

Gateway no: 17933

2 August 2012

To: SHA Cluster Chief Executives
NHS CBA Regional Directors
PCT Cluster Chief Executives

Dear colleague,

Implementing the arrangements for emergency preparedness, resilience and response including the establishment of local health resilience partnerships whilst maintaining current resilience arrangements.

We are writing to you in our capacities as the Deputy NHS Chief Executive (Department of Health) and Chief Operating Officer/Deputy Chief Executive (NHS Commissioning Board Authority) with accountability for emergency preparedness, resilience and response (EPRR) across the NHS in England. The former is responsible for EPRR up until the 31 March 2013 after which the responsibility will pass/transfer to the NHS Commissioning Board (NHS CB). Recognising the need to maintain resilience of the current arrangements¹, we now seek your assistance in implementing the revised EPRR model.

The correspondence regarding the local health resilience partnerships (LHRPs), dated 25 July 2012 (Gateway 17820), set out the need to establish the new EPRR arrangements and included a jointly produced information resource pack to support the implementation. This letter provides further detail regarding both the expectation of the NHS in implementing the following EPRR arrangements and additional supporting information:

- a) Implementation of the emergency plans including Command, Control, Communications and Co-ordination (C4) processes within the NHS CBA;
- b) Support the roll out of LHRPs for each local resilience forum (LRF) area, working closely with NHS providers locally, Health Protection Agency (HPA), Public Health England (PHE), local government and LRFs; and
- c) Providing progress reports and assurance that the appropriate level of progress is being made in relation to the above.

Supplementary detail is in Annex A for action and review by SHA emergency planning leads and directors of NHS Commissioning Board Authority (NHS CBA) local area teams. Senior managers are asked to bring the contents of this letter, and the letter dated 25 July 2012 (Gateway 17820), to the attention of their emergency planning staff.

¹ Reference Lyn Simpson's letter dated 14th June
Gateway 17762

This is the first in a series of correspondence which will provide increasing clarity on the EPRR arrangements, as the details emerge, and additional information to assist in their implementation. Future information will be provided regarding: communications; training; testing; exercising; guidance and assurance in September 2012.

Roles of organisations

The 'Summary of the principal roles of health organisations' (Gateway ref 17820) sets out the EPRR roles and responsibilities of organisations in the new health system. The document will be updated as necessary as the new health system continues to develop.

Responsibility for implementation

NHS CBA LATs are responsible for the local implementation of LHRPs and will need to liaise with local authorities and HPA/PHE in managing and monitoring the progress being made. SHA and PCT clusters are asked to support the implementation of the new EPRR model whilst the structures of the NHS CB are populated.

In the absence of any permanently appointed emergency planning capacity in the NHS CBA local and regional teams, NHS CBA Regional Directors should agree with SHA/PCT CEOs how existing emergency planning staff teams in PCTs and SHAs can support the EPRR implementation process. It is recommended SHAs consider nominating an SHA Emergency Planning Lead to lead this work on behalf of the SHA Cluster.

In establishing the new EPRR arrangements, it should be borne in mind that the costs of the new EPRR model need to be contained within the current spend, yet the effectiveness of the new EPRR model must be no less than the existing arrangements.

Resilience throughout transition

The responsibility for NHS emergency preparedness remains with all PCT and SHA cluster chief executives until 31 March 2013². SHA and PCT clusters will need to agree with the relevant NHS CBA regional and local area team (LAT) directors how the transition of these responsibilities can be safely maintained and transferred appropriately. Where possible duplication of responsibility should be avoided.

Allocation of LATs to LRFs

NHS CBA regional directors will need to allocate NHS CBA LATs to cover each LHRP/LRF area and appoint NHS co-chairs, being mindful of the influencing skills required to make the LHRPs successful (model job description and competencies are attached).

LRF health sub-groups

It is for the co-chairs of the LHRP and the chair of the corresponding LRF to agree the coordinated approach to health planning between any existing LRF health sub-group and LHRPs while remaining mindful of the need to avoid any duplication. The LHRPs will become the principal emergency planning forum for the health sector in their areas.

² Civil Contingencies Act 2004 (<http://www.cabinetoffice.gov.uk/resource-library/emergency-preparedness>)

Implementation aligned to exercises

An NHS CBA assurance process (details to follow) will be utilised to confirm the safe implementation of the revised EPRR arrangements. System-wide command post exercises (CPXs) will form a component to this processes. In alignment with these CPXs (see Annex B) and no later than 17 December 2012, the NHS CB at all levels must have implemented the appropriate C4 arrangements and specifically have 24/7 on-call rosters in place to lead the NHS response to an incident as applicable.

In summary, the NHS CBA is required to:

1. Allocate NHS CBA LATs to cover each LHRP / LRF area (31 August 2012)
2. Appoint and provide an NHS LHRP co-chair (one month prior to CPX and no later than 30 November 2012)
3. Lead the establishment of LHRPs (identifying and agreeing membership, establishing a first meeting and agreeing terms of reference and concept of operations).
4. Co-chairs to agree the coordinated approach to health planning between any existing LRF health sub-group and LHRPs with LRF chairs (1-month prior to CPX and no later than 31 January 2013)
5. Establish LAT and regional on-call rosters (one month prior to CPX and no later than 17 December 2012)
6. Identify training requirements for those on 24/7 on-call rosters (one month prior to CPX and no later than 30 November 2012)
7. NHS CBA regional directors to provide a bi-monthly progress report to the NHS EPRR Implementation Programme (September 2012 onwards)

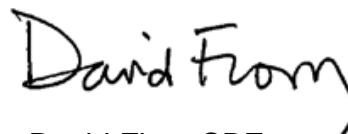
To ensure a coordinated approach to the implementation, we have involved colleagues from the Local Government Association (LGA) and HPA/PHE in the development of these plans and have similarly included them in the distribution of this letter.

In alignment with the Department of Health EPRR governance arrangements, we have established an NHS EPRR Implementation programme to oversee and assist the delivery of the new EPRR arrangements and it is our intention to support you regionally through a series of workshops. Should you be interested in receiving more information or have any queries, please contact Phil Storr (Head of NHS Preparedness, NHS Operations, Phil.Storr@dh.gsi.gov.uk, 0113 2545649).

Yours faithfully



Ian Dalton CBE
Chief Operating Officer / Deputy Chief Executive
NHS Commissioning Board Authority



David Flory CBE
Deputy NHS Chief Executive
Department of Health

Enclosures:

- LHRP co-chair job description
- LHRP NHS co-chair competencies

cc

Lyn Simpson Director – NHS Operations

Department of Health

Carolyn Downs, Chief Executive, Local

Government Association

SHA Regional Directors of Public Health

Dr Felicity Harvey CBE Director General –

Public Health, Department of Health

Helen Shirley-Quirk Interim Director, Emergency

Preparedness and Olympics (DH)

Duncan Selbie Chief Executive Designate

Public Health England

Phil Storr Head of NHS Preparedness

Department of Health

Emergency Planning Leads –

Strategic Health Authorities

Annex A – EPRR Implementation Supporting Information

Principal assumptions

The 'Summary of the principal roles of health organisations' (Gateway ref 17820) provides further clarification of the new emergency preparedness, resilience and response (EPRR) arrangements including the EPRR roles and responsibilities of organisations.

In establishing the new EPRR model, the NHS Commissioning Board Authority (NHS CBA) will wish to work together with Public Health England (PHE) and local authorities, at all levels, to ensure nationally consistent health emergency preparedness and response capability.

As is currently the case, incidents will continue to be dealt with at the most appropriate level and processes must be put in place to facilitate escalation from providers, through the NHS Commissioning Board (NHS CB), at all levels, and ultimately to the national coordination function for major (national) crises and incidents. National coordination will be led by the Department of Health, and bring together the NHS CB and PHE at national level.

Future supporting materials

During the implementation, a package of core competencies will be provided to help organisations select staff and identify their training requirements. Training programmes will be provided to meet the identified demand.

A framework of emergency planning is being developed to clearly identify the minimum requirements expected of all providers of NHS funded care regarding emergency preparedness, resilience (including business continuity planning) and response.

This autumn, off-the-shelf tests and exercises will be provided enabling organisations to exercise their own EPRR arrangements.

Assurance, testing and exercising

The Department of Health (DH) and Government more widely will be seeking assurance that the new health organisations (NHS CB, PHE, local authority director of public health and LHRPs) will have effective EPRR Command, Control, Communication and Coordination ('C4') arrangements in place by 31 March 2013.

To support the implementation, a programme of assurance is being developed to track the progress being made in implementing the new EPRR arrangements and to give assurance of the effectiveness of those arrangements. Evidence will need to be provided that the EPRR structures within health in England are fit for purpose before April 2013. One part of assurance will be provided by a series of system exercises (command post exercises ('CPXs')) that will test the C4 arrangements.

These command post exercises (CPXs) will commence in NHS North of England in the week beginning 7 November followed by NHS Midlands and East week beginning 10 December, then NHS South of England and NHS London in early February 2013. These are progressive exercises and their objectives are set out in Annex B.

Timings

The implementation of NHS CBA's EPRR Command, Control, Communication and Coordination (C4) arrangements must be aligned to the planned CPXs.

Therefore, the organisations being exercised (see Annex A) need to have their: EPRR personnel; Concept Of Operations (CONOPs); Standard Operating Procedures (SOPs); on-call rotas & estate (control rooms) in place in shadow form, as applicable, a month before they are tested.

Establishing NHS CB C4 arrangements

In alignment with the CPXs and no later than 17th December 2012, NHS CB, at all levels, must have implemented the appropriate C4 arrangements, specifically that 24/7 on-call rosters are in-place and tested to lead the NHS response to an emergency as applicable.

- Whilst it is envisaged that on-call rosters, for the director coordinating the NHS response, would include all LAT directors, executives from providers will not be expected to participate. It is for local determination to decide whether to include CCG members, considering the local geography and the number of executives on the roster.
- Executives on the roster must be suitably trained (e.g. undertaking 'strategic leadership in a crisis', 'Surviving Public Enquiries'), have the appropriate competence (Skills for Justice 'Gold' standards) and hold suitable authority to lead the NHS in an incident drawing upon NHS resources as required.
- Identifying on-call executives should be done at the earliest opportunity considering the need to identify and address any training requirements and carry out any local exercising prior to the CPXs.

A template Concept of Operations ('CONOPs') will be provided to assist the NHS CBA in developing its own CONOPs which will set out how the NHS CBA, at all levels, will respond to health emergencies.

It is for local determination how local health service information is gathered and co-ordinated to support the NHS CB LAT director representing the health service at the LRF in planning or at the Strategic Coordination Group (SCG) during an emergency. It is noted, however, that this may be influenced by regional and national requirements.

- The NHS CB are responsible for maintaining command and control infrastructure and providing secretariat support.
- In establishing control rooms, consideration should be given to the use of existing PCT, HPU, SHA and ambulance infrastructure and the efficiencies in co-locating control rooms with PHE.

Ultimately, the NHS CB LATs must ensure that the NHS has integrated health emergency plans in place across the local area. It is for local determination as to what extent LHRPs will facilitate the production of these plans. However, the accountability for producing, testing and assuring these plans will remain with the NHS CB.

In addition to preparing to an emergency, NHS provider organisations are also responsible for maintaining resilience to respond to routine operational pressures. CCGs will support this by ensuring contracts with provider organisations contain relevant EPRR elements (including business continuity). Work is underway to set out the minimum requirements of organisations in maintaining resilient services.

Mapping LATs to LHRPs and selection of co-chairs

LHRPs will be coterminous with LRFs and NHS CBA regional directors will need to allocate NHS CBA LATs to cover each LHRP/LRF area.

It is expected that LATs will have MOUs with all applicable providers of NHS funded care to ensure the allocated LAT can command, control & coordinate NHS resources and ensure that the appropriate resources are made 'available' if required. A template memorandum of understanding will be provided in August 2012.

It is envisaged that the LAT director responsible for EPRR will be the NHS co-chair of the LHRP and the regional directors will need to discuss further if this is not the case and come to an alternative arrangement. Suggested job descriptions and competencies of the NHS LHRP co-chair are attached.

- The co-chair will have an interest in EPRR and have a full working knowledge and understanding of the statutory legislation underpinning EPRR and principles of integrated emergency management.
- It is important to note that the co-chair is a leadership and influencing role and co-chairs must possess the ability to influence LHRP members, and the organisations they represent, to ensure that EPRR and business continuity planning remains a high priority and that all organisations have the appropriate plans in place.
- LATs will need to liaise with local authorities with a view to making simultaneous appointments of both LHRP co-chairs.

Establishing LHRPs

The terms of reference (TOR) and working methodology of LHRPs was provided with the correspondence, dated 25 July 2012 (Gateway 17820). To ensure the effectiveness of the Partnership, the NHS co-chairs will need to give careful consideration to the number of members on the LHRP and their seniority (executive level).

Due to the strategic nature of the LHRPs, the co-chairs will determine the need for any task and finish working groups to complete specific items of work that reflect locally identified risks to the community.

It is for the co-chairs of the LHRP and the Chair of the corresponding LRF to agree the coordinated approach to health planning between any existing LRF health sub-group and LHRPs mindful of the need to avoid any duplication. The LHRPs will be the principal health planning groups for their local areas.

Annex B – Objectives of Command Post Exercises

The overall proposed exercise programme builds up through time. Therefore, the grey boxes indicate which parts of the new arrangements are included in the exercise programme for the first time.

Objective	Objectives of each exercise		
	North	Mids&E	South & London
Activation of the emergency health response at local level within the new arrangements.	√	√	√
Interactions between health and multi-Agency partners in an SCG.	√	√	√
Mutual aid arrangements between the health response in two or more local areas within a region.			√
Mutual aid arrangements between the health response in two or more regions.			√
Command, control and coordination between NHS and public health interests at local level within the new arrangements and communication arrangements with the public.	√	√	√
Command, control and coordination between NHS and public health interests at local level and NHSCB/PHE at regional level. Also demonstrate assurance of communication arrangements with the public.		√	√
Command, control and coordination between NHS and public health interests at local level and NHSCB/PHE at regional level and national headquarters level. Also demonstrate assurance of communication arrangements with the public.			√
Arrangements for requesting and providing Scientific and Technical advice in an emergency (ECOSA and STAC processes).	√ Less ECOSA	√	√