Department of Health

Emergency Preparedness Division

The NHS Emergency Planning Guidance 2005

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Underpinning materials are sections written to provide more detail on the roles and responsibilities of parts of the NHS and specific guidance on aspects of emergency preparedness.

- Acute Trusts and Foundation Trusts
- Ambulance services
- Immediate medical care at the scene
- Non acute and specialist Trusts
- Primary Care Organisations
- Strategic Health Authorities

Preface

The Guidance that follows has been developed with the need to ensure the ability to provide updates, develop new material and provide access to complementary material from other organisations and to share examples of the practice of and approaches to emergency planning from the NHS in England.

The Guidance is entirely web based and there will no longer be formal printed versions available. This approach will allow for rapid updating, for example, of the roles and responsibilities of NHS organisations resulting from the introduction of arrangements proposed in Commissioning a Patient Led NHS. It will also allow for the timely publication and integration of Guidance currently being developed on the following topics:

- Children
- Critical care
- Burns
- Radiation
- Estates, facilities and service resilience
- NHS Direct
- Mental Health

The web-based facility also allows feedback. Comments, observations and responses are welcomed.

This Guidance has been developed with the support of a Steering Group which drew its membership from across the NHS, the Health Protection Agency, regional Public Health Groups and Foundation Trusts. Its development was also informed by the work of sub groups established to review specific subject areas and by a wide range of interviews and meetings conducted within the NHS and with its partner organisations. I would like to express my personal gratitude to all who have contributed their knowledge, experience, time and energy to this process.

A Review Group, based on the membership of the Steering Group, has taken responsibility for overseeing the on-going maintenance and development of this Guidance.

Dr Penny Bevan

Head of the Emergency Preparedness Division

October 2005

Executive summary

1. The purpose of the guidance is to describe a set of general principles to guide all National Health Service (NHS) organisations in developing their ability to respond to a major incident or incidents and to manage recovery whether the incident or incidents has effects locally, regionally, or nationally, within the context of the requirements of the Civil Contingencies Act 2004 (the CCA).

2. This NHS Guidance contains principles for effective health emergency planning that have been developed in consultation with other United Kingdom (UK) Health Departments. It is strategic national guidance for all NHS organisations in England and equivalent guidance will be provided by Health Departments in devolved administrations. This is being copied to NHS Foundation Trusts for information.

3. It replaces the NHS Emergency Planning Guidance 1998 and all other material previously included in, or associated with, that Guidance. Underpinning material supporting the guidance is cross-referenced throughout the document.

4. This guidance is built on best practice and shared knowledge and is intended to provide a platform for all NHS organisations to undertake major incident and emergency planning and associated activities. In the context of this Guidance, the term NHS organisation includes Foundation Trusts.

5. In each NHS organisation, the Chief Executive Officer will be responsible for ensuring that their organisation has a Major Incident Plan in place that will be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan will link into the organisation's arrangements for ensuring business continuity as required by the Civil Contingencies Act 2004.

6. The Chief Executive Officer will ensure that the Board receives regular reports, at least annually, regarding emergency preparedness, including reports on exercises, training and testing undertaken by the organisation, and that adequate resources are made available to allow discharge of these responsibilities. As a minimum requirement, NHS organisations will be required to undertake a live exercise every three years; a table top exercise every year and a test of communications cascades every six months. To support this arrangement it is suggested that an Executive Director of the Board be designated to take responsibility for emergency preparedness on behalf of the organisation. It is further suggested that a Non-Executive Director of the Board be nominated to support the Executive Director lead in this role. In some cases this may be best achieved through the linkage of emergency planning and business continuity to the organisation’s Risk Management Committee (or equivalent). It is considered good practice for NHS organisations to designate an adequately resourced officer, usually referred to as the Emergency Planning Liaison Officer (EPLO), to support the executive in the discharge of their duties for emergency preparedness.

7. Major incident and emergency planning will be undertaken within the context of the NHS Performance Management Framework, delivering to Public Health Core Standard C24 and will be monitored by the Health Care Commission. An Audit and Assessment Framework is available to support the process and to

provide the basis for a framework for plans and for the planning process for all NHS organisations.

8. Command and control arrangements for NHS organisations have been revised. Particular changes include:

    - NHS organisations are required to ensure they have in place robust command and control mechanisms to enable them to plan for, and respond to, major incidents linked with the command and control arrangements of the Strategic Health Authority (SHA), Strategic Coordinating Group (SCG) and the Regional Civil Contingencies Committee (RCCC)

    - The Joint Health Advisory Cell (JHAC) arrangements have been revised and replaced with a more comprehensive means for providing health advice in the course of a major incident regardless of its cause, source or scale

    - Explicit arrangements are made for coordination and delivery of NHS resources in the course of an incident

    - The Department of Health will take control of the deployment of NHS resources in the event of a complex and significant major incident, including those on a UK wide and International scale, through its Emergency Preparedness Division Coordination Centre. All NHS organisations will be expected to respond to instructions delivered under these circumstances.

9. All NHS organisations are required to deliver their responsibilities as defined by the Civil Contingencies Act 2004. This includes ensuring the contribution of all NHS agencies to multi-agency planning frameworks of Local Resilience Forums (LRF). NHS Trusts will need to engage with local multi-agency partners.

10. It is not the intention of this guidance to disrupt existing arrangements and plans that are currently working well. However, NHS organisations will be required to demonstrate clearly that their arrangements for emergency planning meet the requirements of this Guidance document.

Background and context

1. Introduction

1.1. The Emergency Preparedness Division of the Department of Health has developed this guidance with input from a steering group appointed to develop a framework for the future structure and content of the guidance.

1.2. The purpose of the guidance is to describe a set of general principles to guide all NHS organisations in developing their ability to respond to a major incident or incidents, and to manage recovery whether the incident or incidents has effects locally, regionally, or nationally within the context of the requirements of the Civil Contingencies Act 2004 (the CCA).

1.3. This NHS Guidance contains principles for effective health emergency planning that have been developed in consultation with other United Kingdom (UK) Health Departments. It is strategic national guidance for all NHS organisations in England and equivalent guidance will be provided by Health Departments in devolved administrations. This is being copied to NHS Foundation Trusts for information.

1.4. Health emergency planning guidance for Scotland, Wales and Northern Ireland can be accessed on the respective websites for the health services in the Devolved Administrations. In England, it replaces the NHS Emergency Planning Guidance 1998 including

- the Operational Doctrine
- all previous updates detailing the roles and responsibilities of NHS organisations

It makes changes to:

- the arrangements for the organisation and management of immediate medical care at the scene
- the arrangements for oversight of the organisation and management of Mobile Medical Teams or their equivalent
- the arrangements for input to Major Incident Command and Control including the replacement of the Joint Health Advisory Cell (JHAC)

It links to existing national guidance including ‘Beyond A Major Incident’, and ‘National Guidance on Pandemics’. It is built on the principles of co-operation, information sharing, risk assessment, emergency planning, business continuity management and communicating with the public.

1.5. This guidance is based on having:

- identified key legislation, guidance and other material to be incorporated into the main guidance or be used in conjunction with the guidance

- developed means for performance management of the implementation of the guidance within the NHS

- developed means of ensuring that the guidance is maintained in an up-to-date and accessible format

- reflected the interface between the Department of Health (DH) , the NHS, the Health Protection Agency (HPA) and all other relevant organisations

- identified the relevant risk roles and responsibilities of NHS organisations

- ensured the needs of all vulnerable persons including children are reflected in the guidance

- taken into account the requirements of the Mass Fatalities Guidance.

1.6. This guidance requires NHS organisations to reflect in arrangements for emergency preparedness the following:

- the requirements of the Civil Contingencies Act (CCA) 2004 and duties placed on designated responders in NHS organisations. The CCA sets out clear expectations and responsibilities for front line responders at the local level to ensure they are prepared to deal effectively with the full range of emergencies from localised incidents through to catastrophic emergencies. Detailed information is available on the UK Resilience website.

- In each NHS organisation, the Chief Executive Officer will be responsible for ensuring that their organisation has a Major Incident Plan in place that will be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan will link into the organisation's arrangements for ensuring business continuity.

- The Chief Executive Officer will ensure that the Board receives regular reports, at least annually, regarding emergency preparedness, including reports on exercises; training and testing undertaken by the organisation and that adequate resources are made available to allow discharge of these responsibilities. As a minimum requirement, NHS organisations will be required to undertake a live exercise every three years; a table top exercise every one year and a test of communications cascades every six months. To support this arrangement it is suggested that an Executive Director of the Board be designated to take responsibility for emergency preparedness on behalf of the organisation. It is further suggested that a Non-Executive Director of the Board be nominated to support the Executive Director lead in this role. In some cases this may be best achieved through the linkage of emergency planning and business continuity to the organisation’s Risk Management Committee (or equivalent). It is considered good practice for NHS organisations to designate an adequately resourced officer, usually referred to as the Emergency Planning Liaison Officer (EPLO), to support the executive in the discharge of their duties for emergency preparedness.

- As well as ensuring that there is adequately resourced management support for emergency preparedness, NHS organisations should also ensure adequate resources for related matters including training, testing and exercising, provision, maintenance and replacement of equipment. NHS organisations should also ensure that they maximise opportunities for obtaining resources from other sources, for example, from Local Resilience Forums; by charging for participation in exercises with external organisations.

- The Capabilities Programme led by the Cabinet Office and particularly the workstreams led by the Department of Health including: mass casualties; infectious diseases; and, essential services. DH may also require NHS organisations to contribute to other workstreams led by other Government departments. Detailed information can be found on the UK Resilience and Home Office websites.
  All current NHS guidance and policy relevant to emergency preparedness.

1.7. The actual plan is a key component of preparedness and should be able to demonstrate for each NHS organisation that:

- It has up to date plans to deal with major incidents and emergency situations that are compliant and tested in accordance with national guidance

- It has key partner organisations in the preparation and testing of major incident plans

- It has identified the financial resources needed to respond to incidents and emergency situations that could affect the provision of normal services

- It can mobilise staff to respond to incidents and emergency situations that could affect the provision of normal services.

1.8. There are other equally vital access aspects to an organisation's readiness, including ownership and understanding within the organisation, training, exercising and testing of arrangements, and the availability of the right equipment and procedures.

1.9. To comply with the Health Care Commission requirements from National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 - 2007/2008, the major incident plans of NHS organisations will be assessed as part of the performance management framework.

Public Health Core Standard C24 states:

Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services

The Audit and Assessment Framework for Major Incident Planning supports the development, maintenance and reviewing/testing of NHS major incident plans providing organisational, causal and scenario specific audit tools.

1.10. Business Continuity Management forms an important part of risk management arrangements and is a requirement of the Civil Contingencies Act 2004. The aim of business continuity management is to ensure that NHS organisations are able to maintain the highest level of service possible whatever might happen to the infrastructure. There is a range of problems that might affect NHS organisations and services at any time, for example, loss of water or power, flooding, or criminal action.

1.11. The aim of business continuity planning is to enable planning and reaction in a co-ordinated manner. Whilst business continuity and major incident planning are usually separate processes within an organisation, a major incident may occur at the same time as a business continuity issue, or be triggered by it.

1.12. Business continuity management, including processes for recovery and restoration, should be considered by NHS organisations as part of its every day business processes requiring a corporate response. Business continuity should be seen as embedded in the culture of the NHS as principles of health and safety, and there must be demonstrable commitment to the process from the Boards of NHS organisations. The skills to develop business continuity plans are complementary to those involved in emergency planning and may therefore need to be undertaken by separate officers. It is critical though that both plans are integrated and complementary to each other.

1.13. As examples of information available on business continuity, links are provided in the web version to the Business Continuity Institute (BCI), to its Good Practice Guidance and the Continuity Central, a regular update on business continuity issues provide by the BCI.

2. Defining a major incident

This section describes various definitions of emergencies and major incidents as they may apply to NHS organisations, the varying scale of major incidents and the alerting mechanism to be used in the event of a major incident.

2.1. Definition: the Civil Contingencies Act 2004

The Civil Contingencies Act 2004 defines an emergency as:

> **An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK**

The definition is concerned with consequences rather than the cause or source.

2.2. Definition: NHS major incident

2.2.1 For the NHS, major incident is the term in general use. The Civil Contingencies Act guidance on emergency preparedness states

the Act, the regulations and the guidance consistently use the term emergency, but there is nothing in the legislation that prevents a responder from using the term "major incident" in its planning arrangements for the response.

2.2.2 With the implementation of the Civil Contingencies Act, the term "emergency" may be used instead of incident. NHS organisations may continue to use the term major incident, but need to be aware that the term emergency will become common parlance for many of their partners, and they may wish to consider its use. However, if this decision is taken, the NHS organisation must take care to highlight this usage of the term emergency to avoid confusion with other elements of the services it provides.

2.2.3 A major incident is any event whose impact cannot be handled within routine service arrangements. It requires the implementation of special procedures by one or more of the emergency services, the NHS, or a Local Authority to respond to it.

2.2.4 A major incident may arise in a variety of ways:

- Big Bang – a serious transport accident, explosion, or series of smaller incidents
- Rising Tide – a developing infectious disease epidemic, or a capacity/staffing crisis
- Cloud on the Horizon – a serious threat such as a major chemical or nuclear release developing elsewhere and needing preparatory action
- Headline news – public or media alarm about a personal threat
- Internal incidents – fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime
- Deliberate release of chemical, biological or nuclear materials
- Mass casualties
- Pre-planned major events that require planning - demonstrations, sports fixtures, air shows.

2.2.5 For the NHS, a major incident is defined as:

Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements

to be implemented by hospitals, ambulance trusts or primary care organisations.

2.2.6 Each individual NHS organisation must plan to handle incidents in which its own facilities - or neighbouring ones – may be overwhelmed. The organisation itself may be affected by its own internal major incident or by an external incident that impairs its ability to work normally. Fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime or the need to deal with one or more contaminated person(s) may paralyse the provision of services and jeopardise safety arrangements. Planning successfully for these wider disruptive challenges will require more than simply scaling up the current plans of individual agencies.

2.2.7 “Beyond a Major Incident” covers incidents that threaten severe disruption to health and social care and exceed the collective local capability available in the NHS.

2.2.8 Individual NHS organisations can self-declare a major incident when their own facilities and/or resources, or those of its neighbours are overwhelmed. What is a major incident to the NHS may not be a major incident for other local agencies.

2.3. Definition: the scale of a major incident in the NHS

NHS organisations are accustomed to normal fluctuations in daily demand for services. Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of established management procedures and escalation policies.

The levels of incident for which NHS organisations are required to develop emergency preparedness arrangements are:

- **Major** - individual ambulance trusts and acute trusts are well versed in handling incidents such as multi-vehicle motorway crashes within the long established major incident plans. More patients will be dealt with, probably faster and with fewer resources, than usual but it is possible to maintain the usual levels of service.

- **Mass** - much larger-scale events affecting potentially hundreds rather than tens of people, possibly also involving the closure or evacuation of a major facility (for example, because of fire or contamination) or persistent disruption over many days. These will require a collective response by several or many neighbouring trusts.

- **Catastrophic** - events of potentially catastrophic proportions that severely disrupt health and social care and other functions (for example, mass casualties, power, water, etc) and that exceed even collective local capability within the NHS

- In addition, there are pre-planned major events that require planning, for example, demonstrations, sports fixtures, air shows, etc and may also require a response.

Although not formally described, there may be events occurring on a national scale, for example fuel strikes, pandemic or multiple events that require the collective capability of the NHS nationally.

3. The alerting mechanism for the NHS

3.1. Overview

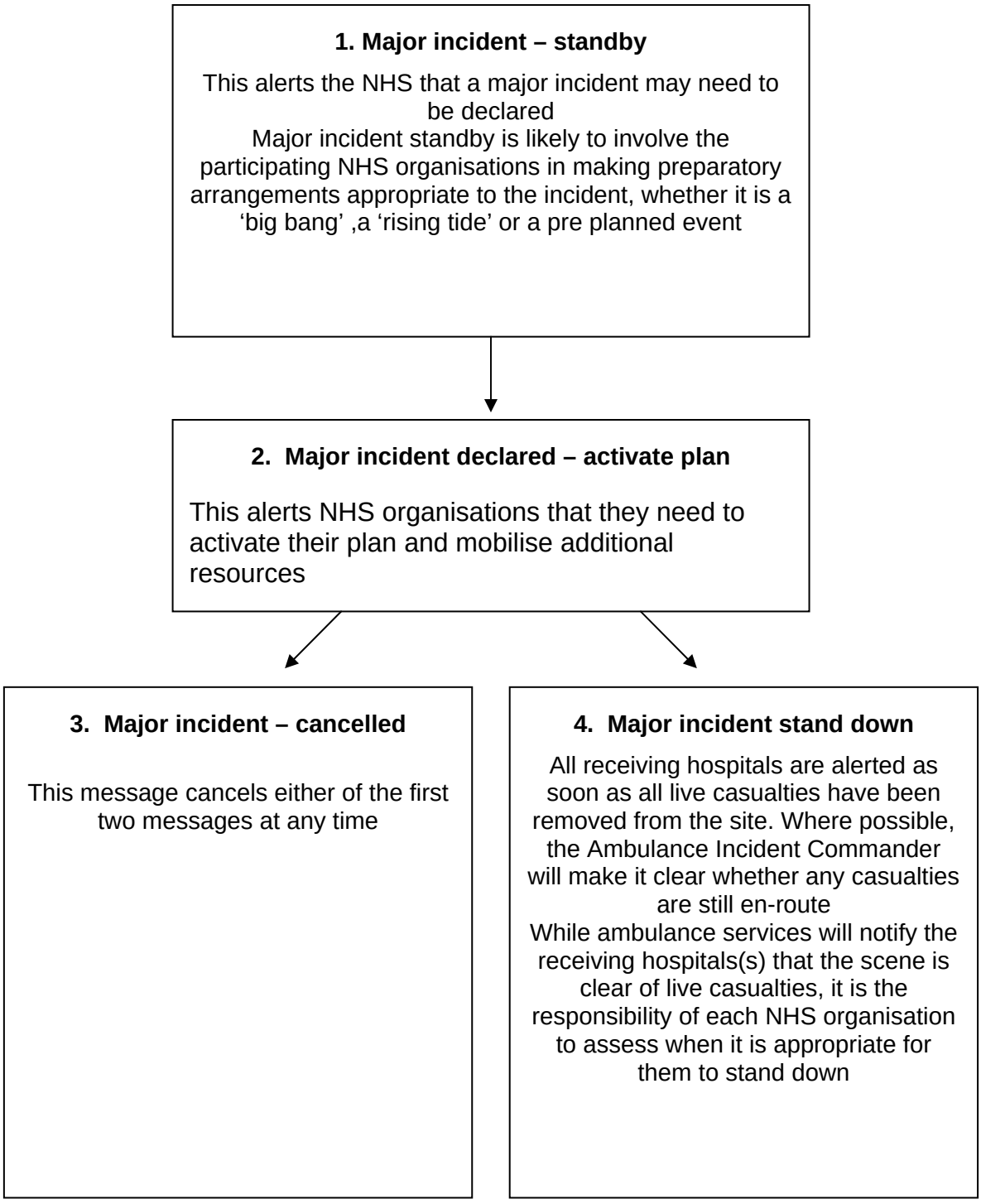
Ambulance trusts have specific responsibilities in terms of alerting NHS organisations in the event of a civil emergency and/or major incident. These are:

- immediately notify, or confirm with police and fire controls, the location and nature of the incident, including identification of specific hazards, for example, chemical, radiation or other known hazards
- alert the most appropriate receiving hospital(s) based on local circumstances at the time
- alert the wider health community as the incident dictates.

Whilst many major incidents are triggered by 'big bang' incidents such as traffic accidents, explosions etc, there are other potential circumstances where an NHS major incident is triggered by a 'rising tide' or non-acute traumatic event, for example, infectious disease outbreak, power cuts, covert radiation leakage. In such cases the ambulance services may be involved but may not be the natural 'alerting' NHS organisation. In the event of a rising tide event, and/or a widespread incident, the communication cascade mechanism used should ensure referral via the Strategic Health Authority (SHA). The SHA will take responsibility for implementing Command and Control mechanisms and also the appropriate deployment of NHS resources. NHS organisations should endeavour to use the standard alerting messages whenever possible and, for this reason, the alerting messages have been standardised.

3.2. Standard Messages Used by NHS Organisations

To avoid confusion about when to implement plans, it is essential to use these standard messages:



4. Emergency Preparedness

This section describes:

- the NHS service-wide objective for emergency preparedness
- the underpinning doctrine for NHS emergency preparedness
  - the underpinning approach to emergency preparedness based on the basic tenets of the Civil Contingencies Act:
  - co-operation
  - information sharing
  - risk assessment
  - emergency planning
  - business continuity management
  - communicating with the public
  - exercising and evaluating plans regularly

4.1. The NHS service-wide objective

The NHS service-wide objective for emergency preparedness and response is:

> **To ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.**

It is particularly important for NHS organisations to ensure their ability to work as part of a multi agency response across organisational boundaries, ensuring the ability to provide and give mutual aid within the context of Local Resilience Forums (LRFs) and their sub groups.

4.2. The underpinning principles

- The underpinning principles for NHS emergency preparedness and response are:
  Speed and flexibility at local operational level, delivered by hospitals, ambulance services, primary care providers, Foundation Trusts, the National Blood Service, NHS Direct, NHS Professionals, independent sector healthcare and staffing providers, the Health Protection Agency and, where necessary, by public health and health protection practitioners

- active mutual aid across organisational boundaries, across national boundaries within the UK and across international boundaries where appropriate

- A strong central capacity to oversee and support SHAs at the Department of Health (DH)

It is the nature of major incidents that they are unpredictable and each will present a unique set of challenges. The task is not to anticipate them in detail. It is to have a set of expertise available and to have developed a set of core processes to handle the uncertainty and unpredictability of whatever happens.

4.3. Co-operation

4.3.1 Under the Civil Contingencies Act, co-operation between local responder bodies is a legal duty.

4.3.2 On the Regional Resilience Forum (RRF), it is recommended that health sector membership be provided from the Health Protection Agency, the Regional Director of Public Health, SHA(s) and the ambulance service(s). RRFs are established by the Government Offices to discuss civil protection issues from the regional perspective and to create a stronger link between local and central government on resilience issues.

4.3.3 At the local level, it is important that major incident planning is co-ordinated within individual NHS organisations, between NHS organisations and at a multi-agency level with emergency services, local authorities, voluntary agencies, the independent health and social care sector and other partner organisations. The local Primary Care Organisations, either individually or working in groups, will undertake the co-ordination role for the NHS in the local communities.

4.3.4 The principal mechanism for multi-agency co-operation at a local level is the Local Resilience Forum (LRF). This is based on police force areas except in London. The recommended health sector membership of LRFs, subject to local interpretation, is: ambulance trusts; the Health Protection Agency and NHS representation appropriate to the local arrangements.

4.3.5 Within Strategic Health Authority areas, the SHA will set up appropriate co-ordination machinery to enable NHS organisations to plan and cooperate appropriately and to performance-manage those organisations for this aspect of their responsibilities.

4.3.6 Training, exercising and testing of major incident plans within individual NHS organisations, between NHS organisations and with multi-agency partners must be an important part of emergency preparedness.

4.4. Information Sharing

Under the CCA, local responders have a duty to share information and this is seen as a crucial element of civil protection work, underpinning all forms of co-operation.

NHS Major Incident Plans must be available in the public domain. However, it is recognised that it is not always possible to share sensitive or confidential information with partner agencies and/or the public. NHS organisations need to consider formally the information that will be required to plan for a major incident. They should determine what information can be made available in the context of the Civil Contingencies Act 2004 and the Freedom of Information Act 2004, while maintaining the confidentiality of, for example, staff telephone contact numbers. Information sharing should continue along informal routes, with formal information requesting mechanisms only used as a fallback. The role of Caldecott Guardians in supporting the discharge of responsibilities in relation to disclosure of information should be taken into account.

4.5. Risk assessment

Risk assessment is seen in the Civil Contingencies Act as the first step in the emergency planning and business continuity processes. It ensures that local responders make plans that are sound and proportionate to risks. Within each Local Resilience Forum, NHS organisations have responsibility in the context of multi-agency planning to contribute to the Community Risk Register. NHS organisations will therefore need to undertake risk assessment exercises appropriate to their facilities and services. Risk assessment is being undertaken at a regional and at a national level, with local risk assessments feeding into those.

Each NHS organisation will need to undertake its own internal risk assessment in order to inform its own response and to contribute an input to the multi-agency risk assessment.

An agreed methodology for risk assessment is now available on the Cabinet Office website.

4.6. Emergency planning

4.6.1 The emergency planning process is a key element of emergency preparedness. The CCA identifies three aspects of performing the organisation's functions in an emergency:

- maintaining plans for preventing the emergency
- maintaining plans for reducing, controlling or mitigating its effects
- maintaining plans for taking other action in connection with the emergency

4.6.2 The essentials of emergency planning are:

- the process of the writing of the plan
- the establishment of appropriate command and control arrangements
- implementation of the plan through training, exercising and testing
- validation of the emergency plan and the processes supporting it through a system of regular review and update

4.6.3 All major incident plans should:

- be fit for purpose and appropriate to the organisation preparing the plan and the locality covered
- incorporate in their entirety a complete response to a major incident and incorporate the principles of Integrated Emergency Management (Assessment, Prevention, Preparation, Response, Recovery) where applicable
- demonstrate multi-agency working, external links to police, fire, military, local authorities, Voluntary Aid Societies (VASs) and Local Resilience Forums (LRFs). Links to the media also need to be demonstrated
- demonstrate where specialist advice could be obtained
- describe local command, control and coordination process
- demonstrate Business Continuity Planning including that processes for recovery and restoration have been developed and are in place
- ensure that risk and threat assessment underpin the planning process
- be compatible with neighbours and provide support in the event of the need for mutual aid including mutual aid to and from the devolved administrations and with EU countries, as appropriate
- meet the requirements of necessary legislation and guidance particularly the Civil Contingencies Act 2004

- be regularly tested, reviewed and presented to the Board. The minimum requirement for each NHS organisation is for a live exercise to be conducted every 3 years, a tabletop exercise to be conducted every 1 year and a communications cascade test to be conducted every 6 months

4.6.4 The Audit and Assessment Framework for Major Incident Planning supports the development, maintenance and reviewing/testing of NHS major incident plans. It is made up of organisation, causal and scenario specific major incident planning audit tools. The organisational audit tools cover responsibilities of SHAs, acute trusts, ambulance trusts, PCTs and specialist trusts, for example, those providing mental health and learning disabilities services. These are designed to be adaptable for other NHS organisations. The causal audit tool covers incidents resulting from chemical, biological, radiological and nuclear sources. Mass casualties are covered in a scenario specific tool.
Examples of emergency plans are included in supporting documentation to this Guidance.

4.7. Business Continuity Management including recovery and restoration

4.7.1 The response of an NHS organisation to a major incident, either internal or external, requires a response incorporating the principles of Integrated Emergency Management (Assessment, Prevention, Preparation, Response, and Recovery). The CCA requires Category 1 responders to maintain plans to ensure that they can continue to exercise their functions in the event of an emergency so far as is reasonably practicable.

4.7.2 Business Continuity Management (BCM) is the management process that helps manage the risks to the smooth running of an organisation or delivery of a service, ensuring that the business can continue in the event of a disruption. These risks can be from the external environment (for example, power failures, severe weather) or from within an organisation (for example, systems failures, loss of key staff).

4.7.3 A business continuity event is any incident requiring the implementation of special arrangements within an NHS organisation to maintain or restore services. For NHS organisations there may be a long 'tail' to an emergency event, for example, loss of facilities, provision of services to patients injured or affected in the event, psychological support to victims and/or staff. The five critical functions that NHS organisations should consider in developing arrangements for business continuity, including recovery and restoration, are:

- Human resources
- Buildings
- Supply chains
- Utilities, including communications
- Service capacity

4.7.4 London Prepared, the website for London Resilience, provides a ten minute assessment comprising five steps of what needs to be considered in terms of business continuity. The use of this assessment is recommended for all NHS organisations .

4.7.5 The aim of business continuity planning is to enable planning and reaction in a co-ordinated manner. Whilst business continuity and major incident planning are usually separate processes within an organisation, a major incident may occur at the same time as a business continuity issue or be triggered by it.

4.7.6 Business continuity management should be considered by NHS organisations as part of its every day business processes requiring a corporate response. The skills to develop business continuity plans are complementary to those involved in emergency planning and may therefore need to be undertaken by separate officers. It is critical though that both plans are integrated and complementary to each other.

Emergency Response

5.1. Command, control and co-ordination: introduction

5.1.1 Most major incidents are geographically local and limited in time and are dealt with in an effective and efficient way by the emergency services and the acute Trusts. Some events require a broader level of co-ordination, say, at a borough or county level, which may necessitate the involvement of the Primary Care Organisation(s) or SHA(s). An example could be the need for a significant increase in community/intermediate bed capacity or community/intermediate support at home to enable the acute Trust to discharge patients to enhance acute capacity.

5.1.2 The emphasis has been on developing local capability to respond at primary care and community level, including public health advice and at individual hospital and ambulance service level. Now the NHS must plan additionally for incidents of a different nature and magnitude, including incidents that may have a long-term impact on the provision of services.

5.1.3 The SHA must be able to assume strategic control of incidents as required. Each SHA needs to ensure that it has an overview of all incidents within its boundary and that appropriate arrangements are made to allow for a well co-ordinated response, taking into account the requirements of the Civil Contingencies Act. SHAs must take a proactive lead in guaranteeing the availability of practical mutual aid and support both within their area, and across SHA boundaries.

5.1.4 In developing arrangements for mutual aid, NHS organisations will need to be clear what aid might be required, what they themselves can offer and who their partners are. Administrative boundaries, including national boundaries within the UK, should not be a reason for not working with organisations over those boundaries in developing mutual aid arrangements.

5.1.5 If the scale of an incident escalates beyond the local SHA's capacity or area, or if its duration or nature is such that wider NHS resources are required, the SHA will enact mutual aid protocols with neighbouring SHA(s) and, where appropriate, the devolved administrations of Scotland, Wales and Northern Ireland. For events that require mutual aid on a large scale, the Department of Health, via the Department of Health (DH) Major Incident Coordination Centre, can implement national co-ordinating arrangements. These arrangements are intended to support the SHAs, ensure wider NHS resources are made available and wider government assistance is accessed, as required. Usually it will be the role of SHAs to contact the DH Major Incident Coordination Centre.

5.1.6 In situations such as this, SHAs will need to liaise closely with Regional Directors of Public Health (RDsPH) to ensure that regional level communications and co-ordination are supportive to these arrangements.

5.2. Defining strategic, tactical and operational roles

The following are a general explanation and definitions of strategic, tactical and operational roles:

- **Strategic**
  The term strategic refers to the person in overall executive command of each service (health, including ambulance services, police, fire, etc) with responsibility for formulating the strategy for the incident response. Each strategic command (sometimes called Gold) has overall command of the resources of their own organisation, but delegates tactical decisions to their respective tactical commanders (sometimes known as Silver). Strategic command has a key role in strategic monitoring of the response to an incident.

- **Tactical**
  The term tactical refers to those who will attend the scene, take charge and be responsible for formulating the tactical plan to be adopted by their service to achieve the strategic direction. Tactical command should oversee, but not be directly involved in, providing any operational response (sometimes referred to as Bronze) in the incident(s).

- **Operational**
  The term operational refers to those who will provide the main operational response in an incident, that is, be closest to the scene, and control the resources of their respective service within a specific area of the incident. They will implement the tactics defined by tactical command.

5.3. Ensuring a co-ordinated local response

5.3.1 In complex large scale incidents there is a need to co-ordinate and integrate the strategic, tactical and operational responses of each service. This is achieved through the formation of a Strategic Co-ordinating Group (SCG) chaired, usually, by the Police Incident Commander. The work of the SCG is to allow organisations to share information and co-ordinate their strategic response options in the management of a major incident.

5.3.2 Where there is more than one NHS organisation in a service area affected by the incident, one of the NHS organisations will be declared the designated lead. Agreement as to which NHS organisation will be the designated lead organisation will be agreed by the senior officer(s) available representing those organisations. This will usually be the NHS organisation in whose area the incident originated or is principally based. They will represent their service on SCG and will have delegated responsibility to allocate resources on behalf of the other organisations.

5.3.3 The SCG will meet at a nominated Strategic Co-ordination Centre (SCC). The SCC is usually a building or group of buildings previously identified in local multi-agency Major Incident Plans. It is usually police based accommodation.

5.3.4 In the vast majority of cases, SCG will operate at the geographical level defined by the local police force boundaries. There may also be situations where there are a number of SCGs operating simultaneously. In addition, in widespread incidents, there may be a need for the establishment of a Regional Civil Contingencies Committee (RCCC). The membership of the SCG or RCCC will be flexible to meet the needs of the incident.

5.4. The role of NHS organisations

5.4.1 It is the responsibility of all Category 1 and Category 2 responders under the Civil Contingencies Act 2004 to ensure an appropriate response to major incidents. The arrangements should enable a co-ordinated NHS response regardless of the nature or scale of incident.
It is acknowledged that not all NHS organisations are covered by the requirements of the Act but it is considered good practice for those NHS organisations not designated to act as if they had to comply with the requirements of the Act.

5.4.2 Central to this response is the integration of health service organisations. At the SCG there are three key health functions to assist the incident commander in the management of an incident or accident. These three functions will be:

- **Ambulance Strategic Command**
  Ambulance Strategic Command directs and commands the response of one or more ambulance trusts including voluntary and private ambulance services. A member of the ambulance executive management team at the SCG/RCCC will represent the ambulance service.

- **NHS Strategic Command**
  NHS Strategic Command directs and commands the response of the NHS and is led by an SHA. It is focused on strategic management of the NHS during the incident by ensuring NHS service delivery for both the incident and for operational service delivery of the NHS. The SHA chief executive or their nominated deputy would usually represent the SHA. Within a health community, the Chief Executive of a Primary Care Organisation, with the prior agreement of the SHA may deliver this function.

- **Public Health Advice**
  The Public Health Adviser will act as the focal point and primary contact for the police incident commander and all responding organisations in the provision of health, public health, health protection and other scientific advice as part of the incident management process. In short, there should be Public Health Advice at the SCG/RCCC to offer health related scientific advice for all incidents that require strategic co-ordination.

5.4.3 The importance of providing clear and consistent public health messages and advice is now both widely accepted and readily sought, in particular in those incidents involving chemical, biological, radiological and nuclear substances, irrespective of the cause: deliberate or accidental.

5.4.4 It is recommended that both a senior Director of Public Health and Senior Health Protection Agency representative attend the SCC to offer broad support, as well as access to further expertise via the Chief Medical Officer's office or the national HPA office. Who "sits" at the SCG as the Public Health Adviser should be negotiated at the time and will be incident-dependent. In most cases it is expected that the person who will fulfil this role will be easily identified, but in establishing these arrangements, NHS organisations, the

HPA and Regional Public Health Groups should discuss a method for achieving this that is appropriate to local circumstances.

5.4.5 It is the intention that the Public Health Adviser will be a senior public health practitioner with specialist skills in incident command. Arrangements are being developed to provide training and development to support those who may have to fulfil this role. It is also intended that the public health adviser role will be delivered by a cadre of people who fulfil criteria to be agreed for this role. Recruitment to a public health adviser cadre is dependent on the ability to deliver effectively the function and is not dependent on their employing organisation.

5.4.6 The function of the Public Health Adviser will be to:

- Co-ordinate the necessary health, public health, health protection and other scientific advice to input into the strategic management of the incident
- Agree clear public health messages via SCG to be given to the public and incident responders especially health care professionals
- Manage the development, and provision, of a Health Advice Team (HAT), which will usually be held at the Strategic Coordination Centre.

5.4.7 Not withstanding the role of ambulance services and public and health protection specialist, the SHA or its designated Lead PCO is in overall command of the NHS response.

5.5. Health Advice Team

5.5.1 This Guidance reflects the changes in the NHS and other agencies including SHAs, PCOs, Regional Public Health Groups and the Health Protection Agency, as well as the need to offer the SCGs a more responsive and unified health advice response. Previously, an advisory committee, either the Joint Health Advisory Cell (JHAC) or the Health Advisory Group (HAG) was called to provide the police incident commander with public health advice in the event of deliberate release of a biological substance or chemical agent. Incidents involving radiological incidents included the provision of health advice through the Health Advisory Group (HAG), again in relation to the public health impact of the incident. The JHAC/HAG consisted of representatives from a range of organisations and specialists appropriate to the incident.

Health advice will now be provided through a Health Advice Team (HAT) led by the designated Public Health Adviser.

5.5.2 The importance of providing clear and consistent public health and health protection messages and advice is both widely accepted and readily sought by police commanders and other organisations. The Public Health Adviser supported by the Health Advice Team will be able to access and provide consistent advice from the NHS and the HPA and ensure its use and dissemination throughout the necessary organisations including its own.

5.5.3 The Public Health Adviser will access comprehensive and authoritative advice from a wide range of sources. To enable them to do this, a Health Advise Team (HAT) will support them. The HAT will need to be linked into the SCG, the NHS Strategic Command arrangements and the Department of Health Emergency Coordination Centre. A senior public health practitioner will chair the HAT. The Public Health Adviser will not usually fulfil the role of chair of HAT, but represent the team at the SCG meetings.

5.5.4 The range of relevant specialists needed to ensure comprehensive and authoritative advice will vary depending on the nature of the incident.

5.5.5 The HAT will include a Director of Public Health or equivalent.

5.5.6 The HAT may also include representatives of microbiology, epidemiology, toxicology, Health Protection Units including Consultants in Communicable Disease Control, Environmental Health Officers, the Environment Agency, the Food Standards Agency, Water Company or Companies, the Defence Science Technology Laboratories (DSTL) often described as the Senior Scientific Officer (SSO – also represented on COBR), the Military, the Atomic Weapons Establishment , the HPA / NHS radiological protection advisor, and others.

5.5.7 Whilst it is desirable, it is recognised that in the course of an incident response, it may be impractical to bring all these agencies together in one location to advise the SCG, especially as some of specialist experts may be few in number and only based at a national level. The Public Health Adviser

will be responsible for obtaining inputs from key advisers using all methods available including video- and tele-conferencing resources.

5.5.8 SHAs with PCOs and their respective RDPH and Regional Director of the Health Protection Agency must agree what arrangements are needed in their area to ensure that an appropriate Public Health Adviser can be nominated and are available at all times with appropriate support.

5.6. Command support

The three key health functions, Ambulance, NHS delivery and Public Health Advice will need to ensure the provision of appropriate command support. This must be based on an awareness of the facilities and equipment available at the Strategic Coordination Centre (SCC). This includes provision of personnel, administrative support, IT resources and other equipment. A key element to the delivery of appropriate command support is the maintenance of appropriate, contemporaneous records and documentation of the incident.

5.7. Regional Civil Contingencies Committee (RCCC)

5.7.1 In a large-scale incident where events threaten to overwhelm local responders, or which have an impact over a wide area, a Regional Civil Contingencies Committee (RCCC) may be formed to co-ordinate a region-wide response. The RCCC will include representation of those organisations that regularly attend the Regional Resilience Forum and other organisations/agencies as required. The RCCC will be defined by the nature and scale of the threat presenting.

5.7.2 The RCCC may meet at one of three levels:

- **Level 1** – the RCCC role would be in a state of readiness and would watch and evaluate how local agencies were handling the incident
- **Level 2** - the RCCC would work to coordinate government resources into the response
- **Level 3** – the RCCC would take a strong strategic and executive role in co-ordinating all resources at both local and regional level.

5.7.3 In all circumstances, the RCCC will be focused on ensuring the direction of appropriate resources to assist local responders in the management of a catastrophic incident, act as another mechanism for sharing information about the impact of the incident between central government and local responders, and consider the recovery and long-term restoration of the region following the incident.

The chair of an RCCC will be nominated at the time of the incident.

5.7.4 In the event of major public health incidents such as pandemic influenza, the Regional Director of Public Health (RDPH) may chair the Regional Civil Contingencies Committee (RCCC) as the regional nominated co-ordinator.

In the absence of the RDPH, Consultants in Public Health Medicine in the regional public health group fulfil the role of representing the Chief Medical Officer in the Region.

5.7.5 A diagram showing the command and control arrangements in the event of a major incident at a local level, regional level, and at national level can be found on the Department of Health website.

5.8. The roles and responsibilities of NHS Organisations in Emergency Planning

This section describes in outline the core roles and responsibilities in emergency planning of:

- the Emergency Preparedness Division of the Department of Health
- Regional Directors of Public Health
- the Health Protection Agency
- NHS organisations.

Department of Health (DH) – Emergency Preparedness Division

- advises Ministers on the development of policy
- is accountable through the Chief Medical Officer (CMO) to Ministers
- ensures NHS and social care preparedness and contributes to the central agenda
- contributes to/leads the central Government response (e.g. Cabinet Office Briefing Room [COBR] or the Civil Contingencies Committee [CCC])
- implements national and international co-ordination arrangements
- oversees and supports the response of the NHS and partners and ensure the resilience of the NHS and partner organisations
- takes command of the NHS during a complex national emergency incident
- contributes to the central work on communications.
- Issues authoritative material to media, professions and public as well as handling national media.

Regional Directors of Public Health

- represent the Chief Medical Officer (CMO) in the Regions
- are accountable through the CMO to Ministers
- ensure co-ordination between Regional Resilience and NHS in preparedness for infectious diseases and other public health emergencies

- work closely with the Regional HPA Director and the SHAs to provide public health advice, support and leadership especially in responding to major public health incidents

- take the lead in providing health input into the Regional Resilience Forum and associated regional communications networks working with the Regional Director of the Health Protection Agency, the NHS and the ambulance service(s) within the region

- contribute to policy formulation within the Department of Health

- ensure sign off of any public health and health protection messages to be communicated to the public.

Health Protection Agency

- provides expert advice to the DH on health protection policies and programmes

- is accountable through the CMO to the DH at a national level

- provides advice and support to NHS and RDsPH

- provides specialist emergency planning advice to NHS organisations

- provides resources to support the provision and delivery of Health Advice to the SCGs and RCCCs

- cooperates with others to provide health protection advice and information to the NHS, to the media and the public, in agreement within the DH

- provides training and exercise support on behalf of the DH.

5.9. NHS Organisations – core preparedness responsibilities

The following core preparedness responsibilities for the NHS have been identified. All NHS organisations, through their Chief Executive Officer, have responsibility for ensuring:

5.9.1. Integrated Emergency Planning

- an integrated emergency planning process is in place that is built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing
- there is a major incident plan that is kept up to date, accessible, tested regularly and specifically addresses any potential causes of a major incident for which the identified NHS organisation is at particular risk
- major incident plans take account of the requirements of the Civil Contingencies Act 2004
- the needs of vulnerable persons, including children, are taken into account
- appropriate arrangements are in place to provide and receive mutual aid locally, regionally and nationally
- working as appropriate with DH, appropriate arrangements are in place to provide and receive mutual aid nationally and internationally
- planning is undertaken in conjunction with NHS Direct, NHS Professionals, NHS Estates and the National Blood Service and other appropriate agencies
- planning is undertaken in conjunction with local partners in the independent healthcare sector including Independent Sector Treatment Centres (ISTCs) and their equivalents, and staffing agencies.

5.9.2. Preparedness

- Boards receive regular reports including, in NHS organisations, annual reports, a specific statement relating to the emergency preparedness including reports on exercises, training and testing undertaken by the organisation and that adequate resources are made available to allow discharge of these responsibilities. To support this arrangement it is suggested that an Executive Director of the Board be designated to take responsibility for emergency preparedness on behalf of the organisation. It is further suggested that a Non-Executive Director of the Board be nominated to support the Executive Director lead in this role. In some cases this may be best achieved through the linkage of emergency planning and business continuity to the organisation's Risk Management Committee (or equivalent).

- mechanisms are in place to identify, select and train staff to participate in a major incident ensuring that those staff:
  understand the role they are to fulfil in the event of an incident

- have the necessary competencies to fulfil that role

- have received training to fulfil these competencies, and,

- as a minimum standard, all NHS staff include in their induction training an introduction to the role of their organisation in major incident planning and response

- mechanisms are in place to ensure the resilience of its own estate, facilities, supply chains, utilities including communications, and systems including human resources enables it to continue to provide core services, as appropriate to the circumstances of the major incident(s)

- a high level of preparedness and planning is demonstrated in conjunction with NHS partners, including walk-in centres (WICs), Minor Injury Units, GPs, out-of-hours (OOH) services and external multi-agency partners

- working relationships are established and maintained with other emergency services, local major organisations and other key stakeholders

- appropriate and effective performance management arrangements are in place.

5.9.3. Response

- a command and control structure is developed that allows appropriate linkages to, membership of, communication with and other responses to local, Regional and National resilience arrangements including Strategic (also known as Gold), Tactical (also known as Silver) and Operational (also known as Bronze) commands

- processes are in place to ensure the health, safety and welfare of NHS staff, its patients and the public using NHS facilities and services. This includes, for example, the use of honorary contracts for general practitioners providing immediate medical care at the scene, appropriate professional indemnity, the provision of appropriate personal protective equipment and of post incident welfare and debriefing for all staff involved in an incident.

5.9.4. Recovery

- major incident plans will link into the organisation's arrangements for ensuring business continuity

- local communications mechanisms are developed that are consistent with central messages and providing information and advice to the public and the media in accordance with agreed media management policies

More detailed descriptions of the roles and responsibilities of individual NHS organisations are included in the underpinning sections of this Guidance.

5.10. Training and Exercising

5.10.1 The Chief Executive of each NHS organisation is required to ensure that arrangements are in place to enable adequate training, exercising and testing of emergency planning arrangements and that the Board receives regular reports, at least one annually, regarding this.

5.10.2 As a minimum requirement, NHS organisations will be required to undertake a minimum of:

- A 'live' exercise every three years
- A 'table top' exercise every year
- A test of communications cascades every six months

5.10.3 Each individual NHS organisation must evaluate its own exercise requirements, which may be in excess of the minimum specification outlined above. Similarly, decisions to direct exercises at specific staff groups and departments should be made after reviewing local emergency planning needs.

5.10.4 NHS organisations should consider holding joint exercises with partners in the NHS and with other multi-agency partners where practicable. Extra consideration should be given to this approach when planning a 'live' exercise.

- Training, testing and exercising should take place within the context of:
- A training needs analysis that reflects normal good training practice
- The definition of different training needs along a spectrum from general awareness to specific training for staff with key roles
- Providing a framework that
  states clearly who is accountable for ensuring training and exercising takes place, the respective frequency for each element,
  is based on an annual plan for the process
  and is supported by appropriate documentation and record keeping and allows for post exercise reporting and debriefing
- Recognising that training involves a significant investment in cost, time and resources. Nevertheless, if they are to effectively manage an incident, organisations must be fully committed to training for responding to major incidents or business continuity issues. A comprehensive training strategy needs to be put in place to ensure that staff are confident in their roles.

5.11. The independent healthcare sector

It is the responsibility of NHS organisations to ensure that providers of independent healthcare care services in their area, including Independent Sector Treatment Centres (ISTCs) and their equivalents, and staffing agencies are engaged in the processes for developing plans and responses to major incidents.

Ambulance Trusts will ensure that they have links to private and voluntary ambulance services that allow for the deployment of agreed resources as required in the event of a major incident. In developing these links, Ambulance Trusts will ensure that services are provided by appropriately trained and equipped personnel and that memoranda of understanding for such services are developed and agreed.

Examples of such Memoranda of Understanding are available on the website.

5.12. Vulnerable Persons

Within the Civil Contingencies Act 2004, the particular needs of vulnerable persons are recognised. The general definition of vulnerable persons is: **people present or resident within an area known to local responders who, because of dependency or disability, need particular attention during emergencies**.
In terms of the Act, vulnerable persons are defined as those:

- under the age of 16. Particular attention should be paid therefore to schools, nurseries, childcare centres and medical facilities for children;

- inhibited in physical movement, whether by reason of age, illness (including mental illness), disability, pregnancy or other reason. Again, attention should be paid to hospitals, residential homes and day centres likely to be housing any of these people and also to means of accessing records for those resident in the community whose address is recorded on lists held by health services, local authorities and other organisations;

- deaf, blind and visually impaired or hearing impaired. The means of accessing these people during an emergency or when one is likely, should be recorded in plans.

Children - children may be involved in a major incident, either as casualties or as members of families or groups caught up in the event. Plans need to reflect procedures for dealing with paediatric casualties arising either directly or indirectly from an incident. Specific guidance on dealing with children in the context of emergency preparedness is currently being developed.

Non-English-speaking Communities And Faith Groups - At the scene of an incident simple language guides will generally be available to assist with incident management. Existing arrangements within a Trust may be sufficient for dealing with the usual number of people from the non-English speaking communities and faith groups. However, the scale of an incident or the particular nature of the incident or the particular group involved in an incident may require assistance being sought from other sources. NHS organisations should identify the mechanism for obtaining this help in preparing their plans.

People With Learning Difficulties And Mentally Ill People –Trusts' existing facilities and procedures may be sufficient to assist people with learning difficulties and mentally ill people during the course of a major incident. However, there may be small numbers for whom additional and/or specialist assistance may be required. Trusts should identify the mechanism for obtaining this help in preparing their plans.

5.13. The Voluntary Aid Societies (VAS)

The responsibilities given by the Civil Contingencies Act on Category 1 and Category 2 responders to co-operate with partners emphasises the need to maximise the benefit of the VAS potential and their potential to contribute towards the successful outcome of an incident. They can have a role in responding to an event to help alleviate pressure on the statutory bodies by providing humanitarian services. They also have a role to play in responding to emergencies, that is, during the consolidation and recovery phases when emergency services personnel and personnel from other responding NHS organisations may be fully deployed elsewhere.

Many NHS ambulance services have worked with VAS to develop a set of competencies and knowledge which define the capabilities of VAS personnel, and have used these as the basis for developing formal Memoranda of Understanding (MOU) to ensure that, in the event of a major incident, that there are common, understood standards for operating, responding to, and supporting professional input.

5.14. Military assistance to a major incident

“Military Aid to the Civil Community”, a pamphlet for the guidance of Civil Authorities and Organisations, generally referred to as MACC is available on the website.

In the event of a major incident, the armed services are authorised to provide all possible assistance to the emergency services where a threat to life exists. Local authorities can call directly upon military assistance under the Military Aid to the Civil Community (MACC) system.

Military Aid to the Civil Authority (MACA) forms part of the overall spectrum of the Integrated Contingency Plan (ICP). It is divided into three categories:

- Military Aid to the Civil Community (MACC);
- Military Aid to other Government Departments (MAGD);
- Military Aid to the Civil Power (MACP).

The immediate assistance that the military may be able to provide will depend on what is available at the time of the incident. Whilst no resources are specifically set aside for such assistance, if the incident is sufficiently grave, additional troops and assets may be tasked into an affected area.

In the event of a major incident, all requests for military assistance must be directed through the appropriate command and control structures.

5.15. Communicating with the public

5.15.1 Responders duties to communicate with the public under the CCA are based on the belief that a well-informed public is better able to respond to an emergency, and to minimise the impact of the emergency on the community and on NHS services.

5.15.2 The CCA gives two distinct legal duties to responders:

- **in planning terms**, warning and informing the public of the likely risks and threats that NHS organisations are preparing to address and examples of the types of responses planned.

- **in responding**, communications arrangements should be appropriate to the message and the kind of audience.

5.15.3 Based on these principles, the response of NHS organisations will be the right people, receiving the right message(s) at the right time.

5.15.4 Media liaison and handling will be an integral part of planning a response to any major incident. Media Protocols and Media Liaison Panels should be in place to ensure consistency of messages provided to the media. Integrated emergency plans, including business continuity plans, should generally provide for the identification of those officers with responsibility for media liaison, as well as identifying the media liaison roles of those with specific duties during an incident (including Chief Executives, On-Call Directors and Managers, as well as Communications Managers). Communication lines, with appropriate control rooms and centres, including the DH Media Centre, should be identified in plans.

5.15.5 Almost any major incident will generate media interest, on a national, and even international scale. Media handling on both local and national levels must be seen as an integral part of emergency planning because:

- The media will be used as the main channel for communicating with the public. Organisations will be required to utilise the media for information dissemination at each stage of an incident.

- Local media will play a key role in message dissemination where an incident is localised.

- The national media reach millions of people and it is therefore important to ensure they have accurate and timely information.

5.15.6 NHS organisations must be clear who is responsible for leading the media response for that organisation. Those designated must be fully involved in the planning and preparation for dealing with major incidents.

5.15.7 To plan and prepare for good media liaison, NHS organisations need:

- a call out procedure which includes a Communications Lead for those organisations among the first to be contacted;

- detailed media handling policies and procedures with which on-call staff are familiar;

- to ensure plans are linked into any local multi-agency press briefing arrangements, which may be run by police or local authorities, including Joint Media Forums and the agreement of Joint Media Protocols;

- to have in place arrangements to call for extra support, at short notice, for the communications lead. For example, networks of communications leads might be established across NHS organisations to enable capacity to be boosted at short notice and to provide cover;

- to agree with other NHS agencies locally the procedure for co-ordinating information in an emergency and for the designation of a lead organisation and lead officer;

- to plan facilities which can be made available at short notice, such as rooms for the media, telephone lines, IT, etc

- to prepare simple, easily digestible information about NHS organisations that might include size, staff numbers, specialties, names and positions/responsibilities of key people to hand out to media in the event of a major incident and to supplement this with prepared messages appropriate to local risks in specific areas – for example on radiation hazards, HAZMAT and COMAH facilities or other local situations that may occur

- to ensure all communications leads, designated spokespersons and others who might have to fulfil the role of spokesperson, have appropriate training and development opportunities to enable them to fulfil their role.

- to make communications leads aware of previously identified regional spokespeople (for example, from HPA or other relevant body depending on nature of incident)

Underpinning material

Underpinning materials are sections written to provide more detail on the roles and responsibilities of parts of the NHS and specific guidance on aspects of emergency preparedness.

- Acute Trusts and Foundation Trusts
- Ambulance services
- Immediate medical care at the scene
- Non acute and specialist Trusts
- Primary Care Organisations
- Strategic Health Authorities
- Training and exercising