NHS SCOTLAND

NHSSCOTLAND RESILIENCE

PREPARING FOR EMERGENCIES

Guidance for Health Boards in Scotland

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DOCUMENT CONTROL

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Target Audience	NHS Chief Executives Directors of Public Health NHS Resilience Officers Regional Resilience Partnerships RABS Voluntary Sector Group Health Professional Colleges and representative bodies Scottish Government Directorates
Document Purpose	To provide strategic guidance for NHSScotland Chief Executives and NHS Leaders on preparing for emergencies in the context of the Civil Contingencies Act 2004
Description	Guidance on implementation of Civil Contingencies Act 2004 and relevant legislation on preparing the NHS for emergencies. Divided into eight sections: two of which set the context, and the others more specifically address developing capability for specific incidents and care for people affected by incidents. Contains appendices to support planning processes.
Superseded Documents	NHS in Scotland Manual of Guidance: Responding to Emergencies, 2005
Action Required	National Health Service in Scotland Manual of Guidance: Responding to Emergencies, 2005

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FOREWORD

Emergency preparedness has always been of paramount importance for the NHS in Scotland. The increasing frequency of various types of disruptive events now confronting large organisations underlines its necessity.

Health Boards need to be able to plan for and respond to a wide range of major incidents that could affect the smooth running of NHSScotland and ultimately public health or patient care. These could be anything from extreme weather conditions or a major disease outbreak, to a major transport incident. Health Boards need to be sufficiently resilient to deal with the consequences of these incidents that may put the organisation under severe pressure, while maintaining patient care.

This *Preparing for Emergencies* guidance encourages and supports Health Board Chief Executives and other NHS leaders to enhance emergency preparedness and the resilience of healthcare organisations.

The concept of resilience is being steadily introduced into the NHS, importantly now beyond emergency preparedness, as it encourages us to ask a different set of questions about the way we manage our resources in adverse circumstances, adapt to sudden change and enhance the robustness of healthcare services and the NHS overall. Focusing on *what* NHS leaders in Scotland should do to be prepared for civil contingencies or major incidents, rather than the *how to do it,* this guidance prompts NHS leaders to think about the implications of, and plan for, various scenarios. It also recognises the complexity of Health Boards and the differing scale of resources at their disposal. In this context, it promotes partnership-working across NHSScotland as well as with other agencies as a means of ensuring adequate response capability.

NHSScotland is a valued partner in civil contingencies and resilience planning. This is reflected by the engagement of highly experienced professionals from various disciplines and sectors who have keenly supported the development of this guidance. Their contributions have ensured that the document is comprehensive, based on new information and best practice, and takes into account the potential implications of legislation such as Equalities and Human Rights.

Being prepared for emergencies should enable NHSScotland to remain open for business during major incidents and respond to disruptive challenges with confidence. In short, emergency preparedness preserves the integrity of NHSScotland.

We urge Chief Executives and senior leaders in NHSScotland to consider this guidance and put in place appropriate plans to ensure emergency preparedness is in line with the Civil Contingencies Act 2004.

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EXECUTIVE SUMMARY

Major incidents can happen anywhere, at any time. They can be anything from prolonged periods of extreme weather conditions, public health incidents, or a major transport accident, all of which cannot be managed within routine service arrangements and require special procedures to be implemented.

Health Boards are expected to be resilient and well prepared to address the disruptive challenges of various types of major incidents while maintaining services to patients. This can be complex, involving many issues including the assessment of risk, the deployment of resources and co-operation with other agencies to develop robust plans.

This guidance is designed to help Health Boards across Scotland be as prepared as they can be to serve the public when such problems arise. Being prepared means that Health Boards, particularly those identified as category 1 and 2 responders under the Civil Contingencies Act 2004 (CCA), clearly understand their vulnerabilities and are ready to respond effectively to major incidents.

Drawing on recent good practice evidence and professional expertise, *Preparing for Emergencies* provides strategic guidance for Chief Executives and other senior health service leaders in the context of their duties under the CCA and other key legislation.

Divided into eight sections, the document explains what should be done to enhance organisational resilience and capability.

Section 1 sets the context of the guidance and explains its purpose, while Section 2 highlights NHSScotland's aims, objectives and principles in relation to preparing for emergencies including what Chief Executives should do to ensure the organisation's readiness. Section 3 outlines relevant legislation underpinning emergency planning and identifies the categorization of Health Boards under the CCA.

Section 4 focuses on planning for emergencies generally, setting out the roles and responsibilities of various leaders and managers in the organisations that comprise NHSScotland, while Section 5 highlights the essential elements of emergency planning, indicating clearly the actions that should be taken to ensure the Health Board can operate effectively during an emergency situation. Section 6 explains the Scottish Government's role during an emergency and how Health Boards may seek support when faced with particular service pressures during a major incident.

Section 7 outlines what Health Boards should do to develop capability for handling the consequences of specific types of major incidents. Section 8 explains the actions required to enable an effective response to be made to potentially vulnerable people in the community.

Preparing for Emergencies replaces *NHS in Scotland Manual of Guidance: Responding to Emergencies, 2005*.

SECTION 1
INTRODUCTION

This section sets out the context of this guidance, explains its purpose and the process of producing it.

Context

1.1 Everyone expects the NHS to be there, functioning normally and safely when they need it. This expectation is constant despite an increasing number of disruptive challenges facing health services. These include severe weather, utilities failures, industrial action, public health and other types of major incidents and acts of terrorism. All carry with them short and long term consequences for operating business as usual.

1.2 The NHS in Scotland continues to operate in a changing environment with new and increasing demands: new health and social care policy and legislation (the integration of health and social care services); the redesign of health services; the development of new healthcare environments and facilities and a greater number of large-scale, major public entertainment and sporting events.

1.3 These changes create new opportunities but also presents potential risks and threats for health services that were previously unrecognised. Relevant Health Boards will also be involved in new arrangements for inter-agency civil contingencies planning and coordination in the form of Regional Resilience Partnerships (RRP) and Local Resilience Partnerships (LRP) in place of the Strategic Coordinating Groups.

1.4 This guidance takes account of the changes facing the NHS and builds on progress that Health Boards have made to date in implementing the Civil Contingencies Act 2004. It replaces *National Health Service in Scotland Manual of Guidance: Responding to Emergencies*, 2005.

Purpose of the guidance

1.5 The purpose of this guidance is to:

- enhance the resilience of NHSScotland and ensure there is a consistent and coordinated approach to resilience planning across the NHS;
- enable NHSScotland Chief Executives, Executive Directors and resilience-planning leads to understand both their own and their Board's roles and responsibilities under the Civil Contingencies Act 2004[1] and other key legislation;

1 Civil Contingencies Act 2004 www.legislation.gov.uk/ukpga/**2004**/36/contents and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 www.**scotland**.gov.uk/Publications/**2005**/02/20630/51567

- ensure Health Boards comply with the relevant duties in preparing for, and recovering from major incidents and emergencies;
- ensure consistent approaches and standards of practice across NHSScotland in relation to responding to major incidents and emergency situations; and
- promote continuous improvement of emergency preparedness across NHSScotland.

About the guidance

1.6 The guidance recommends a framework and general principles for Health Boards to develop and maintain their capability to respond to major incidents and a range of disruptive events.

1.7 The guidance is:

- strategic in focus;
- set in the context of the Civil Contingencies Act 2004 (CCA) and associated regulations, which place statutory duties on some Health Boards regarding emergency capabilities;
- intended for all Health Boards as it is relevant to the full range of healthcare services, not only acute emergency care; and
- set in a 3-year timeframe. It will be reviewed mid-term to ensure that it reflects changes in policy and new developments.

1.8 It should be read in conjunction with Preparing Scotland[2], which provides broader guidance on fulfilling CCA duties, and within the context of other legislation, policy and guidance applicable to NHSScotland.

1.9 *Preparing for Emergencies* has been prepared with advice and support from a multidisciplinary working group (see appendix 1).

Terminology

1.10 Although the term *emergency* is used in the CCA, it is often used interchangeably with *major incident* in civil contingencies planning documents and guidance. The term *major incident* is used predominantly in this guidance. In the NHS context it 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 one or more territorial and/or special health boards simultaneously or in support of each other. It requires considerable resources and strategic input as it potentially threatens the survival of an organisation.*

1.11 The term is deliberately broad so that potential incidents are not missed. It describes events that require special procedures and arrangements to be implemented and the involvement of one or more emergency planning partners. Further, it recognises the fundamental importance of public confidence and trust in the NHS response to any incident.

1.12 A major incident may present as a variety of different scenarios (see Glossary, Appendix 9 for definitions of major incident scenarios). What constitutes a major incident for a Health Board may not be one for another organisation, or vice-versa.

1.13 Some of the terms used in this document are defined in the Glossary.

2 Preparing Scotland – Scottish Guidance on Resilience, March 2012 see http://www.readyscotland.org/ready-government/preparing-scotland/

Health Inequalities Impact Assessment (HIIA)

1.14 This guidance has been subjected to an HIIA scoping which highlighted three key points that need to be considered by Health Boards (category 1 and 2 responders) when preparing for emergencies and deploying resources in emergency situations:

- **Communication**: The most effective and appropriate means of communication should be used to convey important and timely information to staff, patients and the general public. It should include a combination of different methods and approaches so that everyone is given appropriate information.
- **Access to services**: During major incidents or emergencies some services may be disrupted or experience a surge in demand. NHS Bodies should identify services likely to be affected and prepare plans to mitigate the impact on the users of critical services.
- **Staff training**: Staff should have appropriate equalities and human rights training so that they are aware of and are sensitive to the needs of different population groups. This will help staff understand how procedures followed and decisions taken in emergency situations may impact on injured patients and their relatives, particularly in the recovery phase of an emergency.

1.15 The points from the HIIA have been incorporated into and generally underpin this guidance.

Who this guidance is aimed at

This strategic national guidance is principally aimed at NHSScotland Chief Executives, Executive Directors, senior managers and staff responsible for resilience and emergency planning of health services.

NHSScotland includes NHS Bodies, Special and other Health Bodies, including the Common Services Agency (commonly known as NHS National Services Scotland). In this guidance they are collectively referred to as 'Health Boards'.

The terms 'Territorial Health Boards' and 'Special Health Boards' are used when specific advice, information or guidance is directed at particular organisations within NHSScotland.

Health Boards should ensure that primary care contractors are aware of this guidance and, where appropriate, engage them in the relevant major incident planning processes.

SECTION 2
ENSURING PREPAREDNESS

This section highlights the aims and objectives underpinning NHSScotland emergency preparedness, the activities required by Chief Executives to ensure that their Health Boards comply with the relevant duties under the Civil Contingencies Act 2004.

NHSScotland emergency preparedness: aims, objectives, principles

2.1 The overall aim of emergency preparedness is to protect the public and ensure that the NHS in Scotland is safe, resilient and ready to respond when required.

2.2 The underpinning objectives are to:

- ensure that Health Boards can respond effectively to major incidents in a way that delivers optimum care and treatment to those affected;
- minimise the consequential disruption to healthcare services, and bring about a speedy return to normal levels of functioning;
- maintain appropriate capability to respond to various types of major incidents; and
- work in partnership with other agencies and across organisational and professional boundaries to deliver effective, integrated multi-agency responses to major incidents, crises and disasters when necessary.

2.3 NHSScotland's principles for emergency preparedness and response are that NHS Bodies:

- prioritise and deploy resources efficiently and effectively;
- are adaptable, and can respond with speed and flexibility;
- implement knowledge/evidence-based practice;
- provide survivors, patients and their families with the highest possible standards of healthcare by appropriately trained and supported staff;
- provide mutual aid to each other when necessary; and
- receive support from Scottish Government Health and Social Care Directorates when necessary.

2.4 As the Accountable Officer, the Chief Executive of each Health Board is responsible for ensuring the overall readiness of their organisation to manage major incidents and emergencies, including responses to high impact events.

This guidance therefore requires Chief Executives to be able to demonstrate that:

- their organisation is fully compliant with its statutory duties under the Civil Contingencies Act 2004 and all subsequent regulations;
- there is clear and effective leadership, delegation of responsibility and lines of accountability for preparing for, and responding to major incidents. As a minimum requirement, an Executive Director of the Health Board should be the designated lead for emergency preparedness (EP) and for business continuity (BC);
- clear governance arrangements are in place throughout the organisation to oversee emergency preparedness and business continuity. These must include a Resilience Committee, chaired at least by the Lead Executive Director, which will report to the Board on emergency preparedness, training, exercises, resourcing and any gaps in capability or capacity. Reporting should be regular and at least annually;
- there are active and effective links between the organisation's EPBC plans and planning arrangements;
- there are suitably experienced and qualified Lead Officers for EP and BC. These officers are responsible for supporting the Executive Lead(s), advising the Resilience Committee and facilitating delivery of the required capabilities and plans throughout the organisation;
- the Health Board has an up-to-date Major Incident Plan that has been endorsed by the Health Board. This plan should be based on the principles of risk assessment (adopting an all-risks approach), reflect integrated emergency management and complement the organisation's arrangements for business continuity. Other agencies must be made aware of any assumptions in relation to their services; and
- adequate and proportionate resources have been allocated, in line with assessed need, to developing and maintaining emergency preparedness and the resilience of the organisation, including staffing, equipment, training and exercising.

Assurance

2.5 NHSScotland Resilience (Scottish Government Health and Social Care Directorates) will develop core standards based on *Preparing for Emergencies*. Assurance of a Health Board's compliance with this guidance and the core standards will be sought from NHS Chief Executives through an annual assurance process in future.

SECTION 3
LEGISLATION

This section highlights the designation of particular Health Boards as category 1 and category 2 responders under the Civil Contingencies Act 2004. It also highlights key issues in relation to ensuring compliance with the Equality Act 2010 and the Human Rights Act 1998.

The Civil Contingencies Act 2004 and the NHS

3.1 The Civil Contingencies Act 2004 (CCA) and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 provide the primary legislative framework for resilience and civil contingencies matters in Scotland. The CCA divides responder organisations into two categories, depending on the extent of their involvement in civil protection work, and places a proportionate set of responsibilities on each. In relation to NHSScotland,

Category 1 responders are those organisations at the core of emergency response and they are subject to the full set of civil protection duties. They include:

All Territorial Health Boards, and

The Scottish Ambulance Service (a Special Board)

Category 2 responder organisations are cooperating bodies that have lesser obligations placed on them by the CCA than category 1 responders. Primarily their role is to cooperate with, support and share relevant information with category 1 responders. They should be engaged in discussions where they can add value and they must respond to all reasonable requests. They include:

NHS National Services Scotland (a Special Board)

3.2 It is good practice for non-designated Health Boards to ensure that they can comply with the requirements of the CCA, identify how they can support the category 1 and 2 responders and use this guidance to ensure they have the necessary business continuity and emergency plans in place to deal with potential service disruptions or major incidents.

3.3 Other legislation is identified in later sections of this document that must be taken into account by Health Boards in civil contingencies/resilience planning.

Equality and diversity

3.4 Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential, while diversity recognises and values difference in its broadest sense. In developing emergency preparedness plans, Health Boards must be mindful of their duties under the Equality Act 2010[3]. The Equality Duty requires public bodies to consider the needs of all individuals when developing policy, delivering services and in relation to employees. It encourages public bodies to understand how different people will be affected by their activities so that services are appropriate and accessible to all and meet different people's needs. See *Preparing for Emergencies Guidance for Health Boards in Scotland Annex: Equalities, Human Rights and Resilience Planning.*

Human rights

3.5 In addition to complying with the Public Sector Equality Duty (see *Preparing for Emergencies Annex: Equalities, Human Rights and Resilience Planning*), Health Boards must uphold the UK Human Rights Act (1998) in delivering services which requires that account is taken of a range of factors including the dignity of individuals receiving treatment; end of life considerations; prioritisation of treatments and transparency in relation to decision-making as well as an individual's preferences.

3.6 The primary consideration of all agencies involved in a major incident/ civil emergency is the preservation of life. This is also the core of Article 2 of the Human Rights Act 1998 which states that 'everyone's right to life shall be protected by law'.

3.7 Health Boards must undertake an appropriate level of impact assessment (see *Preparing for Emergencies Guidance for Health Boards in Scotland Annex: Equalities, Human Rights and Resilience Planning*) of their emergency preparedness plans and protocols to ensure that they do not negatively affect particular populations, thus perpetuating existing inequalities.

3.8 If for any reason, there is a necessity to restrict any Human Right in an emergency situation, such as freedom of movement or freedom of assembly, this should be proportionate and only for the minimum duration possible. The reason for such a decision being taken should be communicated to the people affected by it and accurately recorded.

3 Equality Act 2010, http://www.legislation.gov.uk/ukpga/2010/15/contents

SECTION 4
PLANNING FOR EMERGENCIES

This section highlights the wider context within which Health Boards should plan and prepare for emergencies. It sets out roles and responsibilities at various stages of the emergency planning process in line with the requirements of the Civil Contingencies Act 2004.

Introduction

4.1 Major incidents are inevitable and each one will present unique challenges. It is important for Health Boards to adopt an all-risks approach to planning for and responding to major incidents, to identify the skills and expertise available to them and how they will be deployed in various circumstances or scenarios, and to have arrangements in place to manage the uncertainty and unpredictability of events.

4.2 The planning process is key to preparing for emergencies. Under the Civil Contingencies Act 2004, Health Boards are obliged to have arrangements in place to plan, exercise and review their capability and responses against a range of disruptive challenges, crises, disasters or emergencies. These obligations involve three key functions as part of the planning process:

- assessing risk;
- ensuring that (scalable) plans are in place *to reduce or mitigate* the effects of the emergency situation if/when it occurs; and
- identifying other actions to be taken in relation to the emergency.

4.3 Health Boards must use the Integrated Emergency Management[4] (IEM) cycle, working together with multi-agency partners via Regional and Local Resilience Partnerships to build resilience. The IEM cycle ensures a constant review of activity and therefore robust preparedness arrangements.

4.4 Essentially, the planning process should demonstrate that the Health Board has:

- engaged key internal and external stakeholders and partner agencies, particularly category 1 and 2 responders and voluntary sector agencies that have an emergency response and support capability in developing its major incident plan;
- developed appropriate and suitably resourced 'command, control and coordination' (C3) arrangements;
- established a programme of training, exercising and testing to ensure effective implementation of the plan;
- incident-recording arrangements and a system for identifying and sharing learning from incidents; and
- established a system for reviewing and updating the plan.

4 Preparing Scotland, Scottish Government, 2007 – Section 2 Integrated Emergency Management

Responsibilities

4.5 Health Boards designated as category 1 and 2 responders should ensure they comply with the requirements of the CCA and are in a position to contribute to a co-ordinated response to major incidents, regardless of their nature or scale.

4.6 Non-designated Health Boards should comply, as a matter of good practice, with the requirements of the CCA and identify how they can support the designated Territorial and Special Health Boards.

4.7 The specific duties of Health Boards under the CCA are to:

1. Assess risk
Risk assessment (of hazards, threats and vulnerabilities) is the first stage in organisational resilience and business continuity planning. All Health Boards should ensure internal corporate risk management processes include risk to continuation of services that single and multi-agency plans are evidence-based and proportionate.

They must develop and maintain an internal/organisational Risk Register and actively participate in the development of multi-agency Local and Community Risk Registers produced by the Regional Resilience Partnership in the context of National Risk Assessment[5].

2. Maintain emergency/major incident plans
Health Boards must produce and maintain major incident/emergency plans for a range of potential scenarios in line with guidance later in this section (See 5.13). They must also actively engage with partners on the RRP to ensure that the role of the NHS is appropriately reflected in multi-agency plans for various major incidents/ emergencies.

3. Maintain business continuity plans
Business Continuity Management (BCM) is an essential activity in establishing an organisation's resilience by enabling it to anticipate, prepare for, respond to and recover from disruptions and to have a clear understanding of dependencies with other organisations.

Health Boards designated as category 1 and 2 responders must have robust up-to-date BCM plans to help maintain their key functions if there is a major incident or disruption. BCM plans should identify:

- management arrangements aligned to relevant risks;
- critical/prioritised services, analyse the effects of disruption and the actual risks of disruption and actions to mitigate them;
- activation procedures and escalation processes;
- recovery steps to ensure the service can return to operation;
- how the plan(s) will be maintained and reviewed; and
- how the plan(s) will be communicated to and accessed by staff.

For further information on BCM see appendix 2.

4. Communicate with the public
Category 1 Health Boards must have communication plans that can:

At the planning stage: Inform the public of the likely risks and threats being prepared for and, in general terms, of their potential responses if they occur; and

At the response stage: Warn, inform and advise the public using different types of messages and a variety of methods appropriate to the needs of the audience.

For further information on Communication, see section 5E.

5 National Risk Assessment https://www.gov.uk/risk-assessment-how-the-risk-of-emergencies-in-the-uk-is-assessed and https://www.gov.uk/government/publications/national-risk-register-of-civil-emergencies

5. Share information

Information-sharing is an integral part of civil protection and interagency cooperation. Health Boards must share information with other categorised responder organisations and their major incident plans should be available in the public domain, accepting that sensitive or confidential information cannot always be shared with partner agencies and/or the public.

Careful consideration must be given to the type of information that is required to plan for a major incident and what information can be shared in the context of the CCA and the Freedom of Information (Scotland) Act 2002[6] while maintaining confidentiality.

Health Boards must ensure that there are free-flowing, informal channels of communication and information-sharing with other agencies involved in civil contingencies work. It is important that Caldicott Guardians advise on disclosure of information and are available to support and guide staff.

6. Cooperate

Health Boards designated as category 1 responders must cooperate with other responders. The principal mechanisms for multi-agency cooperation at local level are the Regional Resilience Partnerships (RRP) and Local Resilience Partnerships (LRP).

Health Boards should be represented on these multiagency groups by staff at an appropriate level within the organisation, as follows:

RRP – Chief Executive or a delegated Executive-level Director (Territorial Health Board); Director of Service Delivery or General Manager of the Scottish Ambulance Service (SAS);

LRP – Resilience Manager/Senior Manager (Territorial Health Board); General Manager or Head of Service (SAS).

It is important that Health Boards, especially those within the same RRP, develop capacity and capability for specific incidents especially those that may have a longer-term impact on service provision, by collaborating with each other, with NHS National Services Scotland (a category 2 responder) and with relevant non-designated Health Boards. Primary care services, relevant independent contractors, local authorities and voluntary agencies should be involved in these planning processes, as appropriate, so that they are aware of the Health Boards plans and/or its expectations in the event of a major incident.

Legal frameworks, public inquiries and civil action

4.8 NHS legal obligations and duty of care for patients does not change during major incidents or emergencies that are likely to generate high profile media attention or scrutiny. In such situations it is likely that legal investigations and challenge such as criminal investigations, fatal accident and/or public inquiries or civil action may follow. These may occur a long time after the incident.

4.9 When planning for major incidents it is essential that Health Boards have arrangements in place to record the decisions made and actions taken and store all the records and documentation safely for future reference should they be required for evidential or audit purposes.

6 http://www.legislation.gov.uk/asp/2002/13/pdfs/asp_20020013_en.pdf

SECTION 5
ESSENTIAL ELEMENTS OF EMERGENCY PLANNING

This section highlights the essential elements that are required to be in place so that Health Boards are able to respond effectively to major incidents.

Command, control and coordination (C3)

5.1 In general, major incidents are local, time-limited and effectively dealt with either by emergency services or the designated hospital's Emergency Department. However, some will be of a greater magnitude with potential consequences beyond the local Health Board area. These types of incidents will necessitate a higher level of coordination, initially by the LRP or RRP as well as by the Scottish Government Resilience Room (SGoRR).

5.2 In times of pressure and when responding to major incidents, internally or externally, Health Boards need a structure which provides clear leadership, accountable decision-making and arrangements for communicating up-to-date information. C3 is a structured approach to incident management under pressure.

Responsibilities

5.3 Health Boards must have pre-determined C3 arrangements in place (at Board, hospital/divisional level) to respond effectively and efficiently to a major incident that it can either handle alone or through support provided as part of a wider multi-agency response.

5.4 C3 arrangements should:

- include a suitable functional space for making decisions, collecting and sharing information quickly;
- be able to be activated with the necessary personnel, standard operating procedures and equipment without undue delay;
- have clearly defined roles and (decision-making) responsibilities for Executive-level Directors and other staff delegated to assume control of an internal incident or an external one as part of multiagency strategic command group; and
- have clearly defined processes for maintaining appropriate, contemporaneous records and documenting the incident.

5.5 An adequate pool of staff should be trained as Loggists to support the management of an incident or response. It is essential that incident logs produced reflect best practice standards and that Loggists understand the evidential value and rationale of a robust audit trail.

5.6 All staff identified to assume C3 responsibilities should be given an appropriate level of training in line with the competencies for the various roles they are expected to fulfil.

Communications systems

5.7 Effective and resilient telecommunications systems are essential in enabling C3 groups to communicate with key personnel internally and externally during a major incident. Therefore, Health Boards should ensure that:

- appropriate telecommunications systems (such as Airwave, MTPAS) are available and accessible to the staff who may need them, with accompanying protocols for their use;
- all staff who may be called on to fulfil a C3 function are competent to use the telecommunications systems in emergency situations; and
- communications testing exercises take place regularly.

Mutual aid agreements

5.8 Mutual aid agreements are an important aspect of emergency preparedness. They ensure that an NHS body will have access to appropriate supplementary and/or specialist resources and support from other health organisations in the event of a major incident.

Responsibilities

5.9 The Chief Executive must ensure that his/her organisation has a mutual aid agreement with other Health Boards, category 2 responders and other relevant organisations not covered by the CCA in the RRP area and beyond if necessary. The agreement should clearly outline what aid might be required, what can be offered, who the partners are, and governance arrangements. It should be reviewed and revised at least annually.

5.10 Mutual aid requests for support should be formally triggered by the Chief Executive or named Deputy to maintain normal service provision. This should take place only after the Health Board has invoked its surge capacity plans and the incident C3 Group concludes that the capacity and capability thresholds for operating safely have been reached.

5.11 If the incident is likely to be of a longer duration or deemed to require coordination or mutual aid on a larger scale, the Scottish Government Resilience Room will be activated to fulfil a national, strategic coordination function and to ensure that government assistance is provided if required. (see Role of the Scottish Government, section 6).

5.12 In the event of mutual aid resulting in the clinical care of patients being transferred to another Health Board, there must be a clear agreement on clinical accountability and arrangements for follow-up care to ensure that movement across Health Board boundaries are taken in the best clinical interests of the patient and to ensure close, coordinated clinical supervision.

The major incident plan

5.13 Major incident plans are the culmination of risk assessment (see section 4.7). They reflect that the organisation has an understanding of the challenges that could arise from various types of major incidents or emergencies and is prepared for them. The plan provides the basis for ensuring an effective and efficient response.

5.14 Effective planning requires the Health Board to have an overview of all major incidents that have occurred in its local area, as well as those within other Boards in the RRP area, to assess or monitor their impact and learn from them.

Responsibilities

5.15 The major incident plan is a key component of preparedness and all category 1 and 2 Health Boards should have one. It should set out how they plan for, respond to and recover from various types of major incidents, and must:

- be fit for purpose and appropriate to the geographical area it covers;
- have appropriate governance arrangements, and set out responsibilities for carrying out the plan;
- be based on the principles of integrated emergency management and associated activities (i.e. assessment, prevention, preparation, response and recovery) and encompass all the phases of major incident;
- be consistent with multi-agency working, especially with partners represented within the same Regional Resilience Partnership (RRP) and link to any multi-agency response that the Health Board has a role in, such as public communications and the Scientific and Technical Advisory Cell[7] (STAC) (see information on communications at the end of this section);
- reflect the requirements of the Civil Contingencies Act 2004, the 2005 regulations and other relevant guidance documents and have the capability to deal with all the specific incident scenarios and issues identified in this guidance such as CBRN, mass casualties, communicable diseases, burns injuries and meeting the needs of children, young people and vulnerable people;
- identify where and how specialist advice may be obtained or accessed, especially out-of-hours;
- describe local command, control and coordination (C3) arrangements as detailed in section 5.1; identify lead officer posts (at strategic and operational levels) and outline their roles and responsibilities;
- identify mutual aid arrangements with neighbouring Health Boards and other key agencies and how/when they should be triggered;
- identify reporting procedures and links with RRPs, Scottish Government Health and Social Care Directorates (SGHSCD) NHSScotland Resilience as necessary, and how and when they are to be triggered;

7 Preparing Scotland, Scientific and Technical Advice Cell (STAC) Guidance, 2013, Scottish Government Resilience Division www.scotland.gov.uk/publications/2013/02/6297/0

- identify the potential source(s) of financial resources that may be needed to respond to various incidents;
- identify resources to be allocated or accessed to deal with various types of incidents in line with defined planning assumptions;
- identify the staff requirements and mobilisation arrangements to respond to various incidents and how the impact on normal services will be addressed; and
- be regularly reviewed (in the light of exercising, training, lessons learned from incident debriefs and policy changes), and endorsed by the Civil Contingencies/Resilience Committee and/or the Health Board.

5.16 Major incident plans should be:

- exercised in full at least every 3 years;
- tested through a table-top exercise every year; and
- communicated/cascaded within the organisation and to partners every 6 months.

Reporting major incidents

5.17 Health Boards should ensure that all relevant staff are aware of the Scottish Government NHSScotland Resilience reporting arrangements using the agreed NHS Situation Report (SitRep) pro-forma. These arrangements must be used when a major incident:

- occurs within a Health Board;
- has been declared by an RRP partner that requires the deployment of healthcare resources; and
- creates significant service pressures for the Health Board and is likely to impact on business as usual.

5.18 The reporting frequency will be agreed by the Health Board representative and SGHSCD depending on the nature of the incident and the assessment of its impact on the Health Board.

Training and exercising plans

5.19 Training and exercising programmes are important in ensuring that incident response plans are up-to-date and will be effective when implemented. They are a means of providing the Health Board with assurance of its capability for various types of major incidents.

Responsibilities

5.20 The Chief Executive must ensure that arrangements and resources, including financial commitments, are in place to enable adequate training, exercising and testing of the Health Board's emergency preparedness. Accordingly, a budget should be allocated to meet the costs of the agreed programmes. Health Board members should be advised at least annually of the Board's state of preparedness.

5.21 As a minimum, Health Boards should have:

- an annual training and exercising plan, the implementation of which is monitored and recorded;
- a process and system for recording and reporting the outcome of exercises and for ensuring that lessons-identified and lessons-learned are incorporated into revisions of the appropriate plans and protocols; and
- training/skills records to help inform capability analysis that are kept up-to-date.

5.22 Disciplines from across the Health Boards services (acute services, public health, primary and community care etc.) as well as contractors and other key LRP/RRP partners where appropriate should be involved in these exercises. It is recommended that scenario-specific exercises are undertaken to test particular aspects of the organisation's capabilities.

5.23 Health Boards should assess their own overall exercise requirement, which for some may be in excess of this minimum.

5.24 Wherever possible, Health Boards should collaborate with each other to organise and participate in joint exercises, involving multiagency partners where practicable. The lessons-identified and lessons-learned from these exercises should be disseminated across the service via appropriate networks as a means of enhancing the overall resilience of NHSScotland.

5.25 Training, testing and exercising should take place in the context of a training needs analysis and a progressive, targeted and graduated training programme that reflects the roles and responsibilities of staff in particular operational settings. Senior managers should ensure that appropriate staff are released to participate in relevant training programmes.

Communication

5.26 Communication with the public is a duty under the CCA and plays a central role in preparing for, responding to, and recovering from emergencies. Effective communication requires Health Boards to think strategically about how they communicate internally, with one another, and how they communicate with patients and with members of the public.

5.27 During an emergency, Health Boards must cooperate with other agencies to develop a communications strategy and issue information that is clear, timely, relevant and accurate. The public expect to be informed quickly and efficiently and, in an incident that has potential health consequences, they will look to the NHS to communicate with them both directly using websites and social media, as well as the mainstream news media.

5.28 Liaising with the media during an emergency is a resource-intensive operation. It requires those involved to have the necessary skills and training to cope with a surge of repeated requests for information, especially in the early stages of a major incident. Effective handling of the media will affect how the emergency and the response to it are reported and that, in turn, can enhance the effectiveness of that response, both immediately and in the longer term.

Responsibilities

5.29 Health Boards should appoint a Lead Communications Officer who should participate in the multi-agency strategic communications group formed to deal with the incident.

The following guidance is presented under the various IEM activities.

(1) Preparation

5.30 Health Boards must have a communication plan (see Appendix 4), which is developed in conjunction with the RRP and integral to its major incident plan. They should ensure that managers responsible for emergency response are familiar with media needs, methods and time schedules, and should prepare and train them and other appropriate staff for media liaison duties.

5.31 The communications plan should:

- outline the roles and responsibilities of the organisation and staff (particularly in the communications department) at various levels, the resources to be made available to them and the use of websites and social media;
- indicate the procedures to be followed by the on-call Communications Officer in the event of a media enquiry or a statement by a member of the public on social media alerting the Health Board to a possible incident;
- indicate how and when NHS 24 emergency helplines and its social media outlets will be used to keep the public informed;
- indicate actions to be taken at various phases during and after an emergency has occurred; and
- be exercised, and the communications arrangements should be tested in as practical a way as possible. All training and exercising should take account of lessons identified from previous emergencies and exercises.

5.32 The communication plan as a whole and the specific arrangements for communicating with the public and staff should be assessed against Equalities and Human Rights Act duties.

5.33 Use of social media has the ability to reach a vast and varied audience in a very short period of time, respond to requests for information, answer queries or counter rumours and inaccurate information. Using social media in a coordinated way with multi-agency partners can have a positive effect on public perception and reassurance.

5.34 Health Boards should:

- have suitably equipped space for use as a Media Centre in the event of an emergency;
- have their own website and identified staff with access to update the website 24 hours a day. Consideration should be given to:
  - communications departments having the ability to make their websites a low graphic text-only version in the event of an emergency; and
  - having a mobile-friendly version of the website so that potentially large numbers of people can visit the site using mobile devices;
- have in place social media platforms, such as Facebook and Twitter; and
- ensure that communications team staff have 24-hour access to the social media outlets and be trained in how to use them to disseminate 'real time' information to the public.

(2) Response

5.35 In relation to the response phase, the communications plan should clearly set out:

- the procedure to be followed in the event of a major incident being caused, or suspected to be caused by an act of terrorism, the potential consequences of security being imposed on casualties and the hospitals treating them. It is important that, as far as possible, a communications procedure/protocol is agreed with multi-agency partners in advance. This will help ensure that essential healthcare personnel are not prohibited from entering hospital grounds or reporting for duty; media briefings on site that are coordinated by the police are cleared by the Health Board's senior Communications Officer; and that a clear and timely message is communicated to staff who normally work at the hospitals;
- the procedures and standards to be followed at first and subsequent media briefings; and

- the point at which assistance will be required from communications staff from other Health Boards in the event of a major incident/emergency and liaise with the Scottish Government Communications Directorate (SGCD).

5.36 Patient confidentiality and staff's right to privacy must be maintained during an emergency situation. No information about particular patients being treated should be released without first checking with the police and the consultant responsible for their care. Interviews or photographs must not be permitted without the consent of the patient concerned.

Internal communications

5.37 Internal communications are also important during a major incident. Any major incident will have an impact on the local community in which staff live and they will have an obvious need to be informed. While staff will get updates from the external communications channels outlined above it is good practice to disseminate regular updates, including key messages and reassurance, to staff through agreed internal communications channels in line with internal communications protocols.

VIPs

5.38 VIPs or other dignitaries will often visit the site of a major incident and hospitals involved in the response to it; they may also be admitted to NHS facilities as patients. The SGCD in consultation with other press offices as appropriate will be responsible for providing advice on media coverage on such occasions. Health Boards should have a VIP protocol for such occasions that has been agreed with the police.

(3) Recovery

5.39 It is likely that a major incident could run on for some weeks or months. While local authorities lead during the recovery phase, it may be necessary for health information to be provided by Health Boards in an ongoing, consistent manner during this period as part of a process of public reassurance. This may have resource implications for the organisation. NHS 24 may have a key role in assisting the Health Board on such occasions by acting as a point of contact for disseminating information or providing helpline support.

5.40 All Health Boards should, as part of their communications plans, outline how they will accommodate this situation and collaborate with NHS 24 to develop outline protocols and agreements for responding quickly on such occasions.

SECTION 6
ROLE OF THE SCOTTISH GOVERNMENT

This section outlines the role of the Scottish Government in civil protection and resilience. It also highlights the action to be taken by Health Boards when faced with exceptional service pressures as a result of a major incident.

6.1 The Scottish Government, although not a category 1 or 2 responder, has a key role in civil protection and resilience. This can be broken down into:

- Preparation: Having appropriate structures, policies and procedures in place to respond to major incidents and to develop relevant legislation and guidance; and
- Response/Recovery: Creating the conditions to support other category 1 and 2 responders and the option of invoking emergency powers under Part 2 of the Civil Contingencies Act 2004 to enable responders to deal with exceptionally serious emergencies, including requesting cross-border mutual aid.

6.2 When the scale or complexity of an incident is such that it would benefit from central government coordination or support, the Scottish Government (SG) will activate its emergency response arrangements through the Scottish Government Resilience Room (SGoRR). The role of SGoRR will vary according to the nature, scale and impact of the incident.

6.3 During a SGoRR activation, Health Boards should submit Situation Reports (SitReps) to SG Health and Social Care Directorates (HSCD) via the NHSScotland Resilience Team. The reporting requirement and frequency will vary according to the impact of the incident and Health Boards will be informed of this at the time of the response.

Role of the Scottish Government Health and Social Care Directorates (HSCD)

6.4 HSCD's role during an emergency response is to:

- collate and coordinate incident information provided by Health Boards;
- brief the Cabinet Secretary for Health and Wellbeing and HSCD Director-General;
- provide government support for the NHS and the particular Health Board involved and ensure that all other health boards are in readiness to support if necessary;
- maintain an up-to-date overview of national critical care capacity;
- assess the impact of the incident on the Board's scheduled work and determine any action that needs to be taken;

- assess whether mutual aid is required from other nations in the UK if local capacity and capability is overstretched or inadequate; and
- maximise available communication channels at national and local levels to inform the public.

Health Board considerations

6.5 The following actions should be taken by a Health Board when the consequences of a major incident puts exceptional pressure on services, requiring external support. They are predicated on:

- decision-making in the interests of patients;
- the safety of patients and staff being paramount;
- the existence of up-to-date surge capacity plans for critical/intensive care and other priority services; and
- arrangements for mutual aid agreements with identified triggers with neighbouring Health Boards and other planning partners.

6.6 When the Health Board has invoked its major incident plan, the Command, Control and Coordination (C3) Group should, amongst other functions, monitor the impact of the emergency situation on 'business as usual'.

Suspension of legislative obligations in exceptional circumstances

6.7 Some major/mass casualty incidents will place considerable pressure on the Health Board's total capacity and capability and have a wider impact on the delivery of services in line with legislative obligations, such as Treatment Time Guarantees (TTG).

6.8 The Chief Executive or named Deputy may request assistance from neighbouring Health Boards to maintain scheduled appointments and TTG.

6.9 In exceptional circumstances a request for the suspension of TTG may be made to HSCD if it is clear that all reasonable interventions have been taken by the Health Board to manage the incident.

6.10 The initial request should be made via the NHSScotland Resilience Team and, where necessary, the extent of pressures and recovery measures will be discussed with the Health Board. However, the Health Board must also comply with the Treatment Time Guarantee Regulations and Directions set out in CEL 17 (2012)[8] by ensuring that a written request is made to Scottish Ministers. The Scottish Government Health Care Directorates will have measures in place to ensure the approval of the suspension will be submitted to the Cabinet Secretary of Health and Wellbeing and Parliament timeously.

6.11 Once operational pressures linked to the management of the major incident have receded, HSCD will support the Health Board to restore service levels in line with TTGs as quickly as possible.

8 http://www.sehd.scot.nhs.uk/mels/CEL2012_17.pdf

SECTION 7
PREPARING FOR SPECIFIC INCIDENTS

This section sets out the requirements of Health Boards in relation to preparing for and managing a range of incidents of varying nature and scale.

Communicable diseases

7.1 Travel-related illnesses (e.g. Crimean Congo Viral Haemorrhagic Fever (VHF), Tuberculosis) have recently increased as a result of inward tourism, migration and increased travel abroad by residents of Scotland. These factors, together with an increasing number of large scale public/crowd events, combine to potentially heighten the risk of communicable infectious diseases of varying scale and impact in Scotland.

7.2 The NHS in Scotland routinely deals with illnesses related to infections that develop either in the community or in hospital, some of which may not have been previously recognised in a territorial Health Board area. The virulence of the organism causing infection and the potential impact on the community normally dictates whether it constitutes an outbreak, epidemic or pandemic in public health terms, and this in turn dictates the actions to be taken by Health Boards.

7.3 A number of factors determine the impact of an infectious disease in terms of health, societal and economic costs. These include background levels of immunity (via natural infection or immunisation), infectivity, virulence, whether effective prevention and treatment measures exist, and the availability of appropriate healthcare facilities. These and other factors should be taken into account when planning an appropriate response to the particular condition.

7.4 Most infection is dealt with by primary care, with hospitals dealing with the more severe infections caused by organisms which may be more virulent and less common.

The control of infection

7.5 The Public Health etc. (Scotland) Act 2008[9] provides the legal basis for notifiable organisms and notifiable diseases, and, in conjunction with a wide range of topic specific guidance documents outlined in Appendix 5, provides the framework for action by Health Boards in relation to public health protection.

9 The Public Health etc. (Scotland) Act 2008 http://www.scotland.gov.uk/Topics/Health/Policy/Public-Health-Act/Implementation

7.6 The Act also sets out the notification responsibilities of registered medical practitioners and places a duty on Directors of Diagnostics/Laboratories, where notifiable organisms are identified, to provide written confirmation to the relevant Health Board and Health Protection Scotland (HPS) no later than 10 days after identification, or sooner if the case is considered urgent. In addition, there is a requirement for identification of health risk states (see Glossary). All healthcare professionals should be aware of local 24-hour arrangements for seeking the urgent advice of their Health Board's Consultant in Public Health Medicine if they identify a situation that suggests a health risk state.

7.7 Public Health Departments must be able to identify and respond quickly to new and emerging public health threats, even if the condition is only apparent from symptoms of patients and the precise cause of infection remains unknown. This is particularly relevant in the modern world of global travel and trade.

Responsibilities

7.8 Health Boards are responsible for public health protection, including surveillance, prevention, treatment and control of communicable diseases. They have a shared duty with local authorities and other national agencies (e.g. Care Inspectorate) to ensure adequate standards of infection control are met by all service providers. In line with national guidelines, coordinated Incident Control Plans and Joint Health Protection Plans should be drawn up in collaboration with local authorities and any other public service organisations that may be required to participate in an outbreak response.

7.9 The appropriate response to an outbreak will depend on the particular circumstances. Some outbreaks may not require an Incident Management Team (IMT) to be established, while others may require a locally-based multi-agency IMT. However, in the case of a large scale outbreak or significant public health incident, a coordinated national response will be required, necessitating local and national major incident plans to be activated.

7.10 Some incidents may result in the activation of the local LRP/RRP. In such instances, the LRP/RRP may request the local Health Board to convene and chair a Scientific and Technical Advice Cell (STAC guidance[10]). If so, the Health Board should retain responsibility for the investigation and management of the public health aspects of the incident in line with The Management of Public Health Incidents Guidance, irrespective of a LRP/RRP-led response.

7.11 The Health Board's Director of Public Health should ensure that:

- The Health Board has a range of up-to-date plans (e.g. Business Continuity Plans, Incident Control Plans etc.) and protocols that reflect national guidance and the requirements of the Scottish Government. These should detail measures to:
  - prevent further spread or recurrence of the particular infection or incident;
  - ensure that effective care and treatment is available to all those affected by the outbreak;
  - put in place any necessary control measures including the dissemination of information to the public and appropriate external agencies;

10 Preparing Scotland Scientific and Technical Advice Cell Guidance, Scottish Government Resilience Division, 2013 www.scotland.gov.uk/publications/2013/02/6297/0

  - document the outbreak including its major epidemiological characteristics and causes; and
  - report on the outbreak.
- The plans are flexible enough to cope with the actual or potential hazards from the simplest outbreak to more complex and widespread problems which cross Health Board boundaries and require multiple agencies to investigate and control them.
- The Public Health Protection Team has adequate and appropriately trained staff and other relevant resources at its disposal to establish an effective IMT when necessary to implement the actions outlined in the relevant guidance documents.
- There are effective arrangements within the Public Health department for:
  - ongoing surveillance, including syndromic surveillance (see Glossary), at local level;
  - receiving reports of relevant information from local health care providers and other local agencies;
  - onward reporting of notifiable disease information or information on health risk states (see Glossary) in to HPS for national surveillance purposes;
  - communicating effectively and timeously with other parts of NHSScotland; and
  - debriefing following an incident and providing a (lessons-learned) report.
- The Public Health Department has the necessary resources (including administrative support) available to simultaneously convene and lead a STAC, if required by the LRP/RRP, and respond to the public health tasks associated with the incident.
- Relevant senior managers within Acute Services and Primary Care are made aware of the Health Board's Public Health duties, the relevant (health protection) policies and plans for their respective service areas and their responsibilities for ensuring their implementation.
- Hospital managers implement the Healthcare Associated Infection Guidance (2012) and use the tools within it to ensure that IMTs are fully aware as to who they should inform and involve in the event of a localised (i.e. single ward) or larger scale outbreak or infection incident; and
- Local plans and protocols are regularly exercised with multi-agency partners where appropriate in order to develop all-important expertise and establish the necessary team working arrangements. Local plans should be revised on a regular basis in light of these revised guidelines.

Communication

7.12 As with all major incidents, internal and external communication is important. The issues to consider are covered in Communications (section 5, E).

Hazardous/chemical, biological, radiological, nuclear materials

7.13 All category 1 designated Health Boards have a duty to provide care for people who may be contaminated with chemical, biological, radiological or nuclear (CBRN) material or hazardous material (Hazmat) and a role in managing the consequences of such incidents. Contamination may result from an accidental release of hazardous material (Hazmat), or from the release of CBRN materials through a deliberate or malicious act. Accidental Hazmat incidents are more likely than those caused by deliberate release, and Health Boards should plan on this basis.

7.14 NHS National Services Scotland (through Health Protection Scotland (HPS)) and the Centre for Radiation, Chemical and Environmental Hazards (CRCE)[11] also have a role in providing advice and information to health professionals and 'first responder' organisations during such incidents.

7.15 Territorial Health Boards' public health duties require that they respond to the health protection needs of people who are either exposed to, or 'worried' about exposure to Hazmat or CBRN incidents in line with the national Guidance on Management of Public Health Incidents.

7.16 The term CBRN covers a distinct range of hazards:

(i) Chemical: Poisoning or injury caused by chemical substances, including chemical warfare agents, or misuse of legitimate but harmful household or industrial chemicals.

(ii) Biological: Illnesses caused by the deliberate release of dangerous bacteria, viruses, fungi, or toxins (e.g. the plant toxin, ricin).

(iii) Radiological: Illnesses caused by exposure to harmful, radioactive materials, possibly inhaled or ingested from food or drink.

(iv) Nuclear: Where the explosion of a nuclear device causes widespread effects due to blast, heat, and large amounts of harmful radiation.

11 CRCE Scotland. http://www.hpa.org.uk/AboutTheHPA/WhoWeAre/CentreForRadiationChemicalAndEnvironmentalHazards/

Chemical incidents

7.17 Chemical incidents, which commonly occur during the manufacture, storage, transport or disposal of chemicals, may result in the direct contamination of people or indirect contamination via air, water, food or property. Health services regularly provide treatment and care for patients following a range of chemical incidents. Information is available from various sources (TOXBASE[12], SHPIR[13], CHEMET[14] and SEISS[15]) to support planning for chemical incidents.

Biological incidents

7.18 Some biological agents, in very small quantities, can have a substantial impact on the health of a civilian population. Health Boards have established procedures for dealing with outbreaks of infectious disease, which are applicable to biological incidents. The effects of a biological release/incident are likely to be delayed and prolonged as:

- people exposed may not know that they have been affected;
- incubation periods between exposure and the development of symptoms can vary; and
- biological material dispersed may be deposited on clothing, equipment and other surfaces and when these are disturbed secondary dispersal can occur.

7.19 Urgent identification of infecting agents is critical to managing biological incidents. In the event of a biological incident impacting on a large proportion of the population, Health Boards may have to consider invoking a large scale vaccination programme along the lines of the existing Smallpox response plans.

12 TOXBASE – the National Poisons Information Service www.toxbase.org/

13 Scottish Health Protection Information Resource (SHPIR) www.shpir.hps.scot.nhs.uk/

14 CHEMET (Chemical meteorology) www.metoffice.gov.uk/publicsector/CHEMET

15 Scottish Environmental Incident Surveillance System (SEISS) www.hps.scot.nhs.uk/enviro/ssdetail.aspx?id=107

Radiological and nuclear incidents

7.20 Radioactive material is widely used across industry, healthcare and research and may be released at or whilst in transit to or from such sites or accidentally released from a nuclear reactor. Nuclear incidents generally result from accidental leaks at nuclear sites or CBRN/malicious acts with potentially widespread effects from blast, heat and radiation. The response to the effects of an ionising radiation release from a radiological or nuclear incident and the measures required to mitigate them are broadly similar although management of the consequences would differ significantly.

Responsibilities

7.21 As Hazmat/CBRN incidents pose a threat of environmental contamination with public health impacts, Health Boards should undertake scenario-planning with relevant partner agencies to ensure they have the capability to respond to and/or mitigate the effects of any such incident.

7.22 Territorial Health Boards should ensure that:

- a strategic lead is responsible for ensuring that Hazmat/CBRN incident plans are in place and kept up-to-date;
- their major incident plans appropriately reflect contingencies for providing care and treatment for the spectrum of CBRN-related casualties, including the identification and monitoring of anyone, injured or not, contaminated with hazardous material (including ionising radiation);
- plans are proportionate and flexible to cope with hazards ranging from the simplest accidental incident to more complex or widespread incidents that across Health Board boundaries and may require a variety of agencies to investigate and respond to them. They should identify appropriate arrangements for risk assessment, risk management and risk communication;
- appropriate equipment, including Personal Protective Equipment (PPE) and facilities are available to support the plan, including provisions for compliance with Health and Safety;
- there are effective systems to enable primary care services to notify Public Health Departments and vice-versa of specified organisms, specified diseases and health-risk states where there may be significant risk to public health;
- there is access to suitable laboratory testing facilities, including procedures for the collection, transport and processing of samples to assist with identification of the causative agent;
- staff are trained for the roles they are expected to fulfil during a CBRN incident, and they have access to relevant resources, advice and the expertise required to provide care and treatment for casualties, including arrangements for decontamination of patients and distribution and administration of appropriate pharmaceutical supplies;
- local plans are regularly exercised and reviewed with multi-agency partners (see section 5 D); and
- they develop local plans for recovery to enable return to normal as soon as possible.

7.23 Depending on the scale and impact of an incident, Territorial Health Boards should be prepared to:

- convene and chair a STAC, providing advice to the local LRP/RRP on human health, risk management strategies, countermeasures and longer-term health monitoring; and
- advise SAS and other first responders, other public bodies, the public and the media about effects of a Hazmat incident on human health, and of counter-measures to those effects.

7.24 In planning and preparing specifically for radiological and nuclear incidents, Territorial Health Boards should:

- develop specific arrangements for managing the health consequences of environmental contamination from a release of ionising radiation, as well as arrangements for controlling the distribution and administration of stable iodine tablets as appropriate; and notifying and informing Scottish Government HSCD and other Health Boards;
- comply with their obligations under Radiation (Emergency Preparedness and Public Information) Regulations (REPPIR) to work with the operator of a nuclear installation in their area on the development of the Off Site Plan for the nuclear installation, clearly outlining the health service's role and responsibilities, and be capable of responding to an incident, when required;
- consider the Ministry of Defence- Local Authorities and Emergency Services Information (LAESI, Revised 2013)[16] which outlines action to be taken by a range of organisations in the event of an accident occurring during the transportation of nuclear weapons and special military nuclear material;
- support the local authority in its implementation of pre-negotiated arrangements for Radiation Monitoring Units (RMU)[17], and be prepared to assess and monitor longer term health effects on contaminated individuals and the public, including facilities for screening a potentially large number of people in the context of assessed risk; and
- have an external communications strategy to provide public advice to limit the impact of a Hazmat/CBRN incident.

Further information on the role of some of the main organisations during a radiological or nuclear incident is outlined in Appendix 5.

Decontamination

7.25 Decontamination is not an automatic or inevitable response to a Hazmat/CBRN incident. Decisions on decontaminating individuals involved in an incident will depend on the initial assessment of the nature of the emergency by first responders and subsequently by health professionals within the receiving Emergency Department. Health Boards should plan to accommodate a range of scenarios, ranging from those where casualties may be brought in by SAS (usually, although not always, already decontaminated) from the site of a major incident, to contaminated individuals arriving independently by personal transport.

7.26 Arrangements for decontaminating people exposed to hazardous substances should reflect national guidance[18,19] and Territorial Health Boards should have a plan in place to facilitate the lockdown[20] of areas in the hospital, or the entire hospital if necessary, to prevent possible cross-contamination.

16 Ministry of Defense – Local Authority and Emergency Services Information, Edition, May 2013. https://www.gov.uk/government/publications/local-authority-emergency-services-information

17 HPA – HPA-CRCE-017 – Radiation Monitoring Units: Planning and Operational Guidance. www.hpa.org.uk/Publications/Radiation/CRCEScientificAndTechnicalReportSeries/HPACRCE017

18 Guidance for Hospitals on the Surface Decontamination of Self-presenting Persons, April 2012. http://www.readyscotland.org/media/32009/guidance_for_hospitals_on_the_surface_decontamination_of_self_presentingpersons_-_april_2012.pdf)

19 Guidance for emergency services on decontamination of people exposed to hazardous chemical, biological or radiological substances (restricted). Available from the CBRN Unit, Scottish Resilience.

20 Hospital Lockdown: A Framework for NHSScotland June 2010. http://www.sehd.scot.nhs.uk/EmergencyPlanning/Documents/FinalLockdownGuidanceforweb.pdf

7.27 In order to comply with the Health and Safety duty to protect staff and members of the public from risk to health, Health Boards must:

- carry out an appropriate risk assessment of decontamination arrangements;
- provide staff with suitable facilities and equipment to carry out their duties (including PPE); and
- adequately train staff to fulfil their duties and use relevant equipment.

The needs of children

7.28 Health Boards should recognise the potential for children to be among those affected in a Hazmat/CBRN and plan accordingly, taking into account their vulnerability and the need to keep families together and children with their carers.

7.29 Consideration should be given to the special requirements of children during decontamination procedures. It will be necessary to reconcile any intention to use a designated general hospital to receive contaminated child casualties with existing protocols for reception of paediatric patients. Where child casualties are received directly at NHS care facilities, the feasibility and impact of 'lockdown' arrangements on children should be considered.

Recovery specific to a Hazmat/CBRN incident

7.30 The type, scale and impact of a Hazmat/CBRN incident will generally dictate the potential length of time and the complexity of the recovery period, and these in turn will influence the level of resources required in response.

7.31 The local authority will normally be the lead agency for recovery. However the scale of the incident will determine the level of involvement of international, national, regional and local organisations. In addition, the cause of the incident may dictate whether the recovery is managed as a devolved or reserved matter.

7.32 The main challenges for Health Boards and partner agencies both during and in the aftermath of a Hazmat/CBRN-related incident are manifold, including those arising from the consequences of people being evacuated from affected neighbourhoods and communities, the need for mutual aid and public communication, and the intense media interest. Although these issues are addressed elsewhere in this guidance, consideration should be given to any specific issues that may arise and actions that need to be taken at various stages during the recovery period.

7.33 Territorial Health Boards should have Recovery Plans[21] that identify relevant procedures and resources to address the unique and potentially complex issues in the aftermath of a Hazmat/CBRN incident. The plan should ensure that hospital buildings are returned to use following decontamination in line with relevant national guidance[22].

21 Preparing Scotland – Scottish Guidance on Preparing for Emergencies: Recovering from Emergencies in Scotland. www.scotland.gov.uk/Publications/2010/12/02150415/010

22 Strategic National Guidance: The decontamination of buildings, infrastructure and open environment exposed to Chemical, Biological, Radiological or Nuclear materials, Cabinet Office. www.cabinetoffice.gov.uk/resource-library/strategic-national-guidance-decontamination-buildings-infrastructure-and-open-envir

Management of burn-injured patients

7.34 An incident involving critically injured burn patients can happen in any community or area in Scotland. Such incidents can arise from a major transport accident, an industrial or chemical fire or a terrorist attack.

7.35 In contrast to many other injuries arising from a major incident, what may appear to be a relatively small number of burn-injured patients has the potential to overwhelm the burn care capacity of a Territorial Health Board, region of Scotland, or the collective burns facilities in Scotland. As is the case with healthcare in general, in the event of demand for services exceeding or overwhelming supply, the underlying principle is to achieve best health outcomes for patients based on the ability to achieve health benefits.

Responsibilities

7.36 Territorial Health Boards should plan to manage the care of burn-injured patients in the event of a major incident, ensuring that arrangements:

- identify what might constitute a burn major incident for them;
- identify escalation triggers and responses (see Appendix 7);
- are integrated and consistent with their major incident plan;
- take account of relevant legislation and guidance;
- are consistent with local C3 structure and arrangements; and
- are appropriately and widely supported.

7.37 In planning for the management of burn-injured patients, Health Boards should build on existing day-to-day operational arrangements and liaison between burns services, and integrate these arrangements with the Care of Burns in Scotland (CoBIS)[23] Managed Clinical Network's operational plan.

7.38 The arrangements to transfer and move patients to a Burns service, or between Burns services, should be clearly set out in the local plan and must include early liaison and coordination with the Scottish Ambulance Service (SAS). In setting out their arrangements, Health Boards should consider allocating patients to appropriate destinations and, wherever possible, plan patient movement to avoid secondary transfers.

7.39 Given the nature of burn-related injuries and the potential impact this could have on continuing normal business, Health Boards should have business continuity plans that address arrangements for the recovery and restoration of critical services.

Territorial Health Boards with burns services

7.40 Health Boards with burns services should consider what constitutes a burns 'major incident' in the context of available capacity and capability, and this information should be used as the basis for establishing triggers and escalation arrangements.

23 Care of Burns in Scotland Managed Clinical Network :// www.cobis.scot.nhs.uk/; Department of Health Strategic Burns Guidance April 2011

Territorial Health Boards without burns services

7.41 Patients with burn injuries may be admitted to Emergency Departments anywhere in Scotland. The primary function of Health Boards without burns services should be to assess and stabilise patients, provide treatment and care in an Intensive Treatment Unit where clinically appropriate, and where injuries are severe, or access to specialists requires it, transfer them to a burns unit. Plans should set out arrangements for access to specialist and burns services in Scotland.

Scottish Ambulance Service (SAS)

7.42 The provision of care-at-scene and in-transit to the hospital is the responsibility of SAS. It is not expected that burn specialists would deliver care at the scene of an incident and pre-hospital care of casualties in a burns major incident should be provided according to the agreed pre-hospital arrangements between SAS and Territorial Health Boards.

Care of Burns in Scotland Managed Clinical Network (CoBIS)

7.43 Territorial Health Boards and SAS should:

- take into account CoBIS plans when developing local arrangements, especially where the incident is of such a scale that the numbers of injured patients is likely to be greater than can be managed in Scotland;
- ensure that relevant personnel are aware of the role of CoBIS and raise awareness of this specialist network;
- ensure that all staff are fully informed about planning and preparation for the management of burns-related injuries in the event of a major incident; and
- ensure that C3 and communication arrangements are in place and that any specific burns-related components are incorporated into them.

Mass casualties

7.44 Category 1 and 2 Health Boards will play a significant role in the multi-agency response to mass casualty incidents (MCI). This guidance aims to ensure the NHS actively contributes to multi-agency planning at various levels and that the preparedness of Health Boards (capacity and capability) is assessed in the context of local and national mass casualty planning assumptions[24].

7.45 Mass casualty plans (MCP) should be integral to a Health Board's major incident plan. Owing to the complexities and challenges involved in preparing for mass casualties, MCPs should be regularly reviewed and exercised in line with guidance on other specific topics outlined elsewhere in this document.

7.46 A mass casualties incident is:

> *'A disastrous single or simultaneous event(s) or other circumstances where the normal major incident response of several NHS organisations must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response.'*[24]

7.47 Such incidents typically result in hundreds of casualties; have the potential to overwhelm health services; disrupt business-as-usual arrangements of some health care facilities/services for several days; and require the activation of mutual aid arrangements. These circumstances will require Health Boards to undertake detailed scenario, capacity and surge/escalation-planning. Further information to assist planning for MCI's is outlined in Appendix 7.

24 Planning assumptions contained in Mass Casualties Incidents – A Framework for Planning. NHSScotland, The Scottish Government. May 2009. http://www.sehd.scot.nhs.uk/EmergencyPlanning/Documents/MassCasualtyGuidanceNHSScotland-May-09.pdf

Declaring a mass casualties incident

7.48 A MCI should be declared by the Health Board Chief Executive or named Deputy based on a combination of factors. These include the likely number of casualties, the ability of local health services to cope with demand, and the potential of the incident to overwhelm the combined resources of Health Boards in a local RRP area. The ability of local services to cope with demand may itself be affected if an incident has a direct impact on NHS sites or staff (e.g. through evacuation).

7.49 Any category 1 Health Board may declare a 'mass casualties incident', although in exceptional circumstances (e.g. a rising tide incident such as pandemic flu), a category 2 Board may make the declaration. However, as a 'blue light'/first responder, the Scottish Ambulance Service (SAS) will usually make the declaration. If the organisation declaring is not the SAS, they should immediately advise Ambulance Control Centre to cascade a 'mass casualties incident' declaration.

7.50 Surge management plans or other arrangements for restricting access to NHS services due to a MCI should only be implemented after a formal declaration of the incident has been recorded and approval has been granted by the Health Board Chief Executive/Executive–level Director or those with delegated authority such as a senior manager or on-call strategic lead.

7.51 A decision to declare a MCI will primarily be influenced by casualty numbers and the potential impact and pressures on clinical services. However, other considerations may influence a MCI declaration including:

- media interest – may be intense and reactive; and
- Government interest – a situation-reporting cycle will be influenced or decided by central government information requirements.

Responsibilities

7.52 Health Boards must have a MCP, which has been developed in conjunction with key stakeholders and relevant RRP partners to:

- minimise/mitigate the impact of a MCI on its normal pattern of service provision;
- identify and prepare an adequate level of resources on a stepped basis to respond effectively to a MCI;
- outline the arrangements required to support the organisation during a MCI where there is a potential for the incident to overwhelm the (lead responding) Health Board or other Boards/organisations in the local area. This may involve support for the incident response and for business continuity for defined periods; and
- prioritise and coordinate resources to ensure optimal healthcare for all during a MCI.

7.53 To ensure that there is an effective response to a MCI, Health Boards should have in place:

- accelerated discharge and surge management plans;
- plans to rapidly escalate community services to avoid admissions into acute settings; business continuity management plans for critical functions/services. Some challenges that are relevant to a MCI are: managing capacity across different services/departments and over a long period of time. Demand for services may peak in one part of the hospital (the Emergency Department) after several hours, but there may be increased demand on other areas such as operating theatres and radiology/imaging, for a much longer period

afterwards. There may be a need to expand the capacity of certain types of specialities for particular types of incidents e.g. multiple burns. In these circumstances senior clinicians may need to take a decision to temporarily re-align treatment protocols to re-prioritise patient care;

- policies and practiced plans for the lockdown of buildings and sites[25];
- mutual aid arrangements;
- training and exercising programmes so that capacities can be increased, e.g. through dual-skilling that is consistent with professional codes of practice and competences; and more generally, that all relevant clinical and management staff and partner agencies have a common understanding of their role and responsibilities during an MCI; and
- C3 arrangements which can be activated timeously when a mass casualties incident has been declared.

7.54 MCI plans should reflect how the Health Board, either individually or in collaboration with other Health Boards/ organisations in the RPP area, will respond to different types of events/scenarios (e.g. sudden impact or rising tide incidents) that may result in mass casualties.

Activation

7.55 Receiving hospitals notified of a MCI, or declaring one themselves, should inform the Health Board Chief Executive/named Deputy/on-call senior manager. Depending on the nature of the incident, SAS may also advise 'lockdown' (see Glossary) and Health Boards should ensure that this happens in accordance with national lockdown guidance. Health Boards should therefore ensure that arrangements are in place to cascade that message to all relevant services and staff.

Roles of key agencies and groups

7.56 The roles and responsibilities of Health Boards and other key agencies during a MCI are outlined in Appendix 7.

Pre-hospital medical support

7.57 Some MCIs will result in large numbers of casualties. In these incidents the demand on healthcare services will be extreme and will have an immediate impact on the pre-hospital phase of the response, especially where pre-hospital medical support may be required at or close to an incident site for longer than is usual in major incidents.

7.58 The scope of incidents that would warrant a pre-hospital medical support response is difficult to define specifically. It would include any multiple casualty incidents where paramedics at the scene of an incident identify a potential benefit, following assessment and triage, of having specialist or advanced clinical care and decision-making and critical interventions for adults and children at the scene. Scenario planning and exercising will greatly assist in identifying where risks require specific planning.

7.59 Category 1 Health Boards should produce a joint plan, procedures and ethical guidelines to address these scenarios in a local RRP area, taking into account ambulance service joint agency response arrangements for the most extreme circumstances, and agree the Health Board response with other local agencies. Health Boards should allow for medical staffing at casualty clearing stations and casualty collection points to be sustained for longer periods if the incident is on-going and/or circumstances make casualty movement dangerous. The SAS should describe available specialist resources.

25 Hospital Lockdown – A Framework for NHSScotland. Health Facilities Scotland, June 2010 http://www.sehd.scot.nhs.uk/EmergencyPlanning/Documents/FinalLockdownGuidanceforweb.pdf

7.60 Category 1 and 2 Health Boards in a RRP area should work together to agree a model for immediate medical care at the scene and the provision of Site Medical Teams or their equivalents. This is to ensure support for SAS at the scene to triage, treat and provide appropriate specialist interventions.

7.61 All category 1 Health Boards should ensure they have access to pre-hospital medical emergency care services, such as Site Medical Teams and that these services are ready to be sent to the scene of any incident at the request of either the Ambulance or the Medical Commanders.

7.62 Health Boards must have in place clear and effective governance arrangements to support clinicians and paramedics involved in delivering a pre-hospital care response.

Emergency treatment centres/access points

7.63 Territorial Health Boards should ensure that primary care services are engaged in the MCI planning process so they can assist in setting up and staffing Emergency Treatment Centres (ETC) or appropriate facilities for the treatment and management of Priority 3 patients to protect acute hospitals from being overwhelmed. These ETCs can be located both at and remote from healthcare establishments. They should be designed to take some of the pressure off hospital Emergency Departments to allow them to focus on high priority patients.

Scottish National Blood Transfusion Service (SNBTS)

7.64 Territorial Health Boards should ensure that SNBTS and National Procurement is actively engaged in developing the local MCP and contingency planning arrangements for blood supplies and consumable products during a MCI.

Communications

7.65 Health Boards that experience a MCI should be involved in all aspects of public communications, including:

- liaison with multi-agency partners within the multi-agency Public Communications Group, ensuring adherence with the agreed communications strategy;
- coordination of communications across NHS organisations and with partner agencies to ensure consistency of message;
- ensuring the right health messages are communicated to NHS staff and the public in a timely manner;
- working with partner agencies to ensure effective media management; and
- through the appropriate channels, providing regular information to Scottish Government Communications, NHSScotland Resilience and SGoRR.

Action logging system

7.66 Health Boards must have an effective recording system in place that can formulate an action log of events from a MCI.

Mass fatalities

7.67 Health Boards have an important role to play in working with other agencies through the Regional Resilience Partnership (RRP) to plan for an effective response when a major incident results in mass fatalities.

7.68 The term *mass fatalities* is used to mean:

- deaths in large numbers that can or cannot be managed under the normal procedures of one or more agencies, or

- deaths where the number or fragmentation of bodies, taken together with the circumstances of the incident, require special arrangements for statutory investigation, or where the condition of bodies makes victim identification difficult, or
- deaths requiring the implementation of National Emergency Mortuary Arrangements (NEMA).

7.69 Preparing Scotland Guidance[26] distinguishes two types of mass fatalities emergencies:

- intensive emergencies which are localised and usually require further statutory investigation; and
- extensive emergencies, which are not localised and where the general circumstances of the deaths are often already known, such as natural disaster or disease, e.g. pandemic flu.

7.70 The duties of Territorial Health Boards in such circumstances are outlined in the Public Health etc. (Scotland) Act 2008 (Part 6). These duties should be considered along with the specific issues (e.g. Equalities and Human Rights, integrated emergency management, business continuity and communication) covered in other parts of this guidance, when preparing an NHS response to events involving mass fatalities.

Responsibilities

7.71 By definition, mass fatality situations are likely to require the reprioritisation of some health services and temporary changes to normal working practices of others. In these circumstances it will be important for Health Boards to communicate any service changes to the public and to engage with patient groups to explain the reasons for any suspension of normal procedures.

7.72 Territorial Health Boards should:

- have a clear understanding of who the stakeholders are in planning for such emergency situations and engage with them either directly or via the RRP;
- be aware of the role and requirements of the Crown Office in relation to mass fatality situations;
- have a clear understanding of their statutory duties in mass fatality emergencies and have in place business continuity management arrangements to address potential disruptions to the main services that will be impacted on. Key stakeholders should be informed of these arrangements.
- collaborate with local authorities to plan for the provision of an adequate level of mortuary facilities;
- assess and plan for the impact of the increased mortality on body-storage capacity. Such planning should address the possibility that Health Board staff may be required to be deployed within NEMA, away from NHS facilities;

26 Preparing Scotland: Guidance on Dealing with Mass Fatalities in Scotland, Scottish Government, 2009, http://scotland.gov.uk/Publications/2009/09/15110710/5

- identify the death certification process and the role to be played by primary care so as to avoid delays which would result in difficulties for other responders;
- ensure the provision of appropriate (role-based) training for the relevant staff, particularly mortuary staff, in conjunction with other key agencies;
- exercise plans using reasonable worst case scenarios and ensure that the relevant staff participate; and
- maintain up-to-date Pandemic Flu plans in the light of lessons learned from exercises and ensure that their Mass Casualties and Mass Fatalities plans are consistent with each other.

SECTION 8
CARE FOR VULNERABLE PEOPLE AFFECTED BY MAJOR INCIDENTS

This section highlights specific populations in the community who may be vulnerable during major incidents and emergency situations and what Health Boards should do with partner agencies to respond to the needs of these populations.

Vulnerable people

8.1 The Civil Contingencies Act 2004 recognises the particular needs of vulnerable people. Emergency response and recovery may require specific consideration of vulnerable people – those who 'are less able to help themselves in an emergency.' This includes people who are:

- under the age of 16;
- of restricted physical ability because of age, disability, illness (including mental illness), pregnancy or other reason; and
- deaf, blind or have visual or hearing impairment.

8.2 Territorial Health Boards must cooperate with other category 1 and 2 responders to:

- plan for and meet the needs of those who may be vulnerable in times of emergency[27];
- develop arrangements that will assist in reducing the time taken to produce dynamic lists of vulnerable people specific to the location, scale and type of incident;
- build interagency networks;
- agree data sharing protocols and activation triggers/cascade systems; and
- determine/estimate the scale and requirements of vulnerable people in advance of an emergency.

8.3 In order to be prepared to act without delay during a major incident or in an emergency situation, Territorial Health Boards should:

- work with partners on the RRP Care for People Teams[28] to identify and agree people and/or communities who may be vulnerable during different types of major incidents;
- endeavour to maintain up-to-date information about vulnerable people as well as accessible lists of all residential and day care facilities and health centres in their area on which vulnerable people and their carers

27 Detailed potential vulnerability and requirements-Framework in Cabinet Office Guidance Identifying People Who Are Vulnerable In a Crisis, 2008. https://www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders

28 Preparing Scotland 2009, Section 6: Care For People Teams http://scotland.gov.uk/Publications/2009/09/17113218/6

depend. It is recommended that these lists are reviewed on a quarterly basis and that this task is overseen by the identified Executive-level Director/Lead for emergency preparedness/resilience;

- identify how, when and what personal data can be shared about people with vulnerabilities with other statutory responder agencies, within the framework of the Data Protection Act 1998[29] and the Civil Contingencies Act 2004;
- have arrangements for supporting Survivor Reception Centres and Family and Friends Reception Centres, and contingency plans for dealing with an influx of family and friends arriving at hospital facilities following a major/mass casualty incident;
- actively encourage all primary care (GP) contractors to have up-to-date Business Continuity Plans and arrangements for identifying potentially vulnerable patients who depend on the practice. The Health Board's Primary Care Lead should obtain confirmation of the existence of the BC plans and arrangements from General Practice managers; and
- ensure that all services commissioned by the Health Board to support and care for vulnerable people have rigorous, up-to-date Business Continuity Plans, including arrangements for identifying vulnerable people.

8.4 As far as possible within the confines of the organisation's confidentiality policy and in consultation with the Caldicott Guardian, the Health Board should endeavour to develop joint lists with the local authority to enable a quick response in the interests of vulnerable people during emergency situations.

8.5 All lists produced should be marked as 'Protect' under the Government Protective Marking System[30] and be accessible out-of-hours.

8.6 In preparing their major incident plans, Territorial Health boards:

- must take into account the needs of vulnerable children, vulnerable adults and kinship carers;
- must be able to access language guides, interpreter facilities, or advocate-supporters from particular faith groups to support vulnerable people from minority ethnic communities who are casualties of or caught up in/affected by a major incident; and
- should ensure they can access a pool of staff or accredited volunteers (i.e. people who have been Disclosure Scotland [PVG Scheme] checked and trained by the Health Board or a recognised partner agency) to provide additional support or special assistance to people with disabilities, in support of the emergency services effort.

Children and young people

8.7 Children are more vulnerable in emergency situations than adults for a number of reasons. In younger children size, skeletal maturity and other physiological characteristics make them more susceptible to serious injury than adults. Behavioural and developmental immaturity may impair their ability to recognise or escape from hazardous environments. Children may be less able to describe or assert their needs to others and are particularly vulnerable when separated from parents or carers. Children of all ages are vulnerable to the long term psychological effects of traumatic experience.

29 The Data Protection Act 1998, http://www.legislation.gov.uk/ukpga/1998/29/contents

30 Government Protective Marking System, 2009 http://protectivemarking.co.uk/images/downloads/gpms.pdf

8.8 In Scotland, Acute Services for children are organised in a tiered structure with national, regional, district, and local services. Emergency care is therefore provided from units with a spectrum of capabilities[31]. The larger Children's Hospitals maintain Emergency Departments that are operationally independent from adult services. Adjacent adult Emergency Departments consequently have limited routine practice in the management of seriously ill or injured children.

8.9 This guidance is based on the principle that local District General Hospitals should respond to emergencies involving children. Emergency care, resuscitation, and initiation of intensive care are within the normal range of capabilities for District General Hospitals. The potential need to manage multiple child casualties must be incorporated into major incident plans.

8.10 The needs of children in specific emergency situations are also reflected in other sections of this guidance.

Responsibilities

8.11 Territorial Health Boards should have:

- arrangements to alert local child health services as soon as the possibility of child casualties is recognised. Although the initial response to a major incident will be by the local service, early contact should be made with national or regional services able to provide assistance, or who may need to receive patients for ongoing specialist care;
- arrangements to provide a paediatric intensive care mobile team to support care at the local hospital and transport services to transfer intensive care patients;
- plans to accommodate the possibility that intensive care may be needed for longer periods than normal, and to take responsibility for the transfer of some patients where there is an urgent need for multiple patients to be transferred to a specialist centre;
- arrangements in place to provide children with intensive care at their local hospital before transfer to a Paediatric Intensive Care Unit in Edinburgh or Glasgow. The transfer of paediatric intensive care patients should be undertaken by a specialist paediatric intensive care retrieval team;
- arrangements to support effective collaboration between community or rural general hospitals and supporting paediatric inpatient units; and
- clear protocols, agreed with the Scottish Ambulance Service, to indicate when children would be diverted to adult Emergency Departments and how this would be coordinated, in the event that a mass casualty incident occurred in a Health Board area that has separate Emergency Departments for adult and paediatric patients.

8.12 Territorial Health Boards providing a pre-hospital response should:

- consider their requirements, in terms of equipment and training, to be able to deal with any incident where there are child casualties. This may be a particular challenge for services that do not routinely care for paediatric patients; and
- provide the staff deployed to a major incident or emergency with the appropriate specialist training, equipment, and preparation so that they are able to function effectively and safely.

31 Scottish Government Health Department, Emergency Care Framework, 2009. http://www.scotland.gov.uk/Resource/Doc/149108/0039634.pdf

Children's rights and child protection

8.13 The Health Board's major incident plan and emergency planning arrangements should reflect the specific requirements to maintain both generic children's rights, such as the need to keep children with their parents, and child protection standards.

8.14 In a situation where parents are separated from children, systems must be in place to communicate timeously with parents regarding the location and condition of their child. Consideration should be given to how vulnerable or looked after children can be identified quickly during incidents and their location and condition must be communicated to the responsible local authority as soon as possible.

8.15 In the event of volunteers or staff being recruited by the Health Board to provide support in potential emergency situations, PVG checks must be undertaken as part of the screening process.

8.16 Health Boards should consider what arrangements may be required to provide appropriate follow-up and support for children and families involved in major incidents. Consideration should be given to inclusion of a 'Children's Services Coordinator' for any major incident whose responsibility would be to track the destination and outcome of children involved and coordinate ongoing support for their families. This person might be a paediatrician or senior children's nurse.

Psychosocial care and mental health

8.17 Most people are resilient when faced with adversity. In general, people who are involved in disasters recover over time with the support of their families, friends and colleagues, but some experience extensive and sustained effects on their health, relationships and welfare. The nature of resilience is such that everyone affected can benefit from social support and this principle is the core component of all humanitarian aid, social welfare and healthcare responses to disasters.

8.18 Only certain components of the wide range of responses required by people affected by major incidents and disasters fall within the prime responsibilities of the NHS. Therefore, providing comprehensive responses requires the key agencies in each area of work or professional discipline to plan together. They also need to agree which agency should take the lead on specific issues and to review the adequacy of joint plans on a regular basis.

8.19 Health Boards, particularly category 1 and 2 responders, should consider the recommendations in the Care for People Affected by Emergencies Guidance[32] (2009) and the Supplementary Guidance[33] (2013), and any relevant local arrangements.

Responsibilities

8.20 Territorial Health Boards should have an up-to-date plan outlining what resources the organisation will contribute at particular (short, medium and longer term) stages in the recovery phase of a major incident and the process by which they will be delivered.

32 Preparing Scotland, Care For People Affected By Emergencies, Scottish Government, 2009.

33 Preparing Scotland, Planning For the Psychosocial and Mental Health Needs of People Affected by Emergencies, 2013 (in progress)

The plans:

- should identify mental health staff with particular skills and the key healthcare services that will form the Board's response and provide advice to the RRP Care for People Group;
- should highlight the role for primary care in supporting/following up survivors at various stages in the aftermath of a major incident;
- must identify the occupational health/ psychosocial support to be made available to NHS staff delivering services as part of the organisation's duty of care;
- should outline arrangements for data collection (including evaluation of outcomes) and audit in relation to NHS service provision in such circumstances, to contribute to a multi-agency lessons-learned exercise at the appropriate time;
- must comply with its duties under Equalities and Human Rights legislation;
- must be consistent with actions to be taken in response to mass casualties and mass fatalities; and
- should identify flexible arrangements for Child and Adolescent Mental Health Services to be up-scaled at short notice to address the psychological needs of children and young people who experience trauma following a major incident.

8.21 In line with best practice evidence on psychosocial care in the aftermath of major incidents, Territorial Health Boards should promote a stepped-care model of support and intervention, based on the principles of Psychological First Aid (see Appendix 9).

8.22 Territorial Health Boards must be represented on the local multi-agency Care for People Team by an appropriately experienced and/or senior member of staff with delegated authority and responsibility for:

- making decisions about the organisation's contribution to the interagency (Care for People) plan;
- disseminating information within the organisation and promoting an awareness of NHS provision amongst partner agencies;
- securing the engagement of the relevant healthcare services from the local area or further afield through mutual aid or service level agreement;
- ensuring that the relevant operational staff are trained in line with identified (professional) competences; and
- ensuring that appropriate staff participate in exercises to test the local Care for People Plan.

8.23 In collaboration with the local Care for People Team, Territorial Health Boards should:

- develop methods to enable people, or groups of people, who might be at additional risk following an emergency to be identified quickly by drawing on understanding of, and information about, such people held by partner agencies; promote and/or advise partner agencies on how to access Psychological First Aid training.

8.24 The Health Board's Resilience Committee should receive regular updates on the local interagency Care for People plan and address the potential implications, such as resource requirements, for the organisation.

APPENDICES

APPENDIX 1

MEMBERS OF THE NATIONAL WORKING GROUP

Member	Designation	Representing
Calum Campbell (Chair)	Chief Executive, NHS Borders	
Drs. Alexandra Stirling/ Nicola Steedman/	Senior Medical Officers	Chief Medical Officer's Office, Scottish Government (Public Health)
Dr. Andrew McIntyre/ Duncan McCormick	Consultant Paediatric Intensivist, NHS Greater Glasgow and Clyde (NHSGG&C)	Royal College of Paediatrics and Child Health, Scotland
Clive Murray	Tayside Strategic Coordination Group (SCG)	SCG Coordinators Group
Colin Walker	Chief Inspector, Grampian Police	Association of Chief Police Officers, Scotland/Police Scotland
David Morrison	Resilience Manager, British Red Cross	Resilience Advisory Board, Scotland, Voluntary Sector Group
Doug Irwin	Security Director	State Hospitals Board for Scotland
Dr. Eddie Coyle	Director of Public Health, NHS Fife	Scottish Directors of Public Health
Eddie McLaughlan	Assistant Director	NHS National Services Scotland (NSS)
Frank Clayton	Group Manager, Grampian FRS	Chief Fire Officers Association, Scotland
George Brown	Emergency Planning Officer, NHS Fife	NHSScotland Resilience Forum
Isabelle Laing	Civil Contingencies Manager, NHS Grampian	NHSScotland Resilience Forum
Dr. Jason Long	Consultant, Emergency and Retrieval Medicine, NHSGG&C	College of Emergency Medicine
Jerry Forteath	Social Work Service Manager, Perth and Kinross Council	Association of Directors of Social Work
Dr. Jim McMenamin	Consultant Epidemiologist	Health Protection Scotland, NHS NSS
John Burnside	Business Continuity Manager, NHS Highland	NHSScotland Resilience Forum

June Nelson	Senior Nurse/Operational Manager (Unscheduled Care/Acute Medicine), NHS Borders	Faculty of Emergency Nursing
Dr. Kate McKay	Senior Medical Officer/Consultant Paediatrician (NHSGG&C)	Chief Medical Officer's Office, Scottish Government (Child and Maternal Health)
Lorna Paterson	Resilience Manager, NHS Borders	NHSScotland Resilience Forum
Mike Herriot	General Manager, National Risk and Resilience,	Scottish Ambulance Service
Dr. Mike Johnston	Consultant, Emergency and Retrieval Medicine, NHS Tayside	College of Emergency Medicine
Neil Boyle	Clinical Nurse Manager, Emergency Department (ED), NHS Lothian	ED Nursing
Nikola Brown	Acting Business Continuity Coordinator, City of Edinburgh Council	Local Authority Resilience Group, Scotland
Rhona Geisler	Director of Corporate Services, Falkirk Council	SOLACE
Ron Corrigall	Radiation Protection Adviser, NHSGG&C	Radiation Protection Advisers Group, Scotland
Stuart Wilson	Director of Communications, NHS Lothian	Health Boards Communication Leads
Mike Healy	Head of NHSScotland Resilience	NHSScotland Resilience, Health and Social Care Directorates, Scottish Government (HSCD SG)
Ray de Souza	Deputy Head of NHSScotland Resilience	NHSScotland Resilience, HSCD SG
Megan Keir	Resilience Officer – Secretariat	NHSScotland Resilience, HSCD SG

APPENDIX 2

BUSINESS CONTINUITY MANAGEMENT

Business Continuity Management sets a framework for identifying and managing risks that could disrupt routine services such as severe weather, loss of staff, premises, utilities, equipment and supplies. These disruptions can result in periods of severe pressure and/or a long-term increase in demand for services.

Planning to tackle these effects should go beyond the initial emergency response.

It is essential that Health Board arrangements for Business Continuity (BC) and Emergency Preparedness are appropriately integrated.

It is considered good practice for category 2 Health Boards to act as if they were in a lead role because the resilience of category 1 Health Boards will sometimes depend on them. Further guidance on BC is contained in *Business Continuity – A Framework for NHSScotland.*[34]

Health Boards should consider the 'Seven P's'[35] in developing their BC arrangements:

1. **Programme** – proactive management of the BCM process
2. **People** – promoting understanding and awareness through education
3. **Processes** – understanding how the organisation operates and responds to critical pressures
4. **Premises** – essential buildings, facilities, equipment
5. **Providers** – understanding the supply chain which serves critical services
6. **Profile** – protecting the organisation's image and reputation
7. **Performance** – evaluating performance

The BCM Audit Checklist[36] in the *Business Continuity – A Framework for NHSScotland* guidance is a useful framework for assessing an organisation's BCM arrangements.

34 Scottish Government, NHSScotland Resilience, 2009

35 In Emergency Preparedness, Cabinet Office Civil Contingencies Secretariat, 2005

36 See Annex 5 in *Business Continuity – A Framework for NHSScotland*, NHSScotland, Scottish Government, 2009

APPENDIX 3

DEVELOPING AN EMERGENCY COMMUNICATION STRATEGY

Five Steps to an audience-based approach – The right communication to the right people at the right time

Objective		Actions
1.	Identify the audience	Identify the groups or individuals you need to communicate with. Consider also the needs of different population/vulnerable groups.
2.	Set the communication objectives	Consider what you want to communicate/what action you require people to take.
3.	Develop the information and message	Consider what information is required and how to deliver it. Special care should be taken not to alarm unnecessarily, and protect sensitive information.
4.	Chose the appropriate communication channel	Consider what channels of communication are most appropriate to the audience you wish to communicate with. In types of slow burn emergencies where some degree of pre-planning can take place it might be useful to know in advance how you will communicate with them.
5.	Monitor, evaluate and review	It is important that regular review takes place to enable any changes in message/method to be take place.

APPENDIX 4

MANAGING PUBLIC HEALTH INCIDENTS – RESOURCES

The following resources are useful in enabling Health Boards to plan for various types of public health incidents:

The Management of Public Health Incidents – Guidance on the Roles and Responsibilities of NHS-led Incident Management Teams, Revised October 2011
http://www.scotland.gov.uk/Publications/2011/11/09091844/24

Compendium of Healthcare Associated Infection (HAI) Guidance, 2012.
http://www.documents.hps.scot.nhs.uk/hai/hai-compendium/hai-compendium.pdf

The Waterborne Hazard Plan guidance
www.sepa.org.uk/air/aher_service.aspx

Guidance on the Investigation and Control of Outbreaks of Foodborne Disease in Scotland, (Cairns Smith Report, 2002), Revised May 2006
http://www.hps.scot.nhs.uk/giz/guidelinedetail.aspx?id=15098

The Health and Social Care Influenza Pandemic Preparedness and Response
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133655

The UK Influenza Pandemic Preparedness Strategy, 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130903

Management of Viral Haemorrhagic Fevers and Similar Human Infectious Diseases of High Consequence, Advisory Committee on Dangerous Pathogens (ACDP),July 2012.
http://www.dh.gov.uk/health/2012/07/vhf-guidance/

Communicating with the Public about Public Health Risks
http://www.documents.hps.scot.nhs.uk/about-hps/hpn/risk-communication.pdf

APPENDIX 5

ROLES OF ORGANISATIONS DURING A RADIOLOGICAL OR NUCLEAR INCIDENT

National Arrangements for Incidents involving Radioactivity (NAIR)

NAIR is coordinated by the Health Protection Agency (HPA) CRCE. It includes NHS Radiation Protection Advisers and Medical Physicists and provides expert advice to first responders at incidents involving, or thought to involve, radioactive substances.

Nuclear Installation site specific plans

As part of a Nuclear Installation operator's site plan, Territorial Health Boards should provide advice on health measures drawing on technical assistance, where necessary from the Government Technical Advisor (GTA), monitoring data and assessments from the site operator, HPA (or its successor), HPS, Scottish Environment Protection Agency (SEPA) or other sources. Health Boards will liaise with Scottish Government Health and Social Care Directorates to ensure consistency and synchronisation of health advice at a local and national level.

Emergency reference levels/counter-measures

The Public Health England is responsible for recommending Emergency Reference Levels (ERLs) for intervention after a radiation accident. Doses measured above these levels should trigger the introduction of counter-measures (e.g. sheltering, provision of stable iodine, evacuation etc.) to protect the public.

APPENDIX 6

THE LEVELS OF RESPONSE FOR ADULTS AND CHILDREN THAT NEED TO BE PLANNED FOR IN THE MANAGEMENT OF BURNS ARE SHOWN IN THE TABLE BELOW

Level	Description	Who to Notify
1. Normal	Normal	– No Notification required
2. Concern	Burn major incident with casualties admitted locally. Local Board coping in handling burns casualties, sufficient to absorb additional capacity. Burn Service operating normally.	– Contact neighbouring Boards – Contact relevant Burns service – Notify Board on-call Executive and Board Emergency Planning Lead/Officer or equivalent
3. Pressure	Casualties admitted from Burn Major Incident and normal activity not possible at local Board level. Normal activity being maintained in Burns Service.	– Contact neighbouring Boards – Contact relevant Burns Service to check bed capacity – Notify Board on-call Director and Board Emergency Planning Lead/Officer or equivalent – Notify Scottish Ambulance Service Control Room Tactical Adviser – Notify Scottish Government NHSScotland Resilience Team
4. Severe Pressure	Normal activity not possible in Burn Service. More than one Burn Service now engaged to admit casualties from Burn Major Incident.	– Notify National Burn Bed Bureau. – Establish Burn Network communication to determine when Burn capacity will be exceeded – Notify Board on-call Executive and Board Emergency Planning Lead – Notify Scottish Ambulance Service Control Room or Tactical Adviser – Notify Scottish Government NHSScotland Resilience Team
5. Critical	Combined resources of burns care capacity and capability in Scotland being fully utilised to deal with casualties from incident. Considerations to transfer patients outwith NHSScotland	– Notify National Burn Bed Bureau – Notify Board on-call Executive and Board Emergency Planning Lead – Contact Scottish Government NHS Resilience team for support.
6. Capacity Exceeded	Combined Scottish and UK capacity and capability unable to absorb the additional activity. Consideration of international mutual aid.	– Ask Board on-call Executive to request support from Scottish Government via NHSScotland Resilience Team.

APPENDIX 7

PLANNING AND PREPARING FOR MASS CASUALTIES INCIDENTS

This appendix provides additional information for Health Board resilience leads to consider when planning for mass casualties incidents (MCI).

Optimising health care in a MCI

The principles of optimising healthcare in a MCI should be that:

People will be:

- provided with the best care available under the circumstances
- initially treated by the (category 1 & 2) responders most skilled in their management, as soon as possible after the incident occurs
- triaged and treated in the first instance, wherever possible or transported to the nearest or most appropriate health care facility, as resources allow.
- Health care resources will be:
  - re-prioritised to meet the unexpected increase in demand
  - maximised to capacity and/or used intensively and appropriately to save the maximum number of lives, and to minimise morbidity
  - used for seriously ill patients, not related to the MCI, throughout the emergency situation.

Taking account of the challenges

Aside from the significant number of casualties, a 'sudden impact' or 'no-notice' MCI is likely to generate a range of challenges for NHS responders at the scene of a major incident:

- **Location:** MCIs, especially transport accidents/collisions, may occur in locations where access and egress for emergency services is difficult. Travel time to the scene itself may be considerable;
- **Scene access:** Paramedics may be reliant on specialist rescue capability (e.g. Fire and Rescue) to gain access to casualties or be barred from entering the 'hot zone' until it is deemed safe by Police/Security Services;
- **Transport resources:** The large number of casualties may overwhelm the Scottish Ambulance Services' available transport resources;
- **Weather:** Severe or adverse weather conditions may affect the actions of first responders, e.g. treatment at the scene, telecommunications;

- **Healthcare capacity and capability:** As health boards' capacity is generally based on the assessed/anticipated needs of their local population, the nearest receiving hospital may have insufficient capacity and capability to treat the number of (multi-trauma) casualties and patients and they may need to be transported to another health board or health care facility. Within the receiving hospital, changes in the practice of some health professionals may need to occur through necessity;
- **Time delays:** There is a high likelihood that the above challenges will result in time delays for the casualties to access treatment.

Identifying capacity

The following table is intended to assist Health Board resilience planning leads to work with partners on the Regional Resilience Partnership to identify reasonable worst case scenarios for various types of incidents and associated casualty numbers.

The table below can be used to identify the capacity within the Health Board to respond to the potential impact/consequences of various types of incidents and ultimately, capability gaps.

Planning assumptions for mass casualties triage scenarios

	Adults	Children	Risk (description and casualty impact)	Capacity within the Health Board	Implications for particular clinical/ healthcare services
Priority (P) 1 Immediate (25%)					
Priority (P) 2 Urgent (25%)					
Priority (P) 3 Walking wounded (50%)					

The planning assumptions (triage proportions) identified in the table above (25%-25%-50%) is generally used for a range of risks, although it is acknowledged that the consequences of MCI's will vary greatly.

The number of adult/child casualties for each risk/scenario may exceed Health Board(s) capacity within the local RRP area and the MCI may require rapid capacity-escalation by one or more of the other local Health Boards as well as patient transfers out of the area.

Responding to a mass casualties incident – roles of key agencies and groups

The Table below outlines in general terms the roles and responsibilities of agencies at various levels. It is not intended to be either prescriptive or comprehensive.

Organisation	Role	Key Actions and Outputs
Scottish Government	Activate SGoRR Monitoring and surveillance Inform and advise Scottish Ministers Provide national coordination Liaise with COBR, if necessary Advise and reassure the public Assess financial and resource implications and/or requirements Liaise with international agencies, if necessary	Maintains an up-to-date overview of national critical care capacity, derived from Regional Resilience Partnerships Provides strategic direction for the NHS and the particular health board involved and ensure that all other health boards are in readiness to support Assesses whether mutual aid is required from other nations in the UK if local capacity and capability is overstretched or inadequate Assesses the impact of the incident on scheduled work of the board(s) and what action needs to be taken Obtains advice from Health Protection Scotland/STAC Maximises available communication channels to inform the public Manages national debrief and evaluation of events
Local and Regional Resilience Partneships	To engage partner organisations in the development and implementation of a local integrated emergency plan for the LRP/RRP area. To provide coordinate the responses of members. To assess the ongoing situation, identify, potentially escalate issues and report emerging issues to SGoRR To gather information from agencies as part of debrief and learning process and modify plans accordingly	The LRP/RRP has: Obtained health board partners' agreement to coordinate and/or set strategic priorities for local NHS and healthcare for duration of incident Ensured that all health boards have an identified Executive-level Director with a clear remit and delegated authority from the Chief Executive to contribute to multiagency strategy-setting and response. The Health Board representative has the delegated responsibility to speak for the combined response of all contributing Health Boards Ensured that LRP/RRP partners have bi/multi-lateral Mutual Aid Agreements (MAA) that in the case of Health Boards: • Are annually reviewed and signed by Chief Executive; • Address Clinical Governance issues • Have been cross-referenced with local authorities; • Are collated to form one MAA for the RRP that is signed-off by the RRP Chair; • Are reviewed and tested on an annual basis. Healthcare providers are involved in testing and exercising
		Plans and procedures have taken account of the needs of people with disabilities and or those who are vulnerable. A communications strategy Clearly identified trigger points for escalation to Scottish Government

Territorial Health Boards	To improve the health of the population, address health inequalities and provide high quality services To work in partnership with community planning partners to protect and address the needs of vulnerable people To provide specific or specialist health care for casualties and support for responders To commission services that enhance the health and wellbeing of the local population	**Health Board level** There are arrangements to increase and maintain extra capacity in the event of an incident resulting in large numbers of casualties, including procedures for all elective activity, identifying patients available for rapid discharge, supplementing available equipment and making alternative use of specialist/day care facilities An assessment has been made of equipment and supply issues, notably supply-chains for critical items in an emergency – the option of establishing an emergency store holding a limited stock has been considered Available capacity in private healthcare sector has been identified NHS 24's role in providing advice (and triage) agreed so that only the most serious patients attend or are admitted to hospital Account taken of the needs of the population as well as healthcare staff during the recovery phase of the incident and post crisis response Account taken of the needs of casualties who are vulnerable and/or have a disability **Acute sector** Plans exist for using existing capacity more intensively to create extra capacity for a higher level of dependency Additional appropriately trained and equipped clinical support can be provided at the scene Hospital BC plans reflect the need to maintain critical clinical and managerial functions during disruptive challenges Mitigation of the impact of the incident and other scheduled work and resource availability is considered There are arrangements for senior clinical managers to temporarily realign treatment protocols to re-prioritise patient care and adapt normal clinical practices, if necessary Non-acute facilities are identified to supplement maximum bed capacity (e.g. in independent sector) by agreement with local authorities

Unused physical capacity (disused NHS wards) or beds in the independent sector, and options for utilising hotels, local halls of residence etc are pre-identified with local authorities and relevant organisations

There are plans for managing large numbers of people making contact in person or by phone with hospital services

Receiving hospitals have agreed plans with local police to document casualties and details of the deceased and share this information with the Casualty Bureau, ensuring that these plans are integrated with those of the local authorities for providing people with humanitarian assistance and/or using Rest Centres

Arrangements have been made with local authorities and primary care to assist in expediting appropriate early discharges from acute care wards

A cohort of recently retired (medical and nursing) staff are trained/retained to assist in critical care skills and a group of existing staff have been trained and supported to work in different ways in the event of mass casualty incidents

Staff in critical care services are advised/aware that they may have to work in a different way in an emergency and there are action cards to highlight what would be expected of them, backed up by a training programme

Primary care services

Primary care contractors have a clear understanding of what is expected of them during a major incident involving mass casualties, and have business continuity plans to manage the impact of an incident with a large number of casualties affecting their service and staff

Health board/acute sector plans identify how GP's and primary care staff can assist in setting up facilities away from acute hospital services to triage, diagnosis/ treatment and support of patients who are not obviously seriously ill or injured

There are contingency plans, developed in conjunction with relevant local authorities to maintain patients in the community and to reduce/avoid referrals to acute hospital services

Arrangements have been agreed with GPs and community staff so that they can be deployed to supplement acute sector services if required. The arrangements have addressed issues around clinical indemnity and support for practitioners working in a different environment, away from their normal place of work

The emergency care skills of primary care staff have been pre-identified so that they can be deployed/directed to key emergency roles without delay and on a phased/staggered basis during the incident

Scottish Ambulance Service (SAS)	To respond to emergencies, deliver safe and effective person- centred pre-hospital emergency care To prioritise resources in order to save life and improve health outcomes To establish command, control and coordination for healthcare activity at the incident site To continue to deliver pre-hospital emergency care in Scotland, in liaison with partners, coordinated at national level	SAS will: advise the health board/hospital and Gold command of the potential number of casualties and nature and severity of injuries act as the focal point of NHS activity, manage healthcare communications and logistics at the incident site(s) and direct ambulance and medical resources at the site undertake tactical and operational procedures as agreed previously with Scottish Government, emergency services and other agencies, including the deployment of specialised resources issue, through the RRP Communications Group, and in partnership with the health board, a public information notice advising the public not to place any unnecessary burden on the 999 system and A&E have plans to increase capacity to provide triage, treatment and transportation for people in keeping with threat assessments, drawing in mutual aid as needed from voluntary aid organisations, and Ambulance Trusts in England, Wales and Northern Ireland and suitable private ambulance providers place on 'stand-by' a sufficient number of receiving hospitals and specialist units to cater for anticipated/estimated number of casualties, liaising through SGoRR/NHSScotland Resilience to access facilities outside Scotland plans and procedures that take account of the needs of injured people with disabilities and or those who are vulnerable
NHS National Services Scotland	Through Health Protection Scotland (HPS) Scottish National Blood transfusion Service (SNBTS) and National Procurement (NP) To protect the health and wellbeing of the population To ensure uninterrupted blood supply to the NHS is maintained To ensure the delivery of goods to hospitals and other facilities that are crucial to support the running of NHSScotland	Arrangements are in place to: provide accurate and timely advice on health protection issues to the NHS, Scottish Government and the public in relation to the incident provide advice and support to health boards and primary care services on monitoring the long term health impacts of an incident provide specialist advice to the STAC cell Uninterrupted blood supply to NHSScotland Effective arrangements in place to support Health Boards in the supply of goods required

APPENDIX 8

PSYCHOLOGICAL FIRST AID (PFA)

The various components of effective PFA[37] [38] are set out below.

However, there is no particular order to follow, as the order will depend on the individual and the emergency:

- Provide immediate care for physical needs
- Protect from further threat and distress
- Provide comfort and console distress
- Provide practical help and support for real-world-based tasks (e.g. arranging funerals, information gathering)
- Provide education about normal responses to trauma exposure. This should involve two essential elements:
  - Recognising the range of reactions
  - Respecting and validating the normality of the post trauma reaction
- Facilitation of reunion with loved ones where possible and/or connection with social supports
- Provide information on coping and accessing additional support

37 Dr. C. Freeman, A. Flitcroft & P. Weeple – Psychological First Aid: Short Term Post Trauma Responses for Individuals and Groups, NHS Lothian 2002

38 Psychological First Aid Field Operations Guide (2nd Edition). National Child Traumatic Stress Network & National Center for PTSD (2006) Downloadable from: http://www.ptsd.va.gov/PTSD/professional/manuals/psych-first-aid.asp

APPENDIX 9

GLOSSARY OF TERMS

Primary Term	Definition
Business Continuity Management	A management process that helps manage risks to the smooth running of an organisation or deliver of a service, ensuring that it can operate to the extent required in the event of a disruption.
Business Continuity	Strategic and tactical capability of an organisation to plan for and respond to incidents and business disruptions in order to continue business operations at an acceptable predefined level.
Capability	A demonstrable ability to respond to and recover from a particular threat or hazard.
Civil Contingencies	Risks to civilian health, safety and property from emergencies as defined in the Civil Contingencies Act (2004).
Community Risk Register	A Register communicating the assessment of risks within a Local Resilience Area which is developed and published as a basis for informing local communities and directing civil protection workstreams.
Competences	Competences include the knowledge, judgment, skills, energy, experience and motivation required to respond adequately to the demands of one's professional responsibilities.
Decontamination	Removal or reduction of hazardous materials to lower the risk of further harm to victims and/or cross contamination.
Emergency	An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or the security of the UK or of a place in the UK.
Emergency Powers	Last-resort option for responding to the most serious of emergencies where existing powers are insufficient, and additional powers are enacted under part 2 of the Civil Contingencies Act (2004) and elsewhere.

Emergency Preparedness	The extent to which emergency planning enables the effective and efficient prevention, reduction, control and mitigation of, and response to emergencies.
Exercise	A simulation designed to validate organisations' capability to manage incidents and emergencies. Specifically exercises will seek to validate training undertaken and the procedures and systems within emergency or business continuity plans.
Hazmat	Abbreviation for hazardous materials although it is commonly used in relation to procedures, equipment and incidents involving hazardous materials. HAZMAT incidents are not treated as terrorist incidents yet can require a similar NHS response.
Health Risk State	Section 14 (7) of the Public Health etc. (Scotland) Act 2008 defines a 'health risk state' as (a) a highly pathogenic infection; or (b) any contamination, poison or other hazard which is a significant risk to public health.
Health and Safety at Work Act, 1974	Primary legislation covering occupational health and safety in the United Kingdom. The Health and Safety Executive is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment.
Hot Zone	Zone of the highest level of contamination.
Humanitarian Assistance Centre	Assistance centre established following an emergency to cater for the medium and longer term need of people affected by an emergency.
Incident	Event of situation that requires a response from the emergency services or other responders.
Integrated Emergency Management	Multi-agency approach to emergency management entailing five key activities – assessment, prevention, preparation, response and recovery.
Internal Incidents	An organisation may be affected by its own internal major incident (e.g. fire, equipment failure, violent crime) or by an external incident (e.g. utilities failure) that impairs its ability to function normally, impacting on staff morale and public confidence. These incidents should be covered in a Business Continuity Plan. However, where there is no resolution in the short term, the end result would be the declaration of a major incident.

Lockdown	The process of controlling the movement and access – both entry and exit – of people (NHS staff, patients and visitors) around a site or building/area in response to an identified risk, threat or hazard that might impact upon the security of patients, staff and assets or, indeed, the capacity of that facility to continue to operate. A lockdown is achieved through a combination of physical security measures and the deployment of security personnel.
Major Incident Scenarios	**Cloud on the horizon :** Where an incident in one place may impact on others afterwards. Preparatory action is needed in response to an evolving threat elsewhere, even perhaps overseas, such as a major chemical or nuclear release, a dangerous epidemic or an armed conflict. **Slow burner:** Where a problem creeps up gradually, such as occurs in a developing infectious disease epidemic. There is no clear starting point for the major incident and the point at which an outbreak becomes 'major' may only be clear in retrospect, e.g. Pandemic Flu. Long term resilience or business continuity of NHS Services is a key issue. **Headline news:** Where a wave of public or media alarm ensues over a health issue, such as a reaction to a perceived threat. This may create a major incident for health services even if the fears prove unfounded. The issues itself may be minor in terms of actual risk to the population. It is the urgent need to manage information that creates the major incident. **Big bang:** A health service major incident is typically triggered by a sudden major transport or industrial accident. What may not be so obvious at first, however, are the wider implications. A major incident may build slowly from a series of smaller incidents such as traffic/transport accidents or explosions. Also see CBRN, HAZMAT, Internal Incidents, and Mass Casualties
Mass Casualty Incident	An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency services.
Mutual Aid	An agreement between organisations, within the same sector or across sectors and across boundaries, to provide assistance with additional recourse during an emergency.

Preparedness	Process of preparing to deal with known risks and unforeseen events or situations that have potential to result in an emergency.
Recovery	The process of rebuilding, restoring and rehabilitating the community following an emergency.
Resilience	Ability to detect, prevent, and, if necessary to withstand, handle and recover from disruptive challenges and sustain an acceptable level of function, structure and identity. A robust civil contingencies planning process is a key factor in establishing resilience.
Risk Assessment	A structured and auditable process of identifying potentially significant events, assessing their likelihood and impacts, and then combining these to provide an overall assessment of risk, as a basis for further decisions and action.
Science and Technical Advice Cell	Group of technical experts from those agencies involved in an emergency response that may provide scientific and technical advice to the LRP/ RRP chair or single service fold commander.
Regional Resilience Partnerships (RRP) and Local Resilience Partnerships (LRP)	RRPs and LRPs are the principal arenas for multi-agency cooperation in civil protection at local level. They have a key role in both preparation and response to emergencies.
Syndromic Surveillance	Syndromic Surveillance is the real time (or near real time) collection, analysis, interpretation and dissemination of health related data to enable early identification of impact or absence of impact of potential human or veterinary threats which require effective public health action.

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