NHS SCOTLAND

NHS SCOTLAND RESILIENCE

Preparing for Emergencies

Guidance for Health Boards in Scotland

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Document Purpose	To provide strategic guidance for NHS Scotland Chief Executives and NHS Leaders on preparing for emergencies.
Description	An updated version of the 2013 Guidance of the same name, designed to support NHS preparations for emergencies by offering guidance on the implementation of the Civil Contingencies Act 2004 and other relevant legislation. 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Superseded Documents	Preparing for Emergencies: Guidance for Health Boards in Scotland (2013) ISBN: 978-1-78256-874-2 and Annex: Equalities, Human Rights and Resilience Planning
Action Required	Health Boards should follow this guidance to develop organisational plans for emergency preparedness and capability.

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Foreword

It is essential that all public sector organisations plan and prepare for a wide range of potential emergencies. This remains of paramount importance for Health Boards in Scotland, as it was in 2013, when this guidance was originally published. Healthcare services have faced a range of emergency incidents in recent years including a global pandemic and we are continually faced with a range of other types and levels of disruptive events which we must plan and prepare for.

Part of that planning and preparedness includes reviewing this strategic guidance to support individual health boards in their planning for such events.

Health Board services and staff could be affected by a wide range of types of emergencies such as extreme weather conditions or a major disease outbreak, to a major transport incident with multiple casualties and we need to be sufficiently prepared to confidently deal with the potential impact and consequence on our ability to maintain patient care.

Through a more strategic rather than operational lens, this guidance prompts Health Boards to consider the implications of, and plan for, the various scenarios, threats and hazards it may be faced with. It also recognises the complexity of Health Boards across Scotland and the differing scale of resources at their disposal and promotes partnership-working at all levels. Collaboration is vital, and with this in mind a Short Life Working Group (SLWG) was commissioned to review and update this guidance to ensure it is succinct, comprehensive, and based on the latest information and best practice available.

It provides strategic direction to inform local preparations for emergencies and other significant disruptive events and should be shared openly with all staff to further develop and promote a culture of resilience and preparedness within the organisation.

Finally, I would like to thank members of the SLWG and others who contributed to this review for their contribution and support and urge you all to consider how best this can be used to help preserve, maintain, and improve the essential public services the NHS provides to the people of Scotland.

John Burns
Chief Operating Officer
NHS Scotland

Executive Summary

Health Boards need to be resilient and well prepared to address the impact and consequences of various types of emergencies and disruptive incidents while maintaining services to patients. This can be complex and multi-faceted involving a wide range of issues including the assessment of risk, the deployment of resources and co-operation with other agencies to develop robust emergency plans. Being prepared means that Health Boards, particularly those identified as Category 1 and 2 responders under the Civil Contingencies Act 2004 (CCA), clearly understand what is required and they are ready to respond effectively. It is equally important that Health Boards are fully prepared for a wide range of other disruptive events and/or emergency situations, not covered by civil contingencies legislation.

Divided into eight sections with Appendices, this guidance explains what should be done to enhance organisational resilience and capability. Each section of the previous Preparing for Emergencies Guidance (2013) has undergone intense scrutiny and has been reviewed and refreshed by subject matter experts and those that will be implementing the guidance at local level. Below is a summary of each section.

Section 1 sets the context of the guidance and explains its purpose, reflects new legislation, and provides an overview of the role of Integration Joint Boards (IJBs) in preparing for emergencies.

Section 2 highlights the aims and objectives underpinning emergency preparedness and the activities required by Chief Executives to ensure that their Health Board complies with legally mandated duties.

Section 3 focuses on the designation of particular Health Boards as Category 1 and Category 2 responders under the Civil Contingencies Act (CCA) 2004. It also highlights key issues in relation to ensuring compliance with the Equality Act 2010 and the Human Rights Act 1998.

Section 4 explains the wider context within which bodies listed as responders under the Civil Contingencies Act 2004 should plan and prepare for emergencies. It sets out roles and responsibilities at various stages of the emergency planning process in line with legally mandated duties.

Section 5 showcases the 3 key elements of emergency response: Preparations, Responding, and Recovering. All CCA responders must

aid in this process depending on their roles and functions (e.g. response and recovery will be led by Health Boards; IJB functions lend themselves most effectively to strategic planning of health and care services for emergencies, as well as normal business). It also covers the principles of the Joint Emergency Service Interoperability Programme (JESIP).

Section 6 outlines the role of key public bodies in civil protection and resilience, from a health perspective. It also highlights the action to be taken by Health Boards when faced with exceptional service pressures as a result of a major incident.

Section 7 sets out the requirements of Health Boards in relation to preparing for and managing a range of incidents of varying nature and scale. While this document remains strategic in scope, updates cover resources and guidance for incidents with unique challenges. This section has been updated to reflect a range of new information, particularly around: Communicable Diseases, Burns Services and Mass Casualties Incidents / Fatalities.

Section 8 considers specific populations in the community who may be vulnerable during major incidents and emergency situations. It addresses what Health Boards should do with partner agencies to respond to the needs of these populations. This section features refreshed guidance specifically on children and young people.

Appendices provide more information to assist those with a role in planning and preparing for emergencies within Health Boards.

Appendix	Subject / Topic
1	Members of the Short Life Working Group
2	Business Continuity Management
3	Sample Mutual Aid agreement
4	Developing an emergency communication strategy
5	Managing public health incidents resources
6	Roles of organisations during a radiological or nuclear incident
7	Information to assist planning for a MIMC
8	Psychological First Aid (PFA)
9	Additional Information
10	Glossary of Terms

Section 1
Introduction

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

Context

1.1 The public expects the NHS to be there, functioning normally and safely when they need it. This expectation is constant even when faced with disruptive challenges or emergency incidents which may impact capability to maintain these services. The type and range of potential incidents vary hugely and can include adverse weather, utilities failures, industrial action, public health, and other types of major incidents and acts of terrorism. All carry with them short and longer-term impacts and consequences for maintaining business as usual service levels.

1.2 Scotland's health and social care services continue to operate in a changing environment with new and increasing demands such as legislative changes (the integration of health and social care services), the redesign and continuous improvement of our health sector. In light of the Covid-19 pandemic, the challenges facing the health service require a robust approach to emergency preparedness which accounts for high pressures across Health Boards.

1.3 All Territorial and some National Health Boards have roles and responsibilities under the Civil Contingencies Act 2004 (as either Category 1 or Category 2 responders) which requires them to plan and/or co-operate on preparedness for a range of civil contingencies. Integration Joint Boards (IJBs) are also Category 1 responders as per The Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2021 (S.S.I. 147/2021).

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 supersedes 'Preparing for Emergencies: Guidance for Health Boards' in Scotland, published in 2013.

Purpose of the guidance

1.5 The purpose of this guidance is to:

- enhance the resilience of Health Boards and help ensure there is a consistent and coordinated approach to resilience planning

- enable Health Board 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 and other key legislation
- 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 Health Boards in relation to responding to major incidents and emergency situations
- promote continuous improvement of emergency preparedness

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 other disruptive events. It can also be used by Integration Joint Boards in fulfilling their legally mandated emergency preparedness duties and has been prepared with this objective in mind.

1.7 The guidance is:

- strategic in focus and aims to support and inform local planning and preparedness
- set in the context of the Civil Contingencies Act 2004 (CCA) and associated regulations
- intended for use by all Health Boards as it is relevant to the full range of healthcare services, not only acute emergency care
- set in a 3-year review cycle to ensure that it reflects changes in policy and new developments

1.8 It should be read in conjunction with Preparing Scotland, which provides broader guidance on fulfilling CCA duties, and within the context of other legislation, policy and guidance applicable to Health Boards in Scotland such as business continuity and risk management, including linkages with the Scottish Risk Assessment (SRA) and National Risk Register (NRR) and the National Security Risk Assessment (NSRA) as appropriate.

1.9 This guidance was subject to review by a short life working group co-chaired by NHS Lothian and Scottish Government: Health Emergency Planning, Preparedness and Response division (see membership at 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 and 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 national 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 less-likely incidents are not excluded. 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 Health Boards to plan, prepare and respond to such incidents.

1.12 A major incident may present as a variety of different scenarios (see glossary 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 A list of common terms used in this document are defined in the glossary.

Health Inequalities Impact Assessment (HIIA)

1.14 The previous guidance was subjected to a HIIA scoping exercise which highlighted three key issues that need to be considered by Health Boards (Category 1 and 2 responders) when preparing for emergencies and deploying resources in emergency situations. The issues from the HIIA have been incorporated into this guidance document, and the following remain the most relevant:

- **Communication**: The most effective and appropriate means of communication should be used to convey important and timely information to staff, patients, and the public. It should include a combination of different methods and approaches so that everyone is given appropriate, accessible information.
- **Access to services**: During major incidents or emergencies, some services may be disrupted or experience a surge in demand. Health Boards should identify services likely to be affected and prepare plans to mitigate the impact on the users of critical services who are most likely to be affected by these incidents.
- **Staff training**: Staff should have appropriate equalities and human rights training so that they are aware of and sensitive to the needs of different population groups, which will inform planning for emergencies and the duty to communicate effective advice to the public during an emergency. 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.

Who this guidance is aimed at

1.15 This guidance is principally aimed at Health Board Chief Executives, Executive Directors, senior managers, and staff responsible for resilience and emergency planning of health service delivery.

1.16 Health Boards should ensure that primary care (and other external) contractors are aware of this guidance and, where appropriate, engage them in developing and implementing the emergency planning processes relevant to their contracted services. This includes both contracted services directly commissioned by a Health Board and those contracted to deliver a service for a Health Board.

Role of Integration Joint Boards (IJBs)

1.17 Since 2021, IJBs are identified as Category 1 responders under Schedule 1 Part 2 17A of the Civil Contingencies Act (2004). IJBs employ no specific staff and own no facilities, and their business-as-usual function is to offer strategic direction to Health Boards through Health and Social Care Partnerships (HSCPs). They primarily operate a strategic and planning role in their relationships with Health Boards.

1.18 This strategic function should be recognised in emergency planning, where IJBs should play a key role in preparing the strategy for responses and in co-ordinating with Health Boards in line with JESIP principles (see Section 5). Part of this strategic planning should involve considerations of service recovery at the appropriate stage of the emergency response.

1.19 By contributing a strategic view to emergency response, IJBs can identify solutions to be delivered during an emergency, but their primary function should be the strategic planning of emergency responses, supporting and co-ordinating with Health Board preparations.

Section 2
Ensuring preparedness

This section highlights the aims and objectives underpinning emergency preparedness, and the activities required by Chief Executives to ensure that their Health Board complies with legally mandated duties.

Emergency Preparedness: aim, objectives, principles

Aim

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

Objectives

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.
- work in partnership with other agencies and across organisational professional boundaries to deliver effective, integrated multi-agency response

Principles

2.3 Overarching principles for emergency preparedness and response are that Health Boards:

- 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 and/or support to others when necessary
- consult with Scottish Government Health and Social Care Directorates when necessary, receiving support and providing vital information

Requirements of the Chief Executive

2.4 As the Accountable Officer, the Chief Executive is responsible for ensuring the overall readiness of their organisation to manage major incidents and events, both planned (e.g. a major sporting event) and unplanned (e.g. a utilities failure) they should 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, responding to, and recovering from major incidents
- an Executive Director of the Board has been designated to lead on Emergency Preparedness and Business Continuity (this can be the Chief Executive)
- clear governance arrangements are in place throughout the organisation to oversee emergency preparedness and business continuity. These should include a Resilience Committee, chaired by someone no less senior than 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 Emergency Preparedness and Business Continuity plans and planning arrangements.
- there are suitably experienced and qualified Lead Officers for Emergency Preparedness and for Business Continuity. 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 Board leadership. This plan should be based on the principles of risk assessment, adopting an all-hazards approach which accounts for both the National Risk Register (NRR), Scottish Risk Assessment (SRA), and other specific local risks.
- planning should 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.
- adequate and proportionate resources have been allocated, in line with assessed need, to develop and maintain emergency preparedness and the resilience of the organisation. This includes staffing, equipment, training and exercising.

Section 3
Legislation

This section highlights the designation of 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

3.1 The Civil Contingencies Act 2004 and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 provide the primary legislative framework for resilience and civil contingencies matters in Scotland.

3.2 Specific duties of the CCA are laid out in section 4.4 of this guidance.

3.3 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 Health Boards in Scotland[1]:

Category 1 responders are those organisations at the core of emergency response, and they are subject to the full set of civil protection duties. In a health context, this includes: all Territorial Health Boards, the Scottish Ambulance Service, and Integration Joint Boards (IJBs).

Category 2 responder organisations are cooperating bodies that are placed under lesser obligations by the CCA than Category 1 responders. Primarily their duties are to cooperate with and share relevant information with Category 1 and other Category 2 responders. They should be engaged in discussions where they can add value and they must respond to all reasonable requests. NHS National Services Scotland and Public Health Scotland are designated Category 2 responders.

3.4 It is good practice for Health Boards that are not Category 1 or Category 2 responders to comply with the full CCA duties, identify how they can support categorised 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.

1 Correct at time of publication.

3.5 Relevant legislation is identified in this document that must also be considered by Health Boards when preparing for emergencies.

Equality and Diversity

3.6 The Equality Act 2010 requires Health Boards and other public bodies to consider the needs of all individuals, including staff, when developing policy, designing, and delivering services.

3.7 This section summarises public sector duties under Equalities and Human Rights legislation. It highlights specific issues for those concerned with resilience-planning to consider in the process of preparing for emergencies.

3.8 It is important that Health Boards understand how different people will be affected by their activities when responding to major incidents so that services are appropriate to meet the needs of different people.

Public Sector Equality Duty

3.9 The public sector equality duty (known as the 'General Duty') covers protected characteristics: age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation and marriage and civil partnerships. It requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not

Human Rights and Resilience Planning

3.10 The Human Rights Act 1998 applies in its entirety, but some rights can be derogated in exceptional circumstances including in cases of public emergency. This is defined as:

> 'An exceptional situation of crisis or emergency which afflicts the whole population and constitutes a threat to the organised life of the community of which the community is composed.'

3.11 A public emergency must be actual or imminent, potentially affect the whole nation and threaten the continuance of the organised life of the community.

3.12 In most situations to which this guidance applies it is unlikely that the UK would formally derogate from Convention rights. The normal rules of respect for absolute rights and legality, necessity, and proportionality of interference with qualified rights would therefore apply.

3.13 Human Rights under the European Convention on Rights ('ECHR') fall broadly into three categories:

> **Absolute rights:** cannot be infringed under any circumstances and include Article 3 (the prohibition of torture, inhuman and degrading treatment, or punishment), Article 2 (the right to life), Article 4 (prohibition of slavery and forced labour) and Article 7 (no punishment without law).

Limited rights: can be limited in certain circumstances as set out in the ECHR and include Article 5 (the right to liberty and security); and

Qualified rights: that the state can lawfully interfere with in certain circumstances and include Article 8 (the right to a private and family life, home, and correspondence) and Article 10 (freedom of expression).

3.14 An interference with a qualified right must have a legal basis, pursue a legitimate aim (such as public health or the protection of the rights of others), and be the least restrictive measure capable of achieving that aim (the tests of legality, necessity, and proportionality).

Application of Human Rights issues

3.15 There may be a range of situations where human rights issues are engaged in times of an emergency, be it a 9/11 type attack or a pandemic outbreak. It is important that all measures taken by Government to enable services to cope with significant staff shortages and other impacts of emergencies respect human rights, including the avoidance of arbitrary limitation of rights, and discriminatory treatment, and it is vital that individuals are protected from ill-treatment and/or detention.

Triage

3.16 Following a natural disaster or terrorist attack, emergency services and staff will be stretched to the limit. Medical services and health providers may be required to triage patients and in doing so will need to guard against risks to life (Article 2) and to leaving patients in circumstances which would amount to cruel, inhuman or degrading treatment, within the meaning of Article 3.

3.17 Positive obligations under each right require health and other public authorities to take all reasonable steps to avoid real and immediate risks to life or of degrading treatment. This has implications for due diligence in the design and delivery of systems of prioritisation.

Impact Assessments

3.18 There are several types of impact assessments to be considered when planning for emergencies and it is the responsibility of each Health Board to consider what, if any, assessments require to be undertaken/updated.

The links below lead to information and support available via the Scottish Government website. Note: Not all of which may be applicable to Health Boards, but Chief Executives should be aware of, and support, these as part of multi-agency collaboration.

- Equality Impact Assessments (EQIAs)
- Child Rights and Wellbeing impact assessments (CRWIA)
- Human Rights in Policy making assessments
- Island Community Impact assessments
- Data Protection assessments
- Fairer Scotland Duty Assessment
- Strategic Environmental Assessments (SEA)
- Business and Regulatory Impact Assessment

There is additional guidance on EQIAs in the NHS Education for Scotland (NES) Turas Equality & Diversity Zone which includes an e-learning module: Introduction to Equality Impact Assessment (EQIA) and a series of videos to guide people through the assessment.

Section 4
Planning For Emergencies

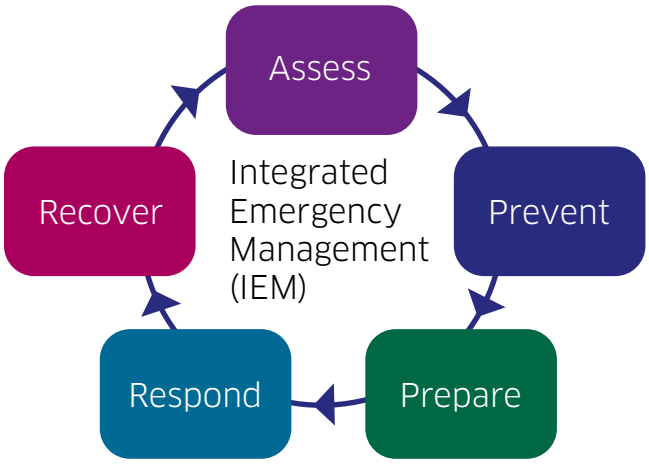
This section highlights the wider context within which bodies listed as responders under the Civil Contingencies Act 2004 should plan and prepare for emergencies. It sets out roles and responsibilities at various stages of the emergency planning process in line with these requirements.

Introduction

4.1 **The planning process is key to preparing for emergencies.** Under the Civil Contingencies Act 2004, Category 1 responders 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 if/when it occurs
- identifying other actions to be taken in relation to the emergency

4.2 Health Boards should use the Integrated Emergency Management (IEM) cycle, working together with multi-agency partners via Resilience Partnerships to build resilience. The IEM cycle (below) ensures a constant review of activity and therefore robust preparedness arrangements.



4.3 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, testing, and exercising to ensure effective implementation of their plans
- appropriate incident recording arrangements in place and a system for identifying and sharing learning from incidents
- established a system for reviewing and updating their plans

Roles and Responsibilities

4.4 Health Boards designated as Category 1 and Category 2 responders must ensure they comply with the legally mandated duties of the CCA associated with their designated status. As such, they should ensure they are able to contribute to a co-ordinated response to major incidents, regardless of their nature or scale.

4.5 Non-designated Health Boards should consider how they may be affected by emergencies. While there is no legal duty on them to adhere to these regulations, failure to adhere will disrupt their normal operations and therefore, every effort should be made to adhere as if a designated Category 1 or Category 2 responder. Failure to do so could result in criticism - for example at a public inquiry. Non-compliance is not simply about potential criticism at an inquiry, but that their day-to-day operations will be more affected if they do not follow regulations, best practice, and have effective measures in place.

4.6 The specific duties of Health Boards identified as Category 1 responders under the CCA are to:

Assess risk

4.7 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.

4.8 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 registers.

Maintain Emergency/Major Incident Plans

4.9 Health Boards must produce and maintain major incident/emergency plans for a range of potential scenarios based on their assessment of possible and major incident scenarios. They must also actively engage with other resilience partners/organisations to ensure that the role of the NHS is appropriately reflected in multi-agency plans for various major incidents/ emergencies.

Maintain Business Continuity Management Plans

4.10 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.

4.11 All Health Boards must have in place robust up to date BCM plans to help maintain their key functions in the event of a major incident or significant 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
- how the plans(s) will be communicated to and accessed by staff

For further information on BCM see Appendix 2.

Communicate with the public

4.12 Category 1 Health Boards must have communication plans that can:

- at the planning stage: inform the public of the risks and threats being prepared for and, in general terms, of their potential responses if they occur
- 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, see the guidance on communication in Section 5.

Share information

4.13 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.

4.14 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 while maintaining confidentiality.

4.15 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.

4.16 Different Health Boards have different roles in sharing and disseminating information. A Territorial Health Board will need measures to communicate patient safety information and advice to those directly affected by an incident, whereas a non-territorial Health Board

will need to prepare advice for the general public. All Boards should, in line with their regular duties and risk assessment processes, consider their potential roles in various types of incidents and prepare to co-operate with other Boards in fulfilling these.

Co-operate

4.17 Health Boards designated as Category 1 and 2 responders must cooperate with other responders. The principal mechanisms for multi-agency cooperation are the Regional/ Local Resilience Partnerships (RRP/ LRP). Category 1 responder Health Boards should be represented on these multi-agency groups by staff at an appropriate level within the organisation, as follows:

RRP Chief Executive or a delegated Executive-level Director (Territorial Health Board); Regional Director or Deputy Director of Scottish Ambulance Service (SAS)

LRP Resilience Manager/Resilience Advisor/Senior Manager (Territorial Health Board); Regional Head of Service or Area Service Manager (SAS)

4.18 Other Health Boards, such as NSS and PHS, which may not be directly represented on these groups should – wherever needed - continually consult with Health Boards on any issues relevant to planning for, responding to, or recovering from an incident. This engagement can be bilateral or multilateral as appropriate.

4.19 It is important that Health Boards, especially those within the same Resilience Partnership area, develop capacity and capability for specific incidents especially those that may have a longer-term impact on service provision, by collaborating with each other. Primary care and other relevant contracted service providers, IJBs, local authorities and voluntary agencies should be involved in these planning processes, as appropriate, so that they are aware of the Health Board's plans and/or its expectations in the event of a major incident.

Legal frameworks, Public Inquiries and Civil Action

4.20 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.

4.21 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.

Section 5
Essential Elements of Emergency Response

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

There are 3 key elements of emergency response: Preparing, Responding, and Recovering. All CCA responders must aid in this process, depending on their roles and functions (e.g. Health Boards will lead response and recovery; IJB functions lend themselves most effectively to strategic planning of health and care services for emergencies, as well as normal business).

Command, Control and Coordination (C3)

5.1 In general, emergencies 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 Health Board area which necessitate a higher level of regional or national Command, Control and Coordination.

5.2 In times of pressure and when responding to emergency 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 (Command, Control, and Co-ordination) is a widely recognised structured approach to incident management under pressure.

5.3 C3 structures have historically been described as Gold (Strategic), Silver (Tactical/Operational oversight) and Bronze (Operational Delivery) commands. Joint Emergency Service Interoperability Programme (JESIP) principles expand on and clarify key elements and should inform the planned structure of any response.

Co-locate: Is the principle of responders using the same location, physical or virtual, to plan a mutual response. In a post-covid world and given the complexity of some incidents requiring multi-agency responses, virtual settings can be used to bring together wide ranges of partners at short notice. This enables an approach which satisfies the CCA-mandated duty to co-operate between agencies with very different remits.

Communicate: Communications should be clear, concise, and accessible, avoiding technical jargon and abbreviations.

Co-ordinate: Co-location and clear communications enable co-ordinated responses between CCA responders, whether on scene, or at a tactical or strategic command group. This minimises the risk of duplicated effort or conflicts of interest.

Jointly understanding risk: In responding in a co-ordinated fashion, jointly understanding risk and shared situational awareness both contribute to and benefit from the joint working enabled by the other JESIP principles above. All organisations identified as Category 1 responders under the CCA should use these principles to fulfil their duties to co-operate in response to major incidents.

The application of simple principles for joint working are particularly important in the early stages of an incident, when clear, robust decisions and actions need to be taken with minimum delay, often in a rapidly changing environment.

CO-LOCATE

Co-locate with other responders as soon as practicably possible at a single, safe and easily identified location.

COMMUNICATE

Communicate using language which is clear, and free from technical jargon and abbreviations.

CO-ORDINATE

Co-ordinate by agreeing the lead organisation. Identify priorities, resources, capabilities and limitations for an effective response, including the timing of further meetings.

JOINTLY UNDERSTAND THE RISK

Jointly understand risk by sharing information about the likelihood and potential impact of threats and hazards, to agree appropriate control measures.

SHARED SITUATIONAL AWARENESS

Establish shared situational awareness by using M/ETHANE and the Joint Decision Model.

Responsibilities

5.4 Category 1 and 2 responders must have pre-determined C3 arrangements in place at all levels to respond effectively and efficiently to a major incident that it can either manage alone, or through support provided as part of a wider multi-agency or national response. Effective C3 arrangements will:

- bring the right people together at the right time, using links with multi-agency response structures
- be adaptive, able to respond to different types of emergencies
- include functional arrangements for making decisions, collecting, and sharing information quickly, accounting for physical and virtual ways of working
- be able to be activated quickly with the necessary personnel, standard operating procedures, and equipment
- have clearly defined roles and decision-making responsibilities for Executive-level Directors, with other staff delegated to assume control of an internal incident or an external one as part of multi-agency strategic command group
- 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 competences for the various roles they are expected to fulfil.

Mutual aid agreements

5.7 Mutual Aid Agreements are an important aspect of emergency preparedness. Health Boards can use these to ensure access to appropriate supplementary and/or specialist resources and support from other health organisations, as stated in NHS (Scotland) Act 1978 s 12J. Health Boards have discretion to tailor the specifics of any mutual aid agreement with any other health provider to promote the best emergency response.

Responsibilities

5.8 The Chief Executive must ensure the organisation has a mutual aid agreement with other Health Boards, responding partners 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 associated governance arrangements. It should be reviewed and revised annually. See sample Mutual Aid Agreement in Appendix 3.

5.9 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 at an agreed point between recipients and providers of mutual aid. This will usually be 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. Chief Executives or their named Deputy

do however have autonomy to agree different thresholds for mutual aid triggers.

5.10 If the incident is likely to be of a longer duration or deemed to require coordination or mutual aid on a larger scale, Scottish Government Resilience Room (SGoRR) may be activated to fulfil a national, strategic coordination function and to ensure that government assistance is provided if required. (See Roles and Responsibilities, Section 6). Major Incidents with Mass Casualties have additional response structures which can be found in Section 7 of this guidance.

5.11 Mutual aid arrangements should be properly accounted for. Any agreed distribution of demand due to a major incident response should documented to allow for a review of activity to clearly understand what should be documented, why, and how, as part of routine post-incident reporting. This may include, for example, accounting for the number of patients moved via business-as-usual processes in response to a major incident.

The Major Incident Plan

5.12 Major Incident Plans are the culmination of risk assessments. They reflect that the organisation understands the impacts that could arise from various types of major incidents or emergencies and is prepared for them. The plan provides the basis for assuring an effective and efficient response.

5.13 Health Boards should have an overview of all emergencies that have occurred in its accountable area, as well as lessons identified from the response to and recovery from those emergencies. These lessons should be shared with other Health Boards, responder organisations and the SGHSCD to enhance collective learning. Precise formats for lessons identified should be flexible to account for the diverse nature of emergencies but always with accessibility in mind.

Planning Responsibilities

5.14 The Major Incident Plan is a key component of preparedness. Health Boards should have, and routinely review these, whether to comply with their CCA responsibilities or as best practice and/or for assurance if they have no CCA-defined duties. The plan should set out how to prepare for, respond to, and recover from various types of major incidents and should:

- have appropriate governance arrangements and set out responsibilities for carrying out the plan
- be consistent with multi-agency working, especially with partners represented within the same Resilience Partnership, 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 (STAC Guidance). (See information on communications at the end of this section)
- reflect the requirements of applicable legislation and guidance such as the Civil Contingencies Act 2004
- have the capability to deal with all the specific incident scenarios and issues identified in this guidance, specifically Section 7, 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, identify lead officer posts (at strategic, tactical, and operational levels), and out line 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) as necessary, and how and when they are to be triggered
- identify resources to be allocated or accessed to deal with various types of incidents in line with defined planning assumptions, as identified during the Health Board's assessment of risks (e.g. impacts, mitigations, contingencies)
- identify the staff requirements and mobilisation arrangements to respond to various incidents and how the impact on normal services will be addressed
- 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
- include an escalation framework for responding to major incidents of varying intensity

5.15 Major Incident Plans should be:

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

5.16 For Category 1 and 2 responders under the CCA, these actions should fulfil the legal duty to maintain effective emergency responses, while remaining advisable for other Health Boards.

Reporting Major Incidents

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

- occurs within a Health Board area
- has been declared by an RP partner that requires the deployment of healthcare resources
- 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(s).

Responsibilities before and during a response

5.19 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 senior leaders should be advised at least annually of the Board's state of preparedness.

5.20 To meet their emergency planning responsibilities, 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 are learned and are incorporated into revisions of plans and protocols
- training/skills records to help inform capability analysis that are kept up to date

5.21 Public bodies from across the health and care services, including acute services, public health, primary and community care, IJBs and HSCPs, should be involved in planning exercises. How these exercises are co-ordinated can be adapted to the best fit for local circumstances; for example, it may be co-ordinated by a Health Board, IJB, or Regional/Local Resilience Partnership. This should also include any contractors providing these services on behalf of a public body, which becomes a legal duty were identified as a responder under the CCA. Health Boards should identify risks specific to their contexts and duties and prepare specific scenarios for exercise in response to these tailored risks.

5.22 Wherever possible and beneficial, Health Boards should collaborate with each other to organise and participate in joint exercises, involving multi-agency partners where practical. The lessons identified from these exercises should be disseminated across the service via appropriate networks (e.g. LRPs/RRPs) as a means of enhancing the collective learning and overall resilience of Health Boards in Scotland.

5.23 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

5.24 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.

5.25 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. Each of the 3 regional resilience partnership areas has a public

communications group which Health Boards are expected to participate in. 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.

5.26 Consulting 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. Media reporting 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. Effective engagement with media organisations should therefore form part of planning.

Communications Responsibilities and Preparations

5.27 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, which are fit for a range of emergency scenarios, requiring swift and reliable access by the staff who need them at short notice, and accompanying protocols for their effective use in emergency situations, are in place
- all staff who may be called on to fulfil a C3 function are suitably trained, experienced, and empowered to use the telecommunications systems in emergency situations
- communications testing exercises take place, with precise frequency to be determined by risk assessment and mitigation practices undertaken by the Health Board
- they work with the Scottish Government, have effective bilateral channels for communicating information to and receiving information from the Scottish Government and relevant responding agencies, whether through standardised on-call numbers, designated in boxes etc.
- they work towards a communications system which is resilient in the event of a major utilities power

5.28 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 (see Section 4 for further information on IEM).

5.29 Health Boards must have a communication plan (see Appendix 4), which is developed in conjunction with the Resilience Partnership 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.

5.30 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
- 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

5.31 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 legislation (see Section 3).

5.32 Use of social media can reach a vast and varied audience in a 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.

5.33 Health Boards with responsibilities for major incident response and whose risk assessment indicates they will need to engage with the public should:

- have access to a suitably equipped and accessible 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
  - 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
- 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

Response

5.34 In relation to the response phase, a 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
- a communications procedure protocol is agreed with multi-agency partners, as far as this is possible, 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 Police Scotland and cleared by the Health Board's Senior Communications Officer
  - » clear and timely messaging is communicated to staff who normally work at the hospitals
- the procedures and standards to be followed at first and subsequent media briefings
- the point at which assistance will be required from communications staff from other Health Boards in the event of a major incident/ emergency and consult with the Scottish Government Directorate for Communications

5.35 Patient confidentiality and staff's right to privacy must be maintained during an emergency. No identifiable information about patients being treated should be released without first checking with Police Scotland and the consultant who is organising their care. Interview or photographs must not be permitted without the consent of the patient concerned.

5.36 Staff who respond to an incident may experience emotional distress and/or work-related stress from working beyond business-as-usual pressures. Health Boards should ensure they have appropriate resources in place to support the wellbeing and mental health of their staff.

Internal Communications

5.37 Internal communications are also important during emergency situations. 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.

High Profile Person visits

5.38 High profile persons will often wish to visit the site of a major incident and/or hospitals involved in the response to it. They may also be admitted to NHS facilities as patients. Health Boards should have a Business-as-Usual protocol for such occasions that has been agreed with key partners.

Recovery

5.39 It is likely that a major incident could last several days, weeks or even months. While local authorities may lead 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 has a key role in assisting the Health Board on such occasions

by acting as a point of contact for disseminating information and/or providing helpline support.

5.40 When planning for emergencies, incidents are split into two distinct phases: response and recovery;

- response is characterised by immediate lifesaving activities using rapidly deployed resources (including the Mass Casualty response)
- recovery concentrates on supporting organisations, individuals, and their communities to make sense of their experiences, heal from injuries and recover from illnesses (including Care for People)

5.41 Health Boards have a role in both and some of their responsibilities during Recovery can include:

- maintaining the Scientific and Technical Advice Cell (STAC) to support decision making
- exploring and responding to the Community Health Impacts of the incident through Community Impact Assessments and the subsequent Joint Strategic Needs Assessments
- developing specialist care pathways to support people whose health (emotional and physical) has been affected
- establishing data collection processes to inform primary and secondary service development and resourcing
- supporting the multi-agency recovery effort with health and care organisations, community organisations and other key partners

5.42 To enable this, it is important to include consideration of the recovery phase when developing reasonable worst-case scenarios and planning assumptions as it is often during this second phase of an incident that the most resources are needed.

5.43 The term ‘recovery’ is often seen differently depending on the individual/agency/community’s role in an incident and for affected individuals and communities, the term ‘recovery’ is often problematic, particularly in incidents when people are still living with the consequences of the emergency.

5.44 Many of the outward facing activities started by the Health Boards during the response phase will need to continue into recovery. For example, maintaining help lines, providing community information, and supporting colleagues involved in responding to the emergency.

Section 6
Roles and Responsibilities

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

Role of the Scottish Government

6.1 The Scottish Government, although not a CCA 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
- **Response/Recovery:** creating the conditions to support Category 1 and 2 responders and other non-designated 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 government coordination or support, 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. This may include supporting Health Boards in their CCA-mandated duties, including on informing and advising the public through media engagement.

6.3 During a SGoRR activation, Health Boards should submit Situation Reports (SitRep) to SG Health and Social Care Directorates (HSCD) via Health EPRR. 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 During incident response and/or a SGoRR activation, HSCD role includes:

- providing strategic direction for the NHS in Scotland and the particular Health Board(s) involved and ensure that all other Health Boards are prepared to support if necessary

- advising and supporting the Scottish Ministers with responsibility for health and social care, NHS Chief Executive, NHS Chief Operating Officer, and other senior officials
- maintaining an up-to-date overview of national critical care capacity
- assessing, in consultation with the Board, the impact of the incident on the Board's scheduled work and any national impacts and determine any action that needs to be taken, including mutual aid from other UK nations or specialists
- maximising available communication channels at national and local levels

Health Board responsibilities

6.5 The following actions should be taken by a Health Board when the consequences of a major incident require 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
- 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, among other functions, monitor the impact of the emergency situation as '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 mutual aid from other Health Boards to maintain scheduled appointments and TTG.

6.9 In exceptional circumstances a request for the suspension of applicable regulations may be made to SGHSCD (utilising national governance structures) in the first instance, if it is clear that all reasonable interventions have been taken by the Health Board to help manage the incident.

6.10 The SGHSCD has measures in place to process such requests which require approval by Scottish Ministers.

6.11 Once operational pressures linked to the management of the major incident have receded, SGHSCD will continue to support the Health Board to restore service levels as quickly as possible.

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. While this document remains strategic in scope, resources, and guidance for incidents with unique challenges are included here.

Communicable diseases

7.1 Increased international movement of people, animals, and goods in to and out of Scotland increases the exposure of the population to novel infections and diseases. The COVID-19 pandemic showed how easily an infectious disease can affect the entire world. Dealing with both imported high consequence infectious diseases (HCID) and more routine endemic infections and outbreaks requires constant vigilance and coordinated public health control measures. These factors, together with large-scale public/crowd events, combine to potentially heighten the risk of communicable infectious disease transmission events of varying type, scale, and impact in Scotland.

7.2 Health Boards have processes in place to deal with disease and infections, including those which may not have been previously recognised in a Territorial Health Board area.

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), infectiousness, virulence, and the availability of appropriate healthcare and/or preventative facilities. An important factor is the health status of the susceptible population, with a healthy, well-nourished, well-educated population less susceptible to outbreaks of infectious disease. The environment also plays an important role with hygienic (uncrowded) living conditions, clean environments at home and in healthcare and sufficient resources/facilities to support provision of healthcare reducing likelihood of outbreaks. These and other factors should be considered when planning an appropriate response to the particular condition.

7.4 Most infections requiring healthcare intervention are dealt with by primary care, with secondary care dealing with the more severe infections caused by organisms that may be more virulent and less common.

The identification of infection

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

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 Public Health Scotland no later than 10 days after identification, or sooner if the case is considered urgent. 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 or Consultant in Public Health if they identify a situation that suggests a health risk state. In addition, there is a requirement for identification and notification of 'health risk states' (which are defined as (a) a highly pathogenic infection; or (b) any contamination, poison or other hazard which is a significant risk to public health).

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

Responsibilities

7.8 Territorial Health Boards are responsible for public health protection, including surveillance, prevention, detection, treatment, and control of communicable diseases. They have a shared duty with local authorities and other national agencies (e.g. Public Health Scotland, and the Care Inspectorate) to support implementation of adequate standards 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 specific 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 Resilience Partnership. In such instances, the resilience partnership may request the local Health Board to convene and chair a Scientific and Technical Advice Cell (STAC Guidance). If so, the Health Board will retain responsibility for the investigation and management of the public health aspects of the incident, in line with Management of Public Health Incidents guidance, irrespective of a resilience partnership-led response.

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

- the Territorial Health Board has a range of up-to-date plans (e.g. Business Continuity Plans, Incident/ Outbreak Control Plans etc.) and protocols that reflect national guidance and the requirements. 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
  - document the outbreak including its major epidemiological characteristics and causes
  - report on the outbreak
- the plans should be flexible enough to cope with the actual or potential incident 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 symptom surveillance 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) into Public Health Scotland (PHS) for national surveillance purposes
  - communicating effectively and timeously with other Health Boards
  - debriefing following an incident and providing a lessons-identified report
- the Public Health Department has the necessary resources (including administrative support) available to simultaneously convene and lead a STAC, out of hours and over a sustained period if required 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 National Infection Prevention and Control Manual (NIPCM) 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
- local plans and protocols are regularly exercised with multi-agency partners where appropriate to develop expertise and establish the necessary team working arrangements. Local plans should be reviewed and updated on a regular basis considering these revised guidelines

7.12 PHS's responsibility will be to work in partnership with others (including the Health Board Public Health Protection Teams), to protect the Scottish public from being exposed to hazards which damage their health and to limit any impact on health when such exposures cannot be avoided. This will include (among other responsibilities), monitoring the hazards and exposures affecting the people of Scotland and the impact they have on their health, coordinating national health protection activity and facilitating the effective response to outbreaks and incidents.

7.13 This may result in PHS assuming responsibility for leading the overall management of the incident on behalf of an NHS Board/SGHSCD, coordinating surveillance, investigation, risk assessment and management, and risk communication.

Communication

7.14 As with all major incidents, internal and external communication is important. The issues to consider are covered in Section 5 of this guidance.

Hazardous Materials (Hazmat)/ Chemical, Biological, Radiological, Nuclear (CBRN)

7.15 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 accidental release of Hazmat or CBRN materials or because of 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.

7.16 PHS and the UK Health Security Agency (UKHSA) Radiation, Chemical, and Environmental (RCE) hazards directorate have a role in providing advice and information to health professionals and first responder organisations during such incidents. In particular, UKHSA RCE have lead national responsibility for providing advice and support in respect of radiation and nuclear incidents.

7.17 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 Management of Public Health Incidents guidance.

7.18 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

Chemical incidents

7.19 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, such as weather information from the Met Office, TOXBASE, the poisons information database for clinical toxicology advice, or the Scottish Health Protection Information Resource (SHPIR), to support planning for chemical incidents. Some of these sources may not be publicly accessible and responsible officers may need to ensure they can be accessed when needed.

Biological incidents

7.20 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
- biological material dispersed may be deposited on clothing, equipment, and other surfaces; and when these are disturbed, secondary dispersal can occur

7.21 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 like the existing smallpox response plans.

Radiological and nuclear incidents

7.22 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 may result from accidental leaks at nuclear sites or malicious acts with potentially widespread effects including 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.

7.23 UKHSA have lead national responsibility for providing advice and support in respect of radiation and nuclear incidents, with additional incident management and support provided by Territorial Board Health Protection Teams and PHS.

Responsibilities

7.24 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.

7.25 Category 1 responders should ensure that:

- a strategic lead is responsible for ensuring that Hazmat/CBRN incident plans are in place and kept up to date
- 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 cross Health Board boundaries and may require a variety of agencies to investigate and respond to them
- appropriate arrangements for risk assessment, risk management and risk communication are in place
- appropriate equipment, including Personal Protective Equipment (PPE) and facilities are available to support the plan, including provisions for compliance with Health and Safety requirements
- there are effective systems to enable primary care services to notify Public Health Departments and vice-versa of specified organisms, specified diseases, exposure to hazards 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/Hazmat incident
- staff have access to the relevant resources, advice and expertise required to provide care and treatment for casualties, including arrangements for decontamination of patients and distribution and administration of appropriate pharmaceutical supplies
- plans are regularly exercised and reviewed with multi-agency partners, including multi-agency training where needed (see Section 5)
- they develop plans for recovery to enable return to normal as soon as possible

7.26 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 Resilience Partnerships on human health, risk management strategies, countermeasures, and longer-term health monitoring
- advise SAS and other first responders, other public bodies, the public and the media about effects of the incident on human health, and of countermeasures to those effects

7.27 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 roles and responsibilities, and be capable of responding to an incident, when required
- consider actions 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 and other partners in the implementation of pre-negotiated arrangements for Radiation Monitoring Units (RMU) 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
- 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 in planning for and responding to a radiological or nuclear incident is outlined in Appendix 6.

Decontamination

7.28 Decontamination is not an automatic or inevitable response to a Hazmat or 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) to contaminated individuals arriving independently by personal transport, and also consider scenarios where mutual aid may need to be deployed.

7.29 Territorial Health Boards should have a plan in place to facilitate the lockdown of areas in the hospital, or the entire hospital, if necessary, to

prevent cross-contamination. This should be in accordance with national lockdown guidance.

7.30 To comply with the Health and Safety duty to protect staff and members of the public from risk to health, Health Boards must comply with the Provision and Use of Work Equipment Regulations 1998 (PUWER) regulations. By doing so this will mean that you must:

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

The needs of children and young people

7.31 Health Boards should recognise the potential for children and/or young people to be among those affected in a Hazmat/CBRN and plan accordingly, considering their vulnerability and the need to keep families together and/or children with their carers.

7.32 Consideration should be given to the special requirements of children and young people 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

7.33 The type, scale, and impact of a Hazmat/CBRN incident will 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.

7.34 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 by Government.

7.35 Hazmat/CBRN incidents present non-clinical challenges including the need for mutual aid and public communication, and 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.

7.36 Health Boards with Category 1 responder status under the CCA (2004) should identify relevant procedures and resources to address the unique and potentially complex issues in the aftermath of a CBRN incident. The plan should ensure that healthcare facilities return to normal operations, following decontamination, in line with relevant guidance on Recovering from Emergencies.

Management of burn-injured patients

7.37 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.

7.38 In contrast to many other injuries arising from a major incident, what may appear to be a 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.

Incident-specific Responsibilities

7.39 The management of burn-injured patients in the event of a major incident should be coordinated through the Scottish National Burns Centre and utilise the Care of Burns in Scotland (CoBIS) Managed Clinical Network's operational plan. Territorial Health Boards should ensure that arrangements:

- identify escalation triggers and responses
- are integrated and consistent with their Major Incident Plan
- take account of relevant legislation and guidance
- are consistent with local C3 structure and arrangements
- are appropriately and widely supported

7.40 The arrangements to transfer and move burns patients should be coordinated with:

- the Scottish National Burns Centre
- the Scottish Ambulance Service (SAS); and if necessary
- the National Burns Bed Bureau if transfers to England or Wales are required

In setting out their arrangements, Health Boards should aim to avoid secondary transfers by consulting and identifying suitable destinations for patients.

7.41 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 a Burns Centre

7.42 The Scottish National Burns Centre is located in NHS Greater Glasgow and Clyde. This Health Board should consider what constitutes a burns 'major incident' both locally and nationally as they will be expected to help manage patients from any major incidents occurring anywhere in Scotland. This information should be used as the basis for establishing triggers and escalation arrangements.

Territorial Health Boards with Burns Services

7.43 Health Boards with Burns Facilities (NHS Grampian and NHS Tayside) or a Burns Unit (NHS Lothian) service 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. They will be expected to consult with the Scottish National Burns Centre where casualty numbers exceed local capacity.

Territorial Health Boards without Burns Services

7.44 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 and provide treatment and care in an Intensive Treatment Unit where clinically appropriate. Where injuries are severe or access to specialists is required, these Boards should transfer them to an appropriate burns facility or centre. Plans should set out arrangements for access to specialist and burns services in Scotland.

Scottish Ambulance Service (SAS)

7.45 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)

7.46 Territorial Health Boards and SAS should:

- ensure that relevant personnel are aware of the role of CoBIS and raise awareness of this specialist network
- consider CoBIS plans, incorporating where needed the National Burns Centre in Glasgow, 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. In this situation, escalation plans will include the National Burn Bed Bureau to plan appropriate patient destinations.
- 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
- include the Scottish National Blood Transfusion Service in relevant communications, as skin tissue is also part of their service provision

Major Incidents with Mass Casualties

7.47 A MIMC for the NHS is defined as: 'An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage'.

7.48 Category 1 and 2 responder Health Boards play a significant role in the multi-agency response to incidents resulting in mass casualties. The National Plan for Major Incidents with Mass Casualties outlines how Health Boards, Health and Social Care Partnerships and Scottish Government will work together at strategic and operational levels to deliver an effective response to major incidents which result in a large number of adult and/or child casualties.

7.49 Owing to the complexities and challenges involved in preparing for mass casualties, the local Major Incident with Mass Casualties (MIMC) plans should be regularly reviewed and exercised in line with guidance on

other specific topics outlined elsewhere in this document.

7.50 Such incidents could 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.

7.51 Several smaller scale Incidents may combine, occur in quick succession to become larger, or be geographically diverse. This can require a MIMC response to be triggered due to the large volume of simultaneous casualties and the potential impact on one or more NHS Boards. For these reasons, the term MIMC is used throughout the National Plan.

7.52 The principles underlining the MIMC Plan are as follows:

- health boards will respond to a MIMC with a collaborative, unified and integrated approach, in conjunction with HSCPs
- there will be a consistent and standardised approach to a MIMC across statutory health and social care services in Scotland
- there will be a 'whole system' response to the treatment and care needs of patients following a MIMC, to secure the best possible outcomes for them
- the needs of children and adults are equally and appropriately addressed
- there will be a holistic approach that addresses patients' physical and psychological care needs
- there will be partnership working with other responders, statutory and third sector services in accordance with Integrated Emergency Management
- Scottish Government and the responding Territorial Boards and HSCPs will work together to support a return to business as usual as soon as possible

Declaring a Major Incident with Mass Casualties

7.53 Any Category 1 Health Board may declare a MIMC. In exceptional circumstances, a Category 2 Health Board may make the declaration, but this will be rare in practice. As a 'blue light'/first responder, the Scottish Ambulance Service (SAS) will usually make the declaration. If the organisation declaring is not SAS, they should immediately advise Ambulance Control Centre to cascade declaration of a MIMC to neighbouring Health Boards.

7.54 A MIMC should be declared by the Health Board Chief Executive or named Deputy based on a combination of factors. These include the 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 resilience partnership 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).

7.55 Any arrangements for restricting access to NHS services due to a MIMC 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.

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

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

MIMC Responsibilities

7.57 The National MIMC plan requires NHS Boards to:

- minimise/mitigate the impact of a MIMC on its normal pattern of service provision
- identify and prepare an adequate level of resources on a stepped basis to respond effectively to a MIMC
- outline the arrangements required to support the organisation during a MIMC, 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.
- prioritise and coordinate resources to maintain optimal healthcare during the MIMC period

Activation

7.58 Within the first 2 hours of the declaration of MIMC, a Strategic Health Group (SHG) should be convened with the membership comprising of:

- the Chief Executives of all NHS Boards
- the Chief Operating Officer, NHS Scotland (previously titled Director of Performance and Delivery)
- a Senior Communications Manager
- a HSCP Chief Officer
- a representative from the Scottish Government Health Emergency Preparedness, Resilience & Response Division

Lockdown

7.59 Depending on the nature of the incident, 'lockdown' may be appropriate 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 that staff are familiar with these arrangements.

Mass Fatalities

7.60 Health Boards have an important role to play in working with other agencies through Resilience Partnerships to plan for an effective response when a major incident results in mass fatalities.

7.61 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 the following national policy on dealing with mass fatalities: Guidance on dealing with mass fatalities in Scotland

7.62 The duties of Territorial Health Boards in such circumstances are outlined in the Public Health (Scotland) Act 2008. 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.

Responsibilities

7.63 By definition, mass fatality situations are likely to require the re-prioritisation 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.

7.64 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 resilience partnership
- 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 critical services that will be affected. Key stakeholders should be informed of these arrangements.
- collaborate with local authorities to plan for the provision of an adequate level of mortuary facilities in the local area
- 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 additional mortuary facilities, including away from the Board's own.
- be aware of, and where necessary contribute to, local planning by death certification providers for service continuity during mass fatality incidents to avoid delays to the respectful handling of the dead 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
- develop and exercise plans using reasonable worst-case scenarios and ensure that the relevant staff participate
- maintain up-to-date pandemic 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, defined as 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
- deaf, blind or have visual or hearing impairment

In conducting their risk assessments to comply with preparedness standards in the CCA (2004), Health Boards should consider other groups less able to help themselves in specific emergencies and develop response plans accordingly to account for their additional needs. They may wish to account for specific groups identified in the Equality Act (2010) in these preparations.

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
- 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
- determine/estimate the scale and requirements of vulnerable people in advance of an emergency

8.3 To be prepared to act without delay during a major incident or in an emergency situation, Category 1 responder Health Boards should:

- work with partners on the LRP and RRP Care for People Teams to identify and agree people and/or communities who may be vulnerable

during different types of major incidents, with further information available in the relevant guidance on Preparing Scotland: Care for People Affected by Emergencies

- 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 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 2018 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
- 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, in consultation with social care specialists where needed (e.g. IJBs) to enable a quick response in the interests of vulnerable people during emergency situations.

8.5 All lists produced should be treated in line with relevant Government Security Classifications and data protection requirements and be accessible out-of-hours.

8.6 In preparing their Major Incident Plans, Territorial Health Boards:

- must consider the needs of vulnerable children, vulnerable adults, and 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
- should ensure they can access a pool of staff or appropriately accredited volunteers to provide additional support or special assistance to people with disabilities, in support of the emergency services effort

Infants, 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. The needs of babies and toddlers should receive particular consideration, given that they may be almost entirely unable to help themselves in an emergency, especially where their parents are incapacitated.

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. The larger children's hospitals maintain Emergency Departments that are operationally independent from adult services. Adjacent adult Emergency Departments consequently may have limited routine practice in the management of seriously ill or injured children.

8.9 This guidance is based on the principle that local hospitals will 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 aid, or who may need to receive patients for ongoing specialist care.
- arrangements to provide a paediatric intensive care support at the local hospital and transport services to transfer intensive care patients, using digital or in-person solutions as appropriate
- considered the special feeding needs of babies, potentially including the provision of specialised feeding equipment to ensure that vital nutrition is maintained during any emergency response
- 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 to support effective collaboration between community or rural general hospitals and supporting paediatric inpatient units
- 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

Children's rights and child protection issues

8.12 The Health Board's Major Incident Plan and emergency planning arrangements should reflect the specific requirements to maintain both children's rights, such as the need to keep children with their parents, and child protection standards.

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

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

8.15 Health Boards should consider what arrangements may be required to provide appropriate discharge, follow-up, and ongoing support for children and families involved in major incidents, which will involve co-ordination by acute services and mental health services where appropriate.

Psychosocial, spiritual and mental health care

8.16 Most 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 support and this principle is the core component of all humanitarian aid, social welfare, and healthcare responses to disasters.

8.17 Comprehensive responses to major incidents require key public services 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.

8.18 Both Category 1 and 2 responder Health Boards should consider the Care for People Affected by Emergencies guidance, Spiritual Care framework, National Trauma Training Programme and any relevant local arrangements.

Responsibilities

8.19 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. The plans:

- should identify mental health specialists with particular skills and the key healthcare services that will form the Board's response and provide advice to the Resilience Partnerships 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 the Human Rights Act 1998 and Equality Act 2010
- must be consistent with actions to be taken in response to mass casualties and mass fatalities incidents
- should identify flexible arrangements for Child and Adolescent Mental Health Services to be up scaled at short notice, alongside other children and young people's services operated by other public services in a crisis, to address the psychological needs of children and young people who experience trauma following a major incident

8.20 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).

8.21 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 among 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
- ensuring that appropriate staff participate in exercises to test the local Care for People Plan

8.22 In collaboration with the local Care for People Team and IJBs wherever appropriate, 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. Pre-defined and tested arrangements should be in place to quickly draw an understanding of, and information about, such people held by partner agencies. Health Boards should also promote and/or advise partner agencies on how to access Psychological First Aid training.

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

8.24 While recovery is out with the remit of this guidance, care for vulnerable people during an incident can place additional strains on services long after a major incident has concluded. Business Continuity Management principles help account for long-term pressures arising from major incidents.

Spiritual Care (Patients and Staff)

8.25 Spiritual Care Teams have a significant contribution to make to patient care and support during, and following, a major incident, or disruption of service delivery. It is good practice to ensure that Spiritual Care Teams are integral in planning for, and responding, to such events and incidents.

8.26 To enhance the provision of spiritual care available to staff, it is good practice to include Spiritual Care Teams in the planning and delivery of services which aim to support staff wellbeing. In particular, Occupational Health Services, Human Resource Departments and Spiritual Care Teams should work together to provide a coordinated response and develop an agreed pathway to ensure collaboration services and prevent duplication.

8.27 The following guidance may be useful in planning for provision for spiritual care. Discovering meaning, purpose and hope through person centred wellbeing and spiritual care: framework

Appendices and useful information

Appendix 1	Members of the Short Life Working Group
Appendix 2	Business Continuity Management
Appendix 3	Sample Mutual Aid agreement
Appendix 4	Developing an emergency communication strategy
Appendix 5	Managing public health incidents resources
Appendix 6	Roles of organisations in planning for and responding to a radiological or nuclear incident
Appendix 7	Information to assist planning for a major incident with mass casualties (MIMC)
Appendix 8	Psychological First Aid (PFA)
Appendix 9	Additional Information
Appendix 10	Glossary of Terms

Appendix 1

Members of the Short Life Working Group

Member	Designation	Representing
Calum Campbell (Co-Chair)	Chief Executive	NHS Lothian
Chris Taylor (Co-Chair)	Head of Delivery & Assurance Unit, Health EPRR	Scottish Government: Directorate for Chief Operating Officer, NHS Scotland
Katie Bryant	Head of Clinical Risk & Governance	Golden Jubilee National Hospital
Nicola Watt	Emergency Planning and Resilience Manager	NHS Forth Valley
Eddie Graham	Head of Civil Contingencies	NHS Grampian
Sally Johnston	Head of Civil Contingencies Planning Unit	NHS Greater Glasgow & Clyde
Kate Cochrane	Head of Resilience	NHS Highland
Caroline McDermott	Head of Planning	NHS National Services Scotland
Aaron Dawson	Emergency Planning and Resilience Manager	NHS Western Isles
Stuart Allan	Emergency Preparedness Officer	Public Health Scotland
Craig Hunter	Head of Strategic Operations & Resilience	Scottish Ambulance Service
Kirsty McRae	Resilience Advisor	Scottish Ambulance Service
Adam Locke	Senior Resilience Officer Health EPRR	Scottish Government: Directorate for Chief Operating Officer, NHS Scotland
Jake Grierson	Resilience Officer Health EPRR	Scottish Government: Directorate for Chief Operating Officer, NHS Scotland

Appendix 2

Business Continuity Management

Business Continuity Management (BCM) gives organisations a framework for identifying and managing risks that could disrupt or halt day to day services. It is an essential tool in establishing any organisation's resilience. An organisation's BCM System will help the organisation to anticipate, prepare for, prevent, respond to, and recover from a range of disruptive events, regardless of the cause or which part of the business is impacted.

The Civil Contingencies Act (CCA) 2004 stablished legislative framework for civil protection within the UK. The Civil Contingencies Act (Contingency Planning) (Scotland) Regulations 2005 describe how the provisions of the Act apply in Scotland. Both place clear obligations on Category 1 & 2 listed responder organisations, in relation to assessing, preparing, and responding to disruptive challenges.

There is a need to ensure that all Health Boards within NHS Scotland, together with those providers who supply a critical service to NHS Scotland (e.g. GP practices, dental practices, pharmacies, etc), are sufficiently resilient to respond to any threat or disruption.[2] Consequently, there needs to be a robust system in place within all organisations to plan, test and exercise, and review their response against a range of disruptive challenges.[3] **Business Continuity Management (BCM) is an essential component of this resilience and a requirement of the Civil Contingencies Act 2004.**

BCM principles that Health Boards and their key partners/contracted services should work to include:

- Improve BCM organisational resilience within each Health Board
- Ensure through the adoption of resilience principles that we have continuous operational delivery of critical healthcare services when faced with a range of disruptive challenges e.g. staff shortages, denial of access, failures in technology, loss of utility services, or failure of key suppliers
- Help drive NHS Scotland's compliance with the Civil Contingencies Act 2004
- Promote a unified and cohesive approach to BCM which replicates the most up-to-date standards, such as ISO 22301 and ISO 22313

2 Standard 7: The NHS Board shall have an overarching Business Continuity (BC) policy and a robust BC Management process. – NHS Scotland: Standards for Organisational Resilience. Second Edition. May 2018

3 Standard 12: The NHS Boards shall have a training and exercising plan in place to test its state of preparedness and to inform its response capability. – NHS Scotland: Standards for Organisational Resilience: Second Edition: May 2018

Appendix 3

Sample mutual aid agreement

NHS BOARDS MUTUAL AID AGREEMENT

Introduction

To comply with the Civil Contingencies Act 2004, NHS Boards must plan for mutual support and cooperation. The Act's accompanying regulations define mutual aid as an agreement between organisations within the same sector and across boundaries to aid and additional resources during an emergency.

It is recognised that major incidents can quickly stretch individual Health Boards' capacity and as such cross-territory mutual aid arrangements have been agreed between the NHS Boards within the (TBC) Emergency Coordination Group namely NHS Board A, NHS Board B etc.

These arrangements allow for the provision of the following resources:

Initial Emergency Phase

- Medical Incident Officers and Site Medical Teams (normally SAS)
- Receiving Hospitals
- Support Hospitals
- Specialist services e.g. burns units

Recovery Phase

- Staff to support the operation of an Incident Management Team
- Staff to support the operation of a Scientific & Technical Advice Cell (STAC)
- Other staff, resources or services that are required to respond effectively to a major incident

Overall Management and Initial Response

The responsibility for provision of initial responders and the management of loaned resources rests with the NHS Board in whose area the incident occurs. This response is to be in accordance with the NHS Board's Major Incident/ Emergency Plan.

The NHS Board in whose area the incident has occurred will:

- request an adjacent Board to provide due to operational demands of the incident, or
- request the attendance of the Emergency Medical Retrieval Service

Pre-hospital Medical Care (PHMC) is provided by SAS via a variety of different teams nationally. Activation of all PHMC Teams is through the SAS West Ambulance Control Centre.

Requests for mutual aid

Initial Emergency Phase

Although the decision to request mutual aid rests with the Chief Executive, or a delegated officer, it is recognised that an extension of routine practices will reduce delay in the initial phase of a response. As such, the Medical Incident Officer should make initial requests for shared resources through the Scottish Ambulance Service Strategic Operations Manager.

Consolidation and Recovery Phase

During the later stages of a response mutual aid will be arranged by appropriate senior managers within Boards contacting their counterparts directly.

Transport

The Scottish Ambulance Service will be responsible for all transport arrangements which should be by the most expeditious means, including by air, and in accordance with normal Scottish Ambulance Service protocols.

Clothing and medical equipment

All medical teams and Medical Incident Officers will wear agreed Red/Saturn Yellow PPE to current specifications. Medical equipment should be compatible between NHS Boards and with that of the Scottish Ambulance Service.

Non-Emergency Coordination Group

Although this agreement is between the NHS Boards that operate within the (TBC) Emergency Coordination Group, it does not preclude the provision or receipt of mutual aid with neighbouring Boards in other Local/Regional Resilience Partnership areas.

Provision of Mutual Aid

Although this agreement is not legally binding it is entered into in a spirit of cooperation and as such Boards will make every reasonable effort to comply with a request within the constraints of their own prevailing capabilities and commitments.

Agreement

This agreement is effective from (date) and shall be reviewed at least once every 2 years to ensure it continues to meet the requirements of the NHS Boards involved.

[Insert Signatories/Date]

Appendix 4

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. Also consider 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 to protect sensitive information.
4.	Choose 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 reviews take place to enable any changes in message/method to be incorporated.

Appendix 5

Managing Public Health Incident 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', Public Health Scotland, (Interim Update 2020)

Compendium of Healthcare Associated Infection (HAI) Guidance

The Scottish Waterborne Hazard Plan (information available for Public Health Protection Teams via the Scottish Health Protection Information Resource: SHPIR)

Scotland's emergency air pollution response service, the Airborne hazards emergency response (AHER) service, led by SEPA

'Dealing with Assertions of Human Health Risks or Effects from Environmental Exposures: A Systematic Approach', Scottish Centre for Infection and Environmental Health, 2000

'Guidance on the management of outbreaks of foodborne illness in Scotland. A supplementary guide to the management of public health incidents' is due to be published in Autumn 2023

'The Health and Social Care Influenza Pandemic Preparedness and Response', Department of Health 2012

'The UK Influenza Pandemic Preparedness Strategy', Department of Health, 2011

'Management of Viral Haemorrhagic Fevers and Similar Human Infectious Diseases of High Consequence', Advisory Committee on Dangerous Pathogens, 2015

'Communicating With the Public About Public Health Risks', Health Protection Scotland, 2008

'Bloodborne Viruses: Managing Severe Penetrating Injuries: for managing risk of BBVs like hepatitis B, hepatitis C and HIV', Public Health England, 2017

'Bloodborne Viruses: Managing Risk in Bomb Blast Victims: Guidance on managing risk of BBVs, such as hepatitis B, hepatitis C and HIV', Public Health England, 2017

'Scotland's national respiratory surveillance plan' Public Health Scotland, 2022

'Plan for monitoring and responding to new SARS-CoV-2 variants and mutations (VAMs)', Public Health Scotland, 2022

'Recognise and respond to chemical, biological, radiological and nuclear (CBRN) incidents: guidance for healthcare professionals', Public Health England, 2018

Appendix 6

Roles of organisations in planning for and responding to a radiological or nuclear incident

National Nuclear Emergency Planning and Response Guidance

This guidance assists local and national organisations in planning for and responding to nuclear emergencies.

Nuclear site-specific emergency plans

Operators of nuclear licenced sites which have the potential to cause an off-site nuclear emergency are legally required under the Radiation (Emergency Preparedness and Public Information) Regulations 2019 (REPPR19), to work with the Local Authority to fulfil their duty to produce an off-site emergency plan.

This plan must include what initial advice is issued to the public in the event of an off-site nuclear emergency and what arrangements are in place to coordinate the provision of further advice, based on information about the emergency, such as monitoring data. This coordination of scientific advice is normally provided by a Scientific and Technical Advice Cell (STAC) in support of a Strategic Coordination Group chaired by the police. For more information see REPPIR19.

National Arrangements for Incidents involving Radioactivity (NAIR)

NAIR is coordinated across all 4 UK nations by the UK Health Security Agency (UKHSA) and provides access to radiation protection advice at the scene of an incident which involves, or is suspected to involve, radiation; where members of the public may be at risk; and where no other radiation expert is otherwise available. It is not intended to fulfil the requirements of users of radioactive material to have plans in place for the transport of radioactive material but can be called upon if plans cannot be put into action. It is also not intended for use for response to malicious incidents involving radiation or nuclear site emergencies.

NAIR can be activated by the emergency services by contacting the UKHSA RCE Radiation On-Call Officer on 01235 834590 (24/7). For more information see NAIR.

Emergency Reference Levels/Protective Action Advice

Planning for a radiation emergency includes deciding on what areas would be affected, to what extent and what the public should do to protect themselves. Underpinning these decisions are the Emergency Reference Levels (ERLs). For each protective action (sheltering, evacuation, stable iodine*) there is a lower and an upper ERL which is expressed as the amount of radiation dose that is needed to be averted by the protective action in order to justify the action.

All protective actions carry a risk, which must be balanced against the risk from the exposure to radiation. When planning for an emergency, it is the norm to use the lower ERL to determine the distance out to which a protective action is required, the lower ERL maximises this distance. If the emergency is more impacting than that which was planned for, any additional distance for protective actions would be initially based on the upper ERL and then re-assessed based on the circumstances faced by responders. ERLs are advised by the UK Health Security Agency (UKHSA).

For more information see 'Public Health Protection in Radiation Emergencies'.

*Stable iodine is only used as a protective action in the event of an emergency involving an operational, or recently (within 90 days) shutdown nuclear reactor.

The Transportation of Defence Nuclear Material

The 'Local Authority and emergency services information' (LAESI) document provides information for the emergency services, local authorities and health authorities on contingency arrangements to be implemented in the unlikely event of an emergency during the transportation of 'defence nuclear material'.

Appendix 7

Information to assist planning for a Major Incident with Mass Casualties (MIMC)

The levels of response for adults and children that need to be planned for are:

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 • Normal activity not possible at local Board level • Normal activity being maintained in Burns Service	• Contact neighbouring Boards • Contact relevant Scottish National Burns Centre 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 Health EPRR
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 Burns 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 Health EPRR
5. Critical	• Combined resources of burns care capacity and capability in Scotland being fully utilised to deal with casualties from incident • Consideration given to transfer patients out with NHS Scotland	• Notify National Burn Bed Bureau • Notify Board on-call Executive and Board Emergency Planning Lead • Contact Scottish Government Health EPRR for support
6. Capacity Exceeded	• Combined Scottish & 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 SG Health EPRR

Appendix 8

Psychological First Aid (PFA)

The various components of effective PFA[4, 5] are set out below.

However, there is no order to follow, as this 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:
  - recognise the range of reactions
  - respect and validate the normality of the post-trauma reaction
- facilitate reunion with loved ones where possible and/or connection with social supports
- provide information on coping and accessing additional support

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

5 Psychological First Aid Field Operations Guide (2nd Edition). National Child Traumatic Stress Network & National Center for PTSD (2006) Downloadable from: Psychological First Aid Field Operations Guide without Appendices (va.gov)

Appendix 9

Additional useful information

Links and Legislation Table

Text Displayed	Link
Airborne hazards emergency response (AHER) service (SEPA)	https://www.sepa.org.uk/environment/air/airborne-hazards-emergency-response-service/
Bloodborne Viruses: Managing Risk in Bomb Blast Victims: Guidance on managing risk of BBVs, such as hepatitis B, hepatitis C and HIV	https://www.gov.uk/government/publications/bloodborne-virus-managing-risk-in-bomb-blast-victims
Bloodborne Viruses: Managing Severe Penetrating Injuries: for managing risk of BBVs	https://www.gov.uk/government/publications/bloodborne-viruses-managing-severe-serial-penetrating-injuries
Business and Regulatory Impact Assessment	https://www.gov.scot/publications/business-regulatory-impact-assessment-toolkit/
C3 (Command, Control, and Co-ordination)	https://ready.scot/how-scotland-prepares/preparing-scotland-guidance/responding-emergencies/response
Caldicott Guardians	https://www.gov.scot/publications/nhsscotland-caldicott-guardians-principles-practice/pages/4/
Care of Burns in Scotland (CoBIS)	https://www.cobis.scot.nhs.uk/
Care for People Affected by Emergencies	https://ready.scot/how-scotland-prepares/preparing-scotland-guidance/care-people-affected-emergencies
Child Rights and Wellbeing impact assessments (CRWIA)	https://www.gov.scot/policies/human-rights/childrens-rights/
Civil Contingencies Act 2004	https://ready.scot/how-scotland-prepares/risk-assessments-and-legislation

Text Displayed	Link
Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2021 (S.S.I. 2021/147).	https://www.legislation.gov.uk/ssi/2021/147/contents/made
The Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005	https://www.legislation.gov.uk/ssi/2005/494/contents/made
Communicating With the Public About Public Health Risks	https://www.hps.scot.nhs.uk/web-resources-container/communicating-with-the-public-about-health-risks/
Community Risk Registers	https://ready.scot/how-scotland-prepares/preparing-scotland-guidance/purpose-regional-resilience-partnerships-risk/community-risk-register
Compendium of Healthcare Associated Infection (HAI) Guidance	https://www.nipcm.hps.scot.nhs.uk/resources/hai-compendium/
Data Protection Act 2018	https://www.gov.uk/data-protection
Data Protection assessments	https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/accountability-and-governance/guide-to-accountability-and-governance/accountability-and-governance/data-protection-impact-assessments/
Dealing with Assertions of Human Health Risks or Effects from Environmental Exposures: A Systematic Approach	https://www.hps.scot.nhs.uk/web-resources-container/dealing-with-assertions-of-human-health-risks-or-effects-from-environmental-exposures-a-systematic-approach/
Emergency Medical Retrieval Service	https://www.emrsscotland.org/
Equality Impact Assessments (EQIAs)	https://www.equalityhumanrights.com/en/publication-download/assessing-impact-and-public-sector-equality-duty-guide-public-authorities
Equal Opportunities	https://www.gov.scot/publications/scottish-governments-equality-duties/
Equality Act 2010	https://www.legislation.gov.uk/ukpga/2010/15/contents
Fairer Scotland Duty Assessment	https://www.gov.scot/publications/fairer-scotland-duty-guidance-public-bodies/pages/1/

Text Displayed	Link
Government Security Classifications	https://www.gov.uk/government/publications/government-security-classifications
Guidance on dealing with mass fatalities in Scotland	https://www.nss.nhs.scot/publications/lockdown-guidance-shfn-03-04/
The Health and Social Care Influenza Pandemic Preparedness and Response (2012)	https://www.gov.uk/government/publications/health-and-social-care-response-to-flu-pandemics
Health and Safety duty	http://www.legislation.gov.uk/ukpga/1974/37
Human Rights Act 1998	https://www.legislation.gov.uk/ukpga/1998/42/contents
Human Rights in Policy making assessments	https://www.gov.scot/policies/human-rights/
Identifying people who are vulnerable in a crisis: guidance for emergency planners and responders	https://www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders
Integrated Emergency Management	https://ready.scot/how-scotland-prepares/preparing-scotland-guidance/philosophy-principles-structure-and-regulatory/chapter-3-integrated-emergency-management-guidance
Introduction to Equality Impact Assessment (EQIA)	https://learn.nes.nhs.scot/44697/equality-and-diversity-zone/introduction-to-equality-impact-assessment-eqia
Island Community Impact assessments	https://www.gov.scot/publications/island-communities-impact-assessments-guidance-toolkit-2/
ISO 22301	https://www.bsigroup.com/en-GB/iso-22301-business-continuity/Introduction-to-ISO-22301/
ISO 22313	https://www.iso.org/standard/75107.html
Local Authority and emergency services information	https://www.gov.uk/government/publications/local-authority-emergency-services-information
Lockdown guidance	https://www.nss.nhs.scot/publications/lockdown-guidance-shfn-03-04/

Text Displayed	Link
Management of Public Health Incidents	https://publichealthscotland.scot/publications/management-of-public-health-incidents-guidance-on-the-roles-and-responsibilities-of-nhs-led-incident-management-teams/management-of-public-health-incidents-guidance-on-the-roles-and-responsibilities-of-nhs-led-incident-management-teams/
Management of Viral Haemorrhagic Fevers and Similar Human Infectious Diseases of High Consequence	https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients
National arrangements for incidents involving radioactivity (NAIR)	https://www.gov.uk/guidance/national-arrangements-for-incidents-involving-radioactivity-nair
National Infection Prevention and Control Manual | National Services Scotland	https://www.nipcm.hps.scot.nhs.uk/
National Nuclear Emergency Planning and Response Guidance	https://www.gov.uk/government/publications/national-nuclear-emergency-planning-and-response-guidance
National Risk Register	https://www.gov.uk/government/publications/national-risk-register-2023
National Security Risk Assessment (NSRA)	https://collaborate.resilience.gov.uk/RDService/home/318756/CMEP-Reference-Documents
National Trauma Training Programme	https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/
NHS (Scotland) Act 1978 s 12J	https://www.legislation.gov.uk/ukpga/1978/29/section/12J
Pandemic Flu plans	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130903
Plan for monitoring and responding to new SARS-CoV-2 variants and mutations (VAMs)	https://publichealthscotland.scot/publications/plans-for-sars-cov-2-variant-assessment-and-response/plans-for-sars-cov-2-variant-assessment-and-response/
Preparing Scotland	http://www.readyscotland.org/ready-government/preparing-scotland/

Text Displayed	Link
Principles for joint working - JESIP	https://www.jesip.org.uk/joint-doctrine/principles-for-joint-working/
Protecting Vulnerable Groups (PVG)	https://www.mygov.scot/pvg-scheme/types-of-pvg-disclosure-record
Provision and Use of Work Equipment Regulations 1998 (PUWER)	https://www.hse.gov.uk/work-equipment-machinery/puwer.htm
Psychological First Aid Field Operations Guide without Appendices	https://www.nctsn.org/resources/psychological-first-aid-pfa-field-operations-guide-without-appendices
Public Health etc. (Scotland) Act 2008 (legislation.gov.uk)	https://www.legislation.gov.uk/asp/2008/5/contents
Radiation emergency preparedness regulations (REPPIR)	https://www.hse.gov.uk/radiation/ionising/reppir.htm
Recognise and respond to CBRN incidents: guidance for healthcare professionals	https://www.gov.uk/government/publications/chemical-biological-radiological-and-nuclear-incidents-recognise-and-respond
Recovering from Emergencies guidance	https://ready.scot/how-scotland-prepares/preparing-scotland-guidance/recovering-emergencies-scotland
The Scotland Act 1998	https://www.legislation.gov.uk/ukpga/1998/46/contents
Scotland's national respiratory surveillance plan 2022	https://publichealthscotland.scot/publications/scotland-s-national-respiratory-surveillance-plan/scotland-s-national-respiratory-surveillance-plan-version-1/
Scottish Risk Assessment (SRA)	https://collaborate.resilience.gov.uk/RDService/home/317593/SRA-2023
SHPIR (Scottish Health Protection Information Resource)	http://www.shpir.hps.scot.nhs.uk/
Spiritual Care framework	https://www.gov.scot/publications/discovering-meaning-purpose-hope-through-person-centred-well-being-spiritual-care-national-framework/
STAC Guidance	https://ready.scot/how-scotland-prepares/preparing-scotland-guidance/stac

Text Displayed	Link
Strategic Environmental Assessments (SEA)	https://www.gov.scot/publications/strategic-environmental-assessment-guidance/pages/3/
Those who may be vulnerable in times of emergency	https://www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders
TOXBASE	http://www.toxbase.org/
Turas Equality & Diversity Zone (NHS NES)	https://learn.nes.nhs.scot/7435
UK Influenza Pandemic Preparedness Strategy 2011	https://www.gov.uk/government/publications/responding-to-a-uk-flu-pandemic
Weather and climate change - Met Office	https://www.metoffice.gov.uk/

Appendix 10

Glossary of Terms

Primary Term	Definition
All Hazards Approach	Concentrating on consequences rather than causes, allows a process of generic planning which can be adapted readily to fit to a wide range of issues around response and recovery.
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.
Category 1 Responder	A person or body listed in Part 1 or Part 2 of Schedule 1 to the Civil Contingencies Act. These bodies are likely to be at the core of the response to most emergencies. As such, they are subject to the full range of civil protection duties in the Act.
CBRN	Chemical, Biological, Radiological and Nuclear
Civil Contingencies/ Civil Contingencies Act	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 Regional Resilience Partnership area, which is developed and published as a basis for informing local communities and directing civil protection workstreams.
Competences	Competences include the knowledge, judgement, 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.

Primary Term	Definition
Disaster	Emergency (usually but not exclusively of natural cause) causing, or threatening to cause, widespread and serious disruption to community life through death, injury, and/or damage to property and/or the environment.
Emergency (CCA definition)	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 EPRR	Scottish Government Health Emergency Preparedness, Resilience and Response Division
Health Risk States	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 piece of 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.
Incident Management Team (IMT)	Event or situation that requires a response from the emergency services or other responders.

Primary Term	Definition
Integrated Emergency Management (IEM)	Multi-agency approach to emergency management entailing five key activities – assessment, prevention, preparation, response, and recovery. See Preparing Scotland.
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 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.
Looked-After (children)	Under the Children (Scotland) Act 1995, 'looked after children' are defined as those in the care of their local authority.
Loggist	An individual responsible for keeping logs of an incident, including what happened and when, a timeline of responses, decisions or actions made and by whom.

Primary Term	Definition
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 help 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.

Primary Term	Definition
Resilience	Ability to detect, prevent, and, if necessary to withstand, manage 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.
Scientific and Technical Advice Cell (STAC)	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 gold commander. (See STAC Guidance).
Regional Resilience Partnership (RRP) and Local Resilience Partnership (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.

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