

Strategic Command Arrangements for the NHS During a Major Incident

Strategic Command Arrangements for the NHS During a Major Incident

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Description	The purpose of this document is to provide guidance to National Health Service (NHS) organisations regarding command, control and co-ordination arrangements, required in planning, preparing and responding to emergencies. It provides a platform for all NHS organisations to undertake emergency planning.
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Executive summary

The purpose of this document is to provide good practice guidance to National Health Service (NHS) organisations regarding command, control and co-ordination arrangements, required in planning, preparing and responding to emergencies. It is intended to provide a platform for all NHS organisations to undertake major incident and emergency planning, and is built on best practice and shared knowledge.

It must be used in conjunction with the NHS Emergency Planning Guidance 2005, the purpose of which is to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the Civil Contingencies Act (CCA) 2004.

The following list covers the guidance provided in this document:

- background to the subject
- SHA response and planning responsibilities
- definitions of strategic, tactical and operational roles
- requirements of a co-ordinated local response
- the role of NHS organisations
- delivery of an appropriate command support
- the formation of a Regional Civil Contingencies Committee
- the roles and responsibilities of NHS organisations in emergency planning

This material should be read in conjunction with the NHS Emergency Planning Guidance 2005. All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency planning in the NHS in England.

The web version of the guidance is available at:-
www.dh.gov.uk/emergencyplanning

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Strategic Command Arrangements for the NHS During a Major Incident

Introduction

1. This document gives guidance to National Health Service (NHS) organisations regarding command, control and co-ordination arrangements required in planning, preparing and responding to all types of emergencies arising from any accident, infectious epidemic, natural disaster, failure of utilities or systems, or hostile act resulting in an abnormal casualty situation or posing any threat to the health of the community. This guidance refreshes the section on command, control and co-ordination originally included as an integral part of the main NHS Emergency Planning Guidance 2005.
2. This document must be used in conjunction with the NHS Emergency Planning Guidance 2005 and the relevant underpinning sections including:
 - Strategic Health Authorities (SHAs)
 - Immediate medical care at the scene
 - Primary care organisations
 - Ambulance services
 - Mass Casualties Guidance
 - Acute and Foundation Trusts
 - Children –due to be published for consultation Spring 2008
 - Critical Care – published December 2007
 - Burn care – published December 2007
 - Bomb & Blast - published December 2007
3. It is essential that there is good communication between different health care services in order to ensure that responses are structured and cohesive and reflect the needs of the whole health economy.
4. The purpose of the NHS Emergency Planning Guidance 2005 is therefore to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the requirements of the Civil Contingencies Act 2004 (the CCA) to:
 - respond to a major incident or incidents or emergency
 - manage recovery whether the incident or incidents or emergency has effects locally, regionally, or nationally.
5. Throughout this underpinning document, the term emergency is used as in the CCA, i.e. to describe an event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. To constitute an emergency this event or situation must require the implementation of special arrangements by one or more Category 1 responders.

6. The responses outlined in this guidance should only be considered appropriate in the event of emergencies that comply with the definition above. Under no circumstances should any NHS organisation seek to initiate or adapt these in order to respond to a problem arising solely from staff shortages, waiting list pressures, management failures or other local institutional deficiency. The accompanying ethical and medico-legal endorsement that will support NHS organisations and staff in an appropriate escalation response will not be applicable in other circumstances.
7. This Guidance is built on best practice and shared knowledge, while also acknowledging that in certain circumstances restrictions or limitations of normal standards of care will be inevitable. It is intended to provide a platform for all NHS organisations to undertake major incident and emergency planning and to provide information on associated activities that may also be required. In the context of this Guidance, the term NHS organisation includes Foundation Trusts
8. The NHS Emergency Planning Guidance 2005 gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a Major Incident Plan in place that is 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 CCA. Responsibility for ensuring that there are appropriate command, control and co-ordination arrangements in place forms part of that responsibility for Chief Executives of all NHS organisations. SHAs and Primary Care Organisations will need to ensure that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances.
9. Whilst it is ultimately the responsibility of the Trust Chief Executive at a local trust level, the NHS Chief Executive has final responsibility for the NHS as a whole and therefore will need to be assured that trusts (including FTs and SHAs) are suitably prepared and resilient to disruptive challenges. The responsibility for providing this reassurance will be through the SHAs.
10. It is the intention of this guidance to:
 - set out proposals for command, control and co-ordination arrangements taking into account the recent and ongoing changes to the organisation of the NHS;
 - take into account the need to maintain a clear line of sight between all elements of the process;
 - help maintain clarity for external partners, in the role of the various elements of the NHS.
 - To provide clear guidance for NHS organisations on strategic command arrangements across the health economy to allow robust planning to take at trust level
11. This document focuses on command, control and co-ordination arrangements in the NHS in England, recognising the need for a high level of networking with services provided in Scotland, Wales, Northern Ireland and where appropriate our colleagues in the European Union, in order to support mutual aid arrangements.

Background

12. Most emergencies and 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, county or regional 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. NHS organisations should ensure that all arrangements made to plan for and respond to emergencies take into account a whole system approach to healthcare and ensure reciprocity.
13. 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. The NHS is now required to plan additionally for incidents of a different nature and magnitude, including incidents that may have a long-term impact on the provision of services.

The Planning Stage

14. The SHA must be able to assume strategic control and leadership of incidents as required. Each SHA needs to ensure that it has an overview of **all** major incidents and emergencies within its boundary and that appropriate arrangements are made to allow for a well co-ordinated response. These arrangements must take into account the requirements of the CCA and therefore SHAs must take a proactive lead in guaranteeing the availability of support and practical mutual aid both within their area, and across SHA boundaries.
15. SHAs may wish to consider designating formally one of its constituent PCOs to act as the lead NHS organisation for emergency planning on its behalf, for example nominating a 'lead PCT'. Where there is a designated Lead PCT/PCO, it is expected that the designated Lead PCT/PCO would provide links to the Local Resilience Forums (LRF) making sure that the SHA is kept aware and fully briefed on decisions agreed in the planning phase. The SHA will provide the link between NHS organisations in the region with Regional Resilience Forums. Where there is no Lead PCT/PCO arrangements, the SHAs will need to retain this role.
16. A Lead PCT model is utilised by several SHAs as a preferred method of ensuring emergency preparedness. Geographically, in an area a Lead PCT might cover will need to be agreed within each SHA region, and where possible, be based on inter-agency emergency planning areas. (or LRFs).
17. Chief Executives of SHAs are responsible for ensuring that, whatever organisational model is used, the provision of strategic command arrangements during both the

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planning phase and the response are in place across the NHS in their region and these arrangements are resilient and robust.

The Response

18. Where the designation of Lead PCTs is agreed, it must be clearly established what roles and responsibilities the Lead PCT is expected to fulfil. This could include:
 - leading health emergency preparedness on a strategic basis within the LRF on behalf of the wider health sector in that locality
 - ensuring health is engaged in the planning process and where appropriate, lead the local planning for health-related workstreams for example Mass Casualties, Human Infectious disease etc.
 - ensure that the health sector is a full partner in the local multi-agency command and control arrangements that would operate in an incident
 - under the leadership of the SHA ensure there are command arrangements across the local health sector with clear and robust lines of control
 - support the SHA by co-ordinating the local response to an incident including upward communications to the SHA and, depending on the scale and nature of the incident, act as the clear NHS executive lead in an incident that escalates beyond 'normal' local mechanisms.

19. 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. SHAs will be responsible for ensuring robust mutual aid plans are in place across the regional NHS, and are able to provide NHS mutual aid outside of their region if necessary.

20. If the scale of an incident escalates beyond the SHA's capacity or region, 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 (DH), via the Department of Health Major Incident Coordination Centre (MICC), 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. It will be the role of SHAs rather than of individual PCOs to contact the DH MICC.

21. During a major incident, the SHA(s) are responsible for notifying the DH Emergency Preparedness Division (EPD), and providing an overview and initial impact assessment of the incident on routine health care provision. In addition, in relation to an on-going response to a major incident, the SHA(s) must establish a mechanism to provide regular briefing reports at a time and pace set by DH EPD. DH EPD will then collate this, and other information, and submit a health briefing note to DH Ministers and to the Cabinet Office Civil Contingencies Committee (known as COBR) if established.

22. With the incorporation of the Regional Directors of Public Health (RDsPH) and the Regional Public Health Groups in the SHAs, RDsPH are the most senior public health and medical officials in the region. They are able to relate to Regional Resilience Directors at Regional Government Offices and Regional Directors from the Health Protection Agency. RDsPH should also ensure that arrangements are made for regional level communications and co-ordination during public health emergencies, and that these responses are supported by other resilience planning arrangements being made by the SHA.
23. SHAs should identify key staff from all sections of the organisation who are willing and able to respond out of hours to support any SHA strategic command arrangements, providing a critical link between the regions and the DH EPD.
24. Whatever arrangements are put in place to suit the local circumstances the SHA retains overall and final responsibility for its two major roles in the health service for preparing and responding to major incidents:
 - **Performance management of NHS organisations** – to ensure that local plans are consistent with NHS major incident planning guidance and other relevant legislation and guidance
 - **Strategic command and control of widespread major incidents** – incidents that cannot be contained within the resources of a local health economy.
25. Whilst SHAs may opt for a Lead PCT model, the ultimate responsibility for ensuring an integrated emergency response from the health sector rests with the Chief Executive of the SHA.

Defining Strategic, Tactical and Operational Roles

26. The following definitions are a general explanation of strategic, tactical and operational roles:
 - **Strategic**
The term strategic refers to the role a person fulfils who is in overall executive command of their organisation (health, including ambulance services, police, fire, etc.) with responsibility for formulating with others the strategy for responding to the incident. Each strategic commander (sometimes called Gold) has overall command of the resources of their own organisation, but delegate's tactical decisions to their respective tactical commanders. Strategic command has a key role in strategic monitoring of the response to an incident.
 - **Tactical**
The term tactical (or sometimes referred to as Silver) refers to those who will be at or near the scene, providing overall management of the response to an emergency. Tactical managers determine, with others, priorities in allocating

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resources, obtaining further resources as required, planning, and co-ordinating tasks. Tactical managers are responsible for formulating the tactical plan for implementation by their organisation to achieve the strategic direction set by Gold. Tactical command should oversee, but not be directly involved in, providing any operational response in the incident(s).

- **Operational**

The term operational refers to those who will provide the main operational response (sometimes referred to as Bronze) in an incident, that is, be closest to the scene, and control the management of resources of their respective organisation within a specific area of the incident. They will implement the tactical plan defined by silver/tactical managers. During a 'big bang incident' (e.g. a train crash) Ambulance service incident command arrangements may also be supplemented by a Medical Incident Commander who works in tandem to the Ambulance Incident Commander. For further information refer to Mobile Emergency Response Incident Teams MERITs guidance at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121072)

27. In complex large scale incidents there is a need to co-ordinate and integrate the strategic, tactical and operational responses of each partner service. This is achieved through the formation of a Strategic Co-ordinating Group (SCG), sometimes called Gold Command, usually chaired 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. In summary, the SCG is a fast moving information sharing and strategic decision making group
28. Where there is more than one NHS organisation affected within an incident area, the lead PCT/PCO may lead the strategic NHS response at the request of the SHA. Agreement must be reached during the planning phase between the designated lead health organisation and other healthcare providers as to how strategic direction will be applied during a crisis. A protocol must be agreed ensuring that the lead health organisation (e.g. the Lead PCT) on SCG or Gold Command will represent the local health service and therefore have delegated responsibility to allocate resources on behalf of the other NHS organisations.
29. 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. Prior arrangements need to ensure that there is adequate space and the necessary equipment available for the NHS to be able to fulfil its SCG role at the SCC. This space must be in addition to space made available for accommodating the Scientific & Technical Advice Cell (STAC)
30. In the majority of cases, SCG will operate at the geographical level defined by the local LRF or police force boundaries. There may also be situations where there are a number of SCGs operating simultaneously. SHAs will need to provide a watching brief providing support to the lead health organisation as appropriate. 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 need to be flexible to meet the needs of the incident, but the SHA will be expected to lead and co-ordinate the health input into the RCCC. However, the SHA is ultimately responsible for ensuring

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strategic co-ordination of the health economy during a crisis. If a lead PCT/PCO agrees to undertake these responsibilities, on behalf of the SHA, the SHA must ensure that the organisation and its staff assuming this role are suitably trained, equipped and resourced the required responsibilities.

The role of NHS organisations

31. 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.
32. Whilst it is acknowledged that not all NHS organisations are covered by the requirements of the Act, it is considered good practice for such organisations to nonetheless comply. This includes those organisations commissioned to provide services on behalf of the NHS.
33. Central to a major incident 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 all NHS resources, including ambulances. It is focused on strategic management of the NHS during the incident by ensuring NHS service delivery for both the incident and normal services. A chief executive or their nominated deputy would usually lead the NHS response and represent the service at the multi-agency Strategic Co-ordination Group. Within a health community, the Chief Executive of a Lead PCT, with the prior agreement of the SHA, may deliver this function at a LRF level.

- **Public Health Advice**

Public health advice, in the form of a Scientific and Technical Advice Cell (STAC) should be available at the SCG/RCCC to offer health-related scientific advice for all incidents that require strategic co-ordination. During the initial phase of an incident, the chair of the STAC will probably be a specialist from public health, who will act as the focal point and primary contact for the police incident commander and all responding organisations. The STAC will provide advice on health, public health, health protection and other scientific advice as part of the incident management process. The importance of providing clear and consistent public health messages and advice is widely accepted, facing a particularly high demand during incidents involving chemical, biological, radiological and nuclear substances, irrespective of the cause.

Scientific and Technical Advice Cell

34. It is recommended that the chair of the Scientific Technical Advice Cell (STAC) decides who is best placed to attend the SCG to provide a single point of specialist advice. Those invited to attend the STAC will need to be determined at the time, and will be dependent on the type of incident. In most cases it is expected that the person who will fulfil the role of the STAC chair will be easily identified. However, in establishing these arrangements, NHS organisations including the Regional Director of Public Health within SHAs, should discuss a robust method for achieving this, ensuring the system is appropriate to local circumstances.
35. The STAC chair will normally be a senior public health practitioner with specialist skills in incident command. The STAC chairs function is to:
 - Co-ordinate the necessary science advice including health, public health, and health protection advice to input into the strategic management of the incident
 - Agree clear public health messages to be given to the public and incident responders, especially health care professionals, via the SCG
 - Manage the development, and provision, of a Scientific Technical Advice Cell which will usually be held at the Strategic Coordination Centre.
36. Notwithstanding the role of ambulance services and public health protection specialists, the SHA is in overall executive command of the NHS response during a period of significant disruption.
37. Further information on establishing a STAC can be found at www.ukresilience.gov.uk

Command Support

38. 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) and includes the 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.
39. Any organisation involved in the strategic response to a major incident must ensure that suitable records are maintained detailing any responses and management decisions made. This is best achieved through the formation of a command support team which will include administration support staff who can provide key tasks, for example decisions about logging or minute taking.

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40. If a Lead PCT model is selected then SHAs must ensure that PCT staff are sufficiently trained and resourced to complete the lead role. Furthermore, the SHAs must have mechanisms in place to support the PCT during the emergency phase of the incident.

Regional Civil Contingencies Committee (RCCC)

41. In a large-scale on going incidents 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 from 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.

42. The RCCC may meet at one of three levels:

- **Level 1** – in a state of readiness, watching and evaluating how local agencies were handling the incident
- **Level 2** – working to coordinate government resources into the response
- **Level 3** – taking a strong strategic and executive role in co-ordinating all resources at both local and regional level

43. 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. It will act as a mechanism for sharing information about the impact of the incident between central government and local responders, and will consider the recovery and long-term restoration of the region following the incident.

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

45. A diagram showing the command and control arrangements at a local, regional, and national level, in the event of a major incident, can be found at the Annex A

The roles and responsibilities of NHS Organisations in Emergency Planning

46. This section describes in outline the core roles and responsibilities in emergency planning of:
- the Emergency Preparedness Division of the Department of Health;
 - the Health Protection Agency;
 - NHS organisations;
47. **Department of Health (DH) – Emergency Preparedness Division:**
- Support the NHS Chief Executive, DH Permanent Secretary and Chief Medical Officer (CMO) to lead the health service response during a catastrophic incident.
 - 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;
 - Support the NHS CE to take command of the NHS during complex national emergencies/incident through the Major Incident Co-ordination Centre (MICC);
 - contributes to the central work on communications;
 - issues authoritative material to media, professions, and the public as well as handling national media.
48. **Strategic Health Authorities & Regional Directors of Public Health.**
- Provide strategic leadership to the health economy during periods of disruptive challenges
 - Assess the impact on the health care system from a major incident
 - Ensure that NHS organisations plan, prepare and exercise for major incidents
 - Act as a central point of contact for DH EPD providing the regular incidents reports during major incidents.
 - Ensuring resilience in response and recovery phase of NHS organisations

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As part of the SHA, Regional Directors of Public Health specific responsibilities are:

- represent the Chief Medical Officer (CMO) in the Regions
- are accountable through the CMO to Ministers;
- ensure pre-planning is co-ordinated between Regional Resilience and the NHS in preparedness for infectious diseases and other public health emergencies as part of their SHA role,
- work closely with the Regional HPA Director to provide public health advice, support and leadership especially in responding to major public health incidents,
- take the lead with SHA colleagues 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,

49. **Health Protection Agency:**

- provides expert advice to the DH on health protection policies and programmes;
- is accountable through the CMO to DH at a national level;
- provides operational public health advice and support to the NHS;
- 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;
- The HPA provides training and exercise support on behalf of DH.
- It has a statutory duty to protect the community against infectious disease and other dangers to health, prevent the spread of infectious disease, and provide assistance on public health issues to responders such as the NHS, other Category 1 Responders, the Devolved Administrations, and the wider general public.
- It will give advice on public health threats and may, where appropriate, make this advice public. While the Agency has some sampling and testing capability, this would not necessarily be deployed during an incident.

Annex A:

Diagram showing the linkages between the health economy and the wider civil resilience structure

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