, via the NHS England national communications team, and LRF communication structures and processes.

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

- **Joined-up communication.** A managed and co-ordinated communication and media response across responding NHS bodies and aligned to the multi-agency response, DHSC and UKHSA, via NHS England regional and national communications teams.

- **Accurate and timely statements to staff and media.** NHS England and NHS-funded organisations should provide regular statements, where appropriate, to both the public and staff. These should include situational updates and reliable, useable information about accessing services, facilities and other aspects of the incident response.

- **Sharing key information to warn and inform the public.** The NHS has a duty to provide timely information, warning and informing the public, in coordination with partner organisations, if an emergency has occurred or is likely to occur.

- **Ensure websites and other digital channels are kept up to date.** The public, media and staff will use digital media to find out about an incident and the response to it. Websites and other NHS digital media must be regularly updated to give clear, accurate, consistent and reliable information about the situation. This should include ensuring that any press statements are put on the relevant organisations' websites and disseminated more widely using social media sites such as Twitter and Facebook.

- **Support designated spokespeople.** The modern media landscape means there is around-the-clock demand for information during an incident. Responder organisations will need a cadre of trained and informed spokespeople to take part as required.

- **Support for any nationally led communications strategy** in response to a Level 4 incident, or similar declaration will be advised via national NHS England communications.

## 12.6 Escalation and de-escalation

The level of the response may need to be escalated or de-escalated. The process for this needs to be agreed in conjunction with health strategic commanders so it can be coordinated across all organisations.

The Appendix shows the criteria for triggering an escalation and or a de-escalation.

## 12.7 Staff welfare

NHS-funded organisations must ensure staff welfare, including wellbeing and comfort. Incident commanders (managers and directors) must ensure they are mindful of their own and their teams' levels of stress and fatigue and be aware of their potential to impact on individual performance and decision-making. Effective arrangements need to be in place to minimise the potential impact, e.g. rest breaks and shift systems for protracted incidents.

Further guidance and resources are available at ResilienceDirect.

## 12.8 On-call staff

Each NHS-funded 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 with delegated authority to allocate resources should always be available to make strategic decisions for the organisation; other staff should also be on-call to provide support. Staff must be appropriately trained, noting the **MOS** relevant to their role within the organisational response.

# 13. Concepts of command and control

The following is based on and adapted from the Emergency response and recovery guidance (Cabinet Office, 2013).

The management of emergency response and recovery is undertaken at one or more of three ascending levels: operational, tactical and strategic. This is based on the concepts of command, control and co-ordination, which are defined as follows:

- **Command** is the exercise of authority that is associated with a role or rank within an organisation, to give direction to achieve defined objectives.

- **Control** is the application of authority, combined with the capability to manage resources, to achieve defined objectives.

- **Co-ordination** is the integration of multi-agency efforts and available capabilities, which may be interdependent, to achieve defined objectives. The co-ordination 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 command

Operational command is the level at which the immediate 'hands on' work is managed. Operational commanders will concentrate their effort and resources on the specific tasks within their geographical or functional area of responsibility. Operational commanders will be identified in the organisational response plans.

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, co-ordination 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 command

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

Where formal co-ordination is required at tactical level, then an LRF tactical co-ordinating group (TCG) may be convened SCG with multi-agency partners within the area of operations. The NHS tactical commander at the TCG will be identified by the ICB. They will ensure that all NHS-funded organisations are coordinated through local health tactical coordination groups. In addition, the NHS ambulance service(s) will be present on the TCG in their role as an emergency service.

The NHS tactical commander 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 to inform tasking of operational commanders
- ensure the health and safety of the public, patients and NHS personnel.

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

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 command

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 operational and tactical; 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 strategic coordinating group (SCG[6]). This group is usually convened by the chair of the LRF following a request from one of the LRF members.

The SCG does not have the collective authority to issue commands to individual responder agencies; each will retain its own command authority and defined responsibilities and will exercise control of its own operations in the normal way.

The local NHS strategic commander at the SCG will be identified and agreed between NHS England and the ICB.

The SofS and/or NHS England may require some organisations to act in a particular way in an emergency, under section 253 of the NHS Act 2006). The organisations that are subject to such orders include:

- NHS England, ICB, NHS trusts and NHS foundation trusts, and
- other organisations that provide services commissioned by the SofS, NHS England, ICB or a local authority under particular sections of the 2006 Act

In addition, the providers of 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 operational and tactical 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 level and allocate personnel and resources accordingly
- formulate and implement media handling and public communication plans

[6] The SCG is the formal response structure based on the same geography and membership of the LRF. The LRF does not have a role in the response to an incident. Whilst the chair of the LRF is set by the group, the SCG chair will be decided at the time based on the type and scale of the incident.

- direct planning and operations beyond the immediate response to facilitate the recovery process.

For incidents across multiple SCG areas, 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. The decision on the impact of the incident on the NHS from across more than one SCG area will be taken by the relevant NHS England (Regional) Director(s) and the NHS England National Director for EPRR.

# 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 incident Level 1 or 2 (see Figure 1 in Section 7) may be managed by an individual organisation through the ICB in liaison with NHS England (Region). For a response at incident Level 1 managed by an individual organisation, the ICB and NHS England (Region) must be informed through their on-call arrangements.

All actions that are or would be undertaken at lower incident levels will need to be maintained, in addition to any actions arising from a higher incident 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 strategic NHS response, then the respective regional team will provide command, control and coordination for the NHS.

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

Responses at incident Level 4 will require NHS England (National) 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 incident Level 4 and in certain situations such as pandemics, national fuel shortage or extensive extreme weather events, NHS England national may require some organisations to respond in a particular way to the emergency. NHS England is able to do this under section 253 of the NHS Act 2006, provided the SofS delegates the appropriate authority to NHS England. The organisations that are subject to such orders include:

- ICBs, NHS trusts and NHS foundation trusts; and
- other organisations that provide services commissioned by the SofS, NHS England, ICBs or a local authority under particular sections of the 2006 Act

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 must be sustainable to operate 24 hours a day, seven days a week to deliver the strategic objectives, over a protracted period where necessary.

## 14.5 Incident coordination centres

The incident coordination centre (**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 by having a formal structure. Benefits of this include:

- **unity of effort** – all team members operate under a common list of objectives
- **accountability** – everyone 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 the range of incidents and hours of operation required.

### 14.5.1 ICC functions

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

- **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 to ensure 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 to the organisation.

### 14.5.2 Organisational ICC requirements

Each NHS-funded organisation needs 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 and supported by a separate strategic facility for overall command and control.

There should be sufficient resilience within the organisation to ensure an alternative ICC can be used 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.

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

## 14.6 Decision-making

Decision-making, especially during an incident, is often complex and decisions are open to challenge. Decision-makers will be supported where they can demonstrate that their decisions have been informed by all known information or situational awareness, assessed risks, and managed these risks reasonably in the circumstances existing at the time. The use of decision support models and processes assist in providing this evidence, particularly in conjunction with decision logs.

The joint decision model (JDM) is suitable for all decisions and has been adopted by JESIP in the Joint Doctrine to practically support decision-makers working under difficult circumstances (see Figure 7). It is organised around the three primary considerations: situation, direction, action.

Decision-makers are expected to use their judgement and experience when deciding what additional questions to ask and what to consider in order to reach a decision. The JDM supports the decision-making process in achieving the desired outcomes.

**Figure 7: Joint decision model**

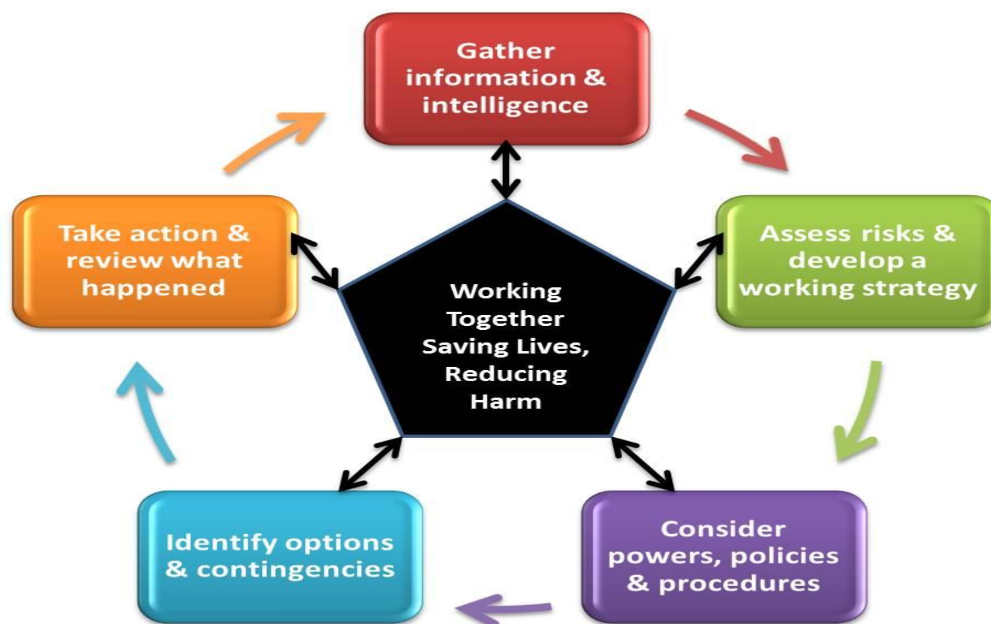


*Figure 7: Joint decision model*

# 15. Recovery

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

The national Emergency response and recovery guidance provides detailed advice for organisations. This advice may also help identify opportunities for service redesign and changes to operational practice.

The recovery phase should begin at the earliest opportunity and should be run in parallel with the response. It does not end until all disruption has been rectified, demands on services have returned to normal and the physical and psychosocial needs of those involved have been met.

# 16. Debriefing

To identify lessons from any incident or exercise, 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 good practice.

The purpose of a debrief is to identify issues that need to be addressed. They must be attended by all staff who had a part in the response to review what went well, what did not go well and what needs to change. The process of debrief should provide a support mechanism and identify staff welfare needs.

Organisations should ensure they use appropriately trained staff to facilitate debriefs.

Debriefs should be held as follows:

- **hot debrief** – immediately after the incident or period of duty, but within 48 hours of stand down
- **cold/structured/organisational debrief** – within 28 days post incident
- **multi-agency debrief** – within eight weeks of the close of the incident (actual timing will be set by the lead organisation for the response)
- **post-incident reports** – within four weeks of the debrief.

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

There should be a mechanism for sharing lessons identified across the local ICS, through the LHRP, the wider NHS and with partner organisations. Following the response to COVID-19, numerous plans have been tested/implemented and this learning should be considered and feedback back into other resilience plans as required.

# 17. Assurance

The minimum requirements that NHS-funded organisations must meet are set out in the Core Standards.  These standards are in accordance with the CCA 2004, the 2005 Regulations the NHS Act 2006, the Health and Care Act 2022 and the Cabinet Office national resilience standards.

All NHS-funded organisations are required to provide evidence of their compliance to their board, at a public board meeting, and for their board to issue a Statement of EPRR Conformity to their commissioners. NHS England will ensure that ICB compliance forms part of the annual assurance process.

NHS England will, in collaboration with LHRPs, ensure an annual assurance programme is undertaken to inform the national report to the SofS.

# 18. Equality and health inequality 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 Framework, we have, by undertaking a detailed equality impact assessment:

- 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.

All guidance developed under this Framework will have due regard to the need to reflect the impact on and from health inequalities in local populations during times of preparing for and responding to major incidents.

Guidance on the NHS equality and health inequalities legal duties can be found here.

## 18.1 Health Inequalities during a major incident

Reducing the actual or unintentional impact from health inequalities during a major incident is vital. During the planning phase, AEOs must ensure the diverse range of local health needs is considered when preparing for a range of incidents.

Additionally, Incident Commanders, as part of their role leading the response to an incident, should consider the impact of their decisions on health inequalities either within the existing population or on the community as a result of an incident. This, along with other decisions, should be appropriately recorded in incident logs along with the rationale underpinning the decision being made.

The NHS England National EPRR team routinely reviews health lessons from a range of incidents as part of a learning cycle to improve and make changes to national EPRR guidance as necessary. As part of learning from COVID-19 and similar incidents, specific guidance on managing health inequalities during a major incident is being developed and will be published in due course.

# 19. Acronyms

Without a common understanding of what specific terms and phrases mean, multi-agency working will carry the risk of potentially serious misunderstandings. Since 2007 the Cabinet Office has worked 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. Key acronyms set out in the Cabinet Office resource are highlighted in the text in bold for ease of reference.

# Appendix: Escalation

The below criteria set out the point at which an issue could be escalated to the next level of incident response. In turn, if the measures are no longer required, the incident response level can be de-escalated.

| **Level 1 – Organisation level response**<br>**Coordinating organisation: NHS-funded organisation** |
|---|
| If the following applies the incident may need to be escalated to Level 2:<br>• Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the provider<br>• A Business Continuity Incident that threatens the delivery of patient services (in line with ISO 22301)<br>• Responding to a declared Major Incident or Major Incident standby<br>• A media or public confidence issue that may result in local, regional or national interest<br>• A significant operational issue that may have implications wider than the organisation e.g. public health outbreak, suspected high consequence infectious disease (HCID), security incident, Hazmat incident |

| **Level 2 – Local level response**<br>**Coordinating organisation: ICB with NHS England (Region)** |
|---|
| If the following applies the incident may need to be escalated to Level 3:<br>• Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the ICB<br>• A Critical Incident that threatens the delivery of **critical** services or presents a risk of harm to patients and/or staff<br>• Responding to a declared Major Incident or Major Incident standby<br>• A media or public confidence issue that may result in local, regional or national interest<br>• A significant operational issue that may have implications wider than the local ICS e.g. public health outbreak, suspected HCID, security incident, Hazmat/CBRN incident |

**Level 3 – Regional level response**
**Coordinating organisation: NHS England (Region)**

If the following applies the incident may need to be escalated to Level 4:

- Capacity and demand reaches, or threatens to surpass, a level that requires national coordination or NHS mutual aid e.g. need for ECMO, HCID, burns treatment or other specialist functions
- A Business Continuity Incident that threatens the delivery of an **essential** NHS England function or a protracted incident effecting one or more NHS England site
- A Critical Incident with the potential to impact on more than one ICB
- A declared Major Incident which may have a significant NHS impact and/or the establishment of an NHS England Incident Coordination Centre
- A media or public confidence issue that may result in regional, national or international interest
- A significant operational issue that may have implications wider than the remit of one NHS England region e.g. flooding, security incident, Hazmat/CBRN incident, Critical National Infrastructure, collapse of a commissioned supplier that provides services to more than one region
- An incident that may require the request and activation of Military Aid to the Civil Authorities (**MACA**)

**Level 4 – National level response**
**Coordinating organisation: NHS England National Team (with DHSC where appropriate)**

If any of the following apply or are required, DHSC should be informed:

- Capacity and demand reaches, or threatens to surpass, a level that requires international coordination e.g. need for ECMO, HCID, burns treatment or other specialist function
- Invocation of central government emergency response arrangements
- Issues that may require **invocation of** 'Emergency Powers' to be invoked under the CCA 2004 or measures under sections 252A or 253 of the NHS Act 2006
- A Business Continuity Incident with the potential to impact on significant aspects of the NHS e.g. NHS Supply Chain, NHS Blood and Transplant
- A declared Major Incident which may have national and/or international implications e.g. CBRN, MTA
- A media or public confidence issue that may result in national or international interest
- A significant operational issue that may have implications wider than the remit of the NHS e.g. Critical National Infrastructure
- An incident that may require the request and activation of MACA

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