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

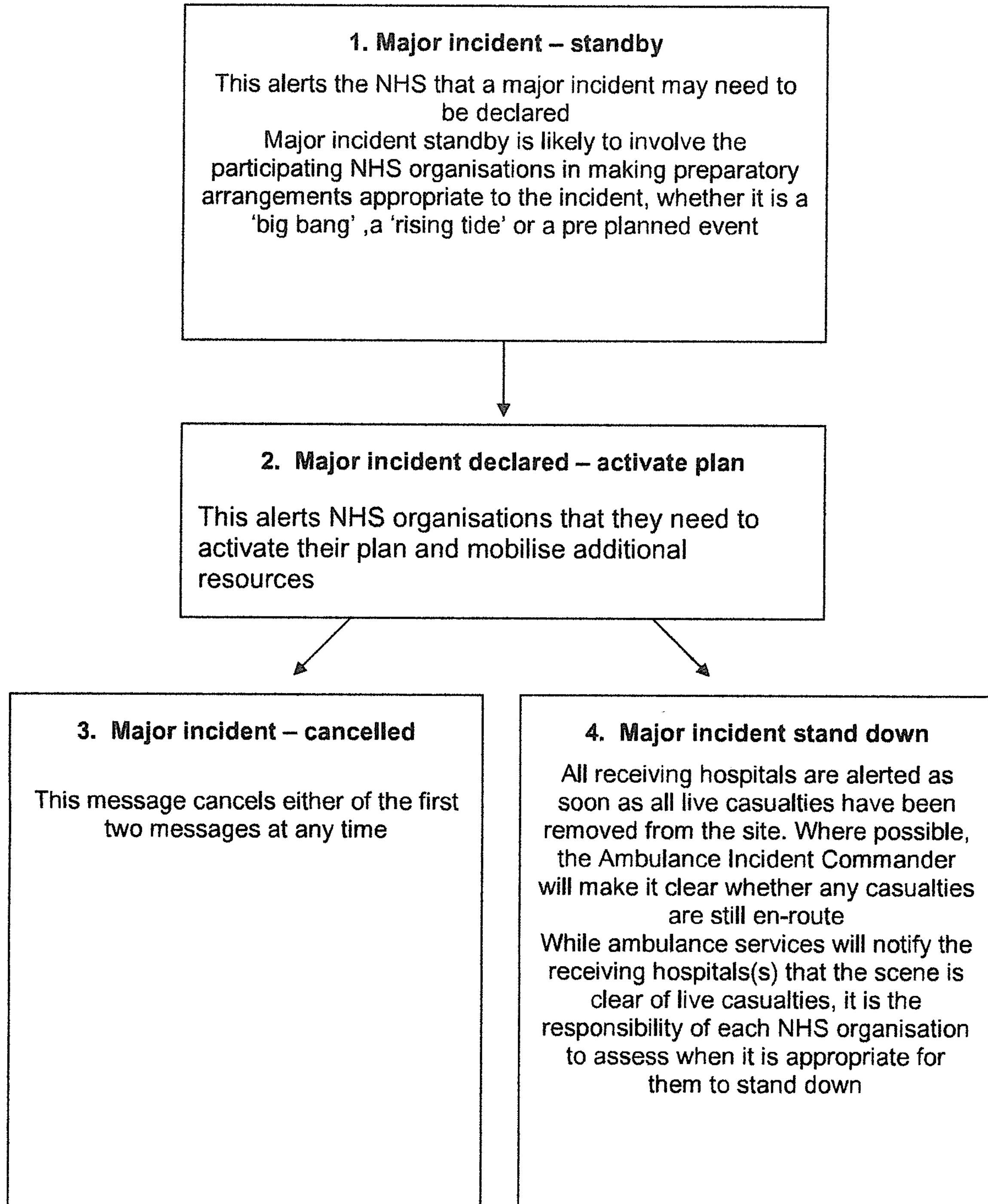
Ambulance trusts have specific responsibilities in terms of alerting NHS organisations in the event of a civil emergency and/or major incident. These are:

- 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.

5. 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