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

平成１８年度厚生労働科学研究費補助金（地域健康危機管理研究事業）
「健康危機管理体制の評価指標、効果の評価および人材育成に係るｅ－ラーニングプログラムの開発評価に関する研究」

地域の健康危機管理研修におけるシミュレーションプログラムの開発評価に関する研究

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研究要旨
地域健康危機管理に携る行政官・公衆衛生従事者の健康危機管理コンピテンシー（実践能力）を高めるために、現在明確にされつつあるコンピテンシーをふまえてｅ－ラーニングプログラムを試作した。コンピテンシーとして既に示されている８つのクラスター内容を視覚的に把握できるように「健康危機特性シート」を作成し、それに基づいてシミュレーション大系を組み立てた。地域の健康危機管理研修におけるシミュレーションの方法論について記述した媒体は筆者が知る限り、これがはじめてである。

A　研究目的

地域健康危機管理を実施するには、大きく①公衆衛生従事者としての事態解析能力、②地域行政官としての地域関係機関調整能力の２つが求められる[1)]。公衆衛生従事者の事態解析能力向上は、技術的問題を主とすることから学習システムを組むことはそれほど困難ではない。一方、地域の連携については、地域によって実情が異なる上に、連携のあり方のガイドラインについて示されたものは未だ極めて少ない[2)]。

特に地域の保健所には、地域医師会、消防、警察をはじめとする地域の関係機関が連携するシステム構築を目的とする研修会を積極的に開催することが勧められているが、このような状況下で、開催の方法論について困惑しているのが現状である。

そこで、健康危機管理に携る者のコンピテンシーと既に抽出されている地域連携の問題点を対応させ、健康危機管理研修におけるシミュレーションのあり方を示すｅ－ラーニングプログラムを試作した。

B　研究方法

B．１

「地域のシミュレーションの開催のあり方」のｅ－ラーニングプログラム

- 近年発生した（するおそれがある）健康危機の中から、行政対応上で問題となったものを抽出した。
- それらの健康危機事例を「拡大性と健康被害」、「発生頻度と健康被害」、「不慣れ度と発生頻度」の３種類から分類し「健康危機特性シート」を作成した。
- このシートをもとに「地域における健康危機管理シミュレーション」のあり方のｅ－ラーニングプログラムを試作した。

B．２

「原因不明の健康危機の対処」のｅ－ラーニングプログラム

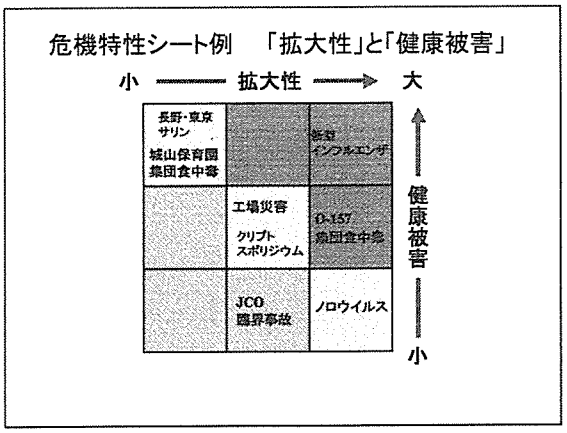
- 東北地方で発生した「スギヒラタケ（疑）脳症」の対応を経時的に検討
- 医学的な問題点をふまえて公衆衛生従事者としての事態解析能力向上のｅ－ラーニングプログラムを試作

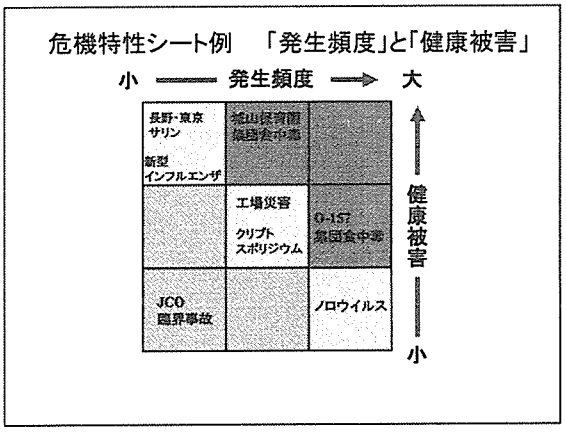
C　研究成果

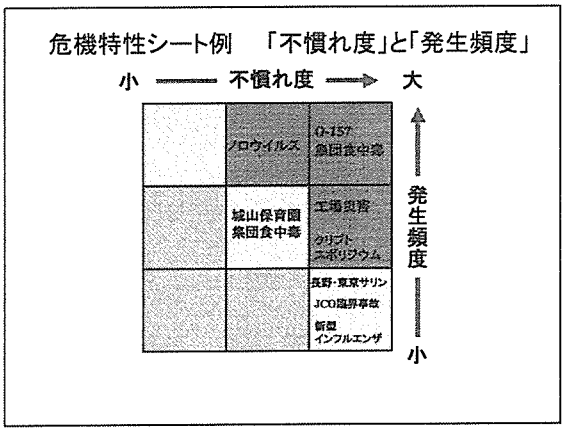
C．１

- 健康危機として①長野・東京サリン、②城山保育園集団食中毒、③工場災害、④クリ

プトスポリジウム、⑤JCO 事故、⑥新型インフルエンザ、⑦O-157 集団食中毒、⑧ノロウイルス事例　を抽出した。それぞれの観点からみた分類を以下に示す。







同じ事例であっても、検討する見地の違いにより重要度が異なることを図示できた。
これを元に作成した「地域における健康危機管理シミュレーション」のあり方のｅ－ラーニングプログラムは別添資料１に示す。

C．２
「原因不明の健康危機の対処」のｅ－ラーニングプログラムを別添資料２に示す。

D　考察

健康危機管理に要するコンピテンシー（実践能力）には①事前リスク評価、②リスク・マネジメント計画、③リスク識別、④定性的リスク分析、④定量的リスク分析、⑤リスク対応計画、⑦リスク対応計画書の実行、⑧リスクの監視コントロール、⑨リスク・マネジメントに関するプロジェクト終了　の８つのクラスターが示されている[1)]。

このクラスターのうち①～④までは「危機特性シート」を作成することで学習しやすく図示できると考えられる。

また、⑤～⑦についても今回示した２つのｅ－ラーニングプログラムに従えば、学習できるように作成した。

今後は、本プルグラムを実際に使用して必要に応じて改善を行っていく予定である。

E　結論

健康危機管理に要するコンピテンシーに基づいて、それを実践するプログラムとして、「地域のシミュレーションの開催のあり方」、「原因不明の健康危機の対処」のｅ－ラーニングプログラムを試作した。

F　研究発表

F．１　論文発表
特になし。

F．２　学会発表
特になし。

G　知的財産権の出願・登録状況

G－１　論文発表
特になし。

Ｇ－２　　学会発表
特になし。

Ｇ－３　　学会発表
特になし。

１）橘とも子：公衆衛生従事者に求められる健康危機管理コンピテンシー：保健医療科学 55 巻第２号．76－92．2006
２）郡山一明：平成 17 年度健康危機管理保健所長等研修会　p 155－165

（資料　１）「地域における健康危機管理シミュレーション」