NHS
Kernow
Clinical Commissioning Group

NHS Kernow CCG
Incident Response Plan

Date approved: 10 October 2018

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Document control sheet

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1	21/02/2018	EPRR Lead	Draft
1.1	24/04/2018	EPRR Lead	Feedback/NHS E
1.2	27/04/2018	EPRR Lead	Feedback/On call staff
1.3	13/08/2018	EPRR Lead	Revision to meet NHS England EPRR core standards: • Definition of critical incident (s.3) • CCG role in a mass casualty incident (s12) • Incident Director action card

			revised to include recovery actions • Clarity on process to request mutual aid and military assistance (ss.13 & 10.2)

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Contents

1. Aim

1.1. This plan sets out how NHS Kernow CCG will support NHS England to mobilise, co-ordinate, stand down and return the local NHS to a state of recovery in the event of an emergency or major incident. Staff with on-call or key response roles must be familiar with this document. This plan should also be read in conjunction with:

- Devon, Cornwall & Isles of Scilly Local Health Resilience Partnership: Health Community Response Plan
- Devon, Cornwall & Isles of Scilly Local Resilience Forum: Combined Agency Emergency Response Protocol (CAERP)

2. Principles and objectives

2.1. A health community response is based on the following principles:

- **Subsidiarity:** Taking decisions at the lowest appropriate organisational level, with co-ordination at the highest necessary level; local agencies are the building blocks of the response to, and recovery from, an emergency of any scale.
- **Shared situational awareness:** Establishing common ground in the context of shared objectives.
- **Integrated emergency management:** Co-ordinating a whole system approach to emergency response, sharing resources when required to effectively deliver health community response objectives. The plan is aligned to the Joint Emergency Services Interoperability programme (JESIP) principles.

2.2. The shared strategic objectives of commissioners and providers of NHS funded care in response to an incident are to:

- Deliver optimum care and assistance to those affected by an incident
- Minimise disruption to health and care services which may occur as a consequence of responding to incidents or emergencies
- Bring about a speedy return to normal levels of service
- Work across organisational boundaries to deliver a multi-agency response;
- Protect the health of the wider population.

3. Definitions

3.1. The table below sets out the different incident types:

Incident Type	Definition	Examples
Business Continuity Incident	An event that disrupts an organisations normal service delivery	• Utilities failure (water/ electricity etc.) • Severe weather preventing staff getting to work/ patients • Capacity pressures, up to and including 'OPEL 3'
Critical Incident	A local incident which results in the temporary or permanent loss of the ability to deliver a critical service, requiring special measures and support from other agencies	• Extensive/ prolonged loss of utilities requiring support of other agencies • Extensive/ prolonged disruption due to severe weather requiring multi-agency co-ordination • Capacity pressures – 'OPEL 4' declared
Major Incident	An incident that presents a serious threat to the health of the community, or causes such types of casualties, as to require special arrangements to be implemented.	• Major transport accident • Terrorist attack • Mass casualties incident • Pandemic Influenza
Outbreak	An incident involving two or more people and a communicable or infectious disease, which presents a real or possible risk to the health of the public and requires urgent investigation and management.	• Influenza • Tuberculosis • Meningitis
Surge/ Escalation	An increase in operational pressures within a single provider or across a local healthcare system that puts essential healthcare provision at risk	• an individual provider or local healthcare system declaring OPEL 3 or OPEL 4

3.2. The NHS is accustomed to normal fluctuations in daily demand for services. Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures; by means of established management procedures and escalation policies. It therefore follows that a major incident is any event where the impact cannot be handled within routine service arrangements.

3.3. What is a major incident to the NHS may not be a major incident for other responding agencies. The NHS can therefore declare a major incident when its own facilities and/or resources or those of partner organisations are overwhelmed.

3.4. A major incident may arise in a variety of ways and the response will be sufficiently flexible to assess and respond appropriately to any of these situations:

- **Big Bang:** A sudden incident, such as a major road traffic incident, explosion or series of smaller incidents
- **Rising Tide:** A developing infectious disease epidemic, or capacity/staffing crisis or forecast of severe weather
- **Cloud on the Horizon:** A serious threat such as a major chemical or nuclear release developing elsewhere, needing preparatory actions
- **Headline News:** Public or media alarm about a perceived threat
- **Internal Incidents:** Anything that affects a provider's ability to deliver services such as fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crime
- **Deliberate Release:** This threat may come from an accident at a chemical or nuclear facility, from a transport incident, from a terrorist or dissident group or disaffected individuals
- **Pre-planned Major Events**: Major events that require planning, such as sports fixtures, mass gathering of people, demonstrations etc.
- **Mass Casualties:** Casualty numbers that are beyond the capacity created by the local implementation of major incident plans – or other major disruptive challenges to the delivery of health care, regardless of their cause (see s.3.7)

3.5. The potential hazards that may affect the communities of Cornwall and the Isles of Scilly have been identified, assessed and ranked according to severity of potential impact and the likelihood of occurrence. These can be found on the Devon, Cornwall and Isles of Scilly Local Resilience Forum's (LRF) Community Risk Register

4. Terminology

4.1. The following messages may be received:

Major Incident Alert Message Definitions	
Term	**Definition**
Major Incident – Standby	Indicates that a the incident has the potential to be a Major Incident; This is a term only used by the NHS
Major Incident – Declared	Indicates that the declaring organisation is implementing special arrangements* in order to be able to respond effectively to the incident
Major Incident – Cancelled	Indicates that the incident is not as serious as initially thought and that special arrangements are not required
Major Incident – Stand-down	Indicates that the declaring organisation has reached the point of being able to return to normal operations, it no longer requires the special arrangements it put in place

4.2. *Special arrangements for the NHS will generally mean establishing an Incident Co-ordination Centre (ICC) and re-deploying staff from normal duties to cope with the needs of the emergency incident.

5. Structures

5.1. This table describes the wider response structures and who represents the NHS:

Structure	Function	NHS Represented by:
Strategic Co-ordinating Group (SCG) • Likely to initially be a teleconference; • If face-to-face meetings are necessary, they	• Multi-agency group – provides strategic direction to the incident response • Established for incidents that are: complex/ of extended duration/ require significant resourcing/ may be politically sensitive • Chaired by a Police Officer of Chief Superintendent or above rank • The Police Chair reports to COBR, if	NHS England Director on-call Acts as the Health '**Gold**' Commander

Structure	Function	NHS Represented by:
will be held at Police Headquarters at Middlemoor, Exeter	it is sitting *(Cabinet Office Briefing Rooms – a meeting chaired by either Prime Minister or a Cabinet Minister)* • May be supported by a Scientific & Technical Advice Cell – see below	
Tactical Co-ordinating Group (TCG) • Likely to initially be a teleconference; • If face-to-face meetings are necessary, they will be held at a Police Station (location notified when called)	• Multi-agency group – plans the integrated tactical response to the incident • Co-ordinates the multi-agency deployment of resources • Established for incidents that require greater co-ordination than local responders have the capacity to provide • Chaired by a Police Officer of Inspector or Chief Inspector rank	NHS England Manager on-call OR CCG Director on-call Acts as the Health '**Silver**' Commander for that TCG (there may be multiple TCGs)
Scientific & Technical Cell (STAC) • Established in support of an SCG	• Chaired & co-ordinated by either a PHE Consultant or a local Director of Public Health (DPH) • Provides advice on hazardous materials and situations to inform the incident response and support the maintenance of public health • NOTE: The STAC **does not** provide Occupational Health advice to emergency response organisations; that is a function that organisations have their own responsibility to provide for their own staff	An NHS England Liaison may attend

6. NHS Kernow CCG Roles

6.1. Although CCGs (as 'Category Two' responders) are not subject to the full set of legal duties under the Civil Contingencies Act 2004, there exists a duty of co-operation and sharing of information:

- Being a point of emergency contact through established on-call arrangements
- Supporting NHS England in mobilising and co-ordinating NHS resources, in particular co-ordinating the escalation aspects of a response
- Contributing to the combined response of all emergency services and other agencies
- Attending local Tactical Coordination Centres and representing the health community at the request of NHS England
- Supporting the delivery of primary and community health services, including the mobilisation of community resources and supporting designated receiving hospitals where appropriate
- Supporting providers to maintain service delivery across the local health economy to prevent business as usual pressures and minor incidents from becoming significant incidents or emergencies

7. NHS Kernow CCG individual responsibilities

7.1. The Chief Operating Officer (Accountable Emergency Officer) is responsible for major incident and business continuity planning. In the event of a major incident the On-call Director is responsible for activating this plan. The Chief Operating Officer or an Executive Director may also activate the plan.

8. Activation

8.1. This plan will be triggered when one of the following criteria is met:

- Threat to health of the community
- Service disruption that cannot be reconciled through normal escalation mechanisms
- Numbers or type of casualties that require special arrangements to be implemented
- Public Health outbreak requiring NHS resources

- Mutual aid request from neighbouring NHS England Area Team / Clinical Commissioning Group
- Establishment or standby of a Strategic Coordinating Group or Tactical Coordinating Group

8.2. Assessment of the situation may take the form of a Police-led pre-event assessment teleconference (PEAT), which can precede the setting up of a Tactical Co-ordinating Group.

9. Alerting

9.1. Provider organisations will contact the CCG On-call Director using the established system through Bodmin Switchboard, where:

- There is intelligence to suggest severe disruption to NHS services is likely, or where significant problems are being experienced by commissioned providers within the County that threaten the provider's ability to provide essential and critical care
- Business continuity arrangements have been activated in support of a critical service
- Estate related matters including theft, fire and vandalism concerning CCG owned/occupied estate have been alerted to the provider
- Serious clinical incidents and Serious Incidents Requiring Investigation (SIRIs) affecting public or patients
- Serious performance issues
- Where the provider has declared an emergency or Major Incident
- The incident requires the mobilisation of NHS resources
- Any incident or occurrence likely to focus media attention on NHS funded care within the County

9.2. The CCG On-call Director will refer to Appendix 2 and make an initial risk assessment to determine action, including ensuring internal staff, provider organisations and the NHS England Director On-call are alerted.

9.3. NHS England will alert the CCG On-call Director in the event of a Health Teleconference, Tactical Coordination Group, or any other Health relevant emergency requiring CCG support. Action will be taken in line with the Devon, Cornwall & Isles of Scilly Local Health Resilience Partnership: Health Community Response Plan.

10. Escalation and reporting

Level	Description	Lead
1	A health related incident that can be responded to and managed by provider organisations within their respective business as usual capabilities.	CCG / Provider (NHS E for Primary Care)
2	A health related incident that requires the response of a number of health provider organisations and will require an NHS England to co-ordinate.	NHS England / Public Health England
3	As above but with regional implications including mutual aid requirements that necessitate NHS England regional co-ordination to meet the demands of the incident.	NHS England / Public Health England
4	As above but with national implications requiring NHS England National co-ordination to support the NHS and NHS England response.	NHS England / DoH

10.1. On declaration or escalation to a level 2 or above incident, all responding health partners should complete and return the NHS England SitRep (Appendix 3) to the following email address: DCIOSATICC@nhs.net Further reporting will be decided at the initial teleconference.

10.2. The CCG On-call Director will:

- Inform the NHS England Director On-call and determine the chain of command for the incident
- Where requested to do so by the NHS England Director On-call, assume the role of the **INCIDENT DIRECTOR** for the local NHS, setting the strategic aims and objectives, and ensuring the mobilisation and co-ordination of local NHS resources as required
- Where the situation requires it, convene an **INCIDENT MANAGEMENT TEAM** (to offer support to the Incident Director and help gather and ensure efficient flow of information)
- Appoint a **LOGGIST** where required
- Activate the **CCG's INCIDENT CONTROL ROOM** (situated at Sedgemoor Level 2). This decision should be based on the scale of the incident, its potential to impact on NHS services, and the anticipated volume of communications likely to be flowing up and down the chain of command
- Ensure that the strategic aims and objectives are in line with NHS England direction, and are reviewed regularly

- Ensure appropriate documents and records are being kept and all organisations are aware of the need to capture accurate financial information of any expenditure incurred as a result of the incident
- Ensure where possible that the response can be maintained within the local health economy, including facilitating local requests for mutual aid.
- Where mutual aid cannot be obtained locally, requesting additional mutual aid through the NHS England Director On-call
- Implement the CCG Business Continuity Plan
- Attend the multi-agency Tactical Co-ordinating Group if requested to do so
- Ensure that the risk assessment is re-visited regularly and that any significant issues are escalated to the NHS England Director On-call immediately
- With the NHS England On-call Director, decide when the incident is over and stand down the local NHS response
- Ensure that the Chief Officer/Chief Operating Officer are kept informed

NB: Military assistance requests – Military Aid to Civilian Authorities (MACA) – must be made through NHS England only.

11. Infectious Disease Outbreak

11.1. In the event of an infectious disease outbreak within, or affecting, the CCG's geography, the CCG has a responsibility to support the response to the outbreak.

11.2. Alert Process:

- The CCG will be alerted through the on-call route by one of: an affected provider, Public Health England (PHE) or NHS England

11.3. CCG Role:

- Participating in an Outbreak Control Team, if requested by PHE/ NHS England
- Participating in an Outbreak Control Team, if requested by PHE/ NHS England
- Supporting providers affected or participating in the response to the outbreak with guidance and, where appropriate, by funding resources necessary to the response – ensuring business continuity plans are followed
- Supporting the communication of public health advice, provided by PHE or the local Directors of Public Health, through the CCG's website and other media

- Providing leadership to the local health community in managing the impact of the outbreak response on service delivery, resource management and business continuity planning.

11.4. Relevant plans and frameworks:

- The LHRP Communicable Disease Outbreak and Incident Strategic Framework
- The LHRP Communicable Disease Operational Response Plan

12. Mass Casualty Incidents

12.1. In the event of a mass casualty incident (where there are hundreds of casualties), acute providers are required to increase their capacity to admit casualties by 10% of bed base within the first 6 hours, and by another 10% of bed base in the next 6 hours (20% overall). This clearing of beds and expansion of capacity will have consequences across the local healthcare system. As system leader, the CCG has a responsibility to manage the system through this disruption.

12.2. The CCG will support and co-ordinate the following:

- An increase in community services provision to support patients moved from acute to community care (eg. Care home, nursing home, patient's own home, etc)
- The provision of care in patient's homes for those who would normally be referred to an acute trust
- Alerting community based services and private providers to advise of the need to reduce/ prevent hospital admission or any referrals to other urgent care facilities
- Making provision to support the non-acute elements of the local healthcare economy in managing the above and any other impacts of the incident on their services and patients

12.3. As the CCG on-call staff are likely to be involved in the co-ordination of NHS resources and directly responding to the incident, these actions may need to be undertaken and co-ordinated by other senior managers within the CCG.

12.4. An Incident Management Team may need to be established to co-ordinate this response.

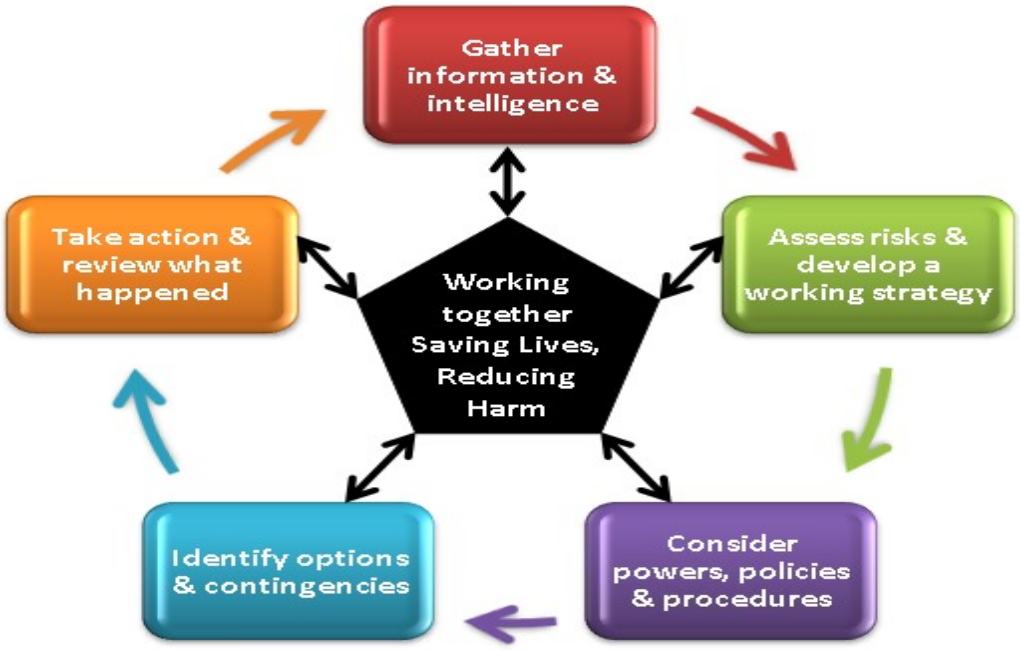
13. Mutual aid

13.1. As system leader, the CCG on-call staff will support providers in obtaining local mutual aid during emergency and business continuity incidents, where mutual aid agreements are not already in place.

13.2. Where mutual aid is not possible within the local system the Director on-call will support providers, where necessary, in attempting to obtain mutual aid through the offices of NHS England.

13.3. It is not envisaged that the CCG itself will require mutual aid during the response to a community emergency. The CCGs critical functions will be maintained through the activation of its Business Continuity Plans.

14. The Joint Decision Model to ensure an effective co-ordinated response



15. Stand down

15.1. The NHS England On-call Director in consultation with the CCG On-call will decide when an emergency or major incident stand down should be declared for

Health (which may be long after the emergency services response is over). This could be either a full or partial stand down with one or more individuals monitoring the situation. Criteria for de-escalation will be based on the following:

- Reduction in internal resource requirements
- Reduced severity of the incident
- Reduced demands from partner agencies or government departments
- Reduced public or media interest
- Decrease in geographic area or population affected

15.2. All response level changes need to be communicated both internally and externally as appropriate. A brief description of the resource implications of the new level should be included.

15.3. Once the decision has been taken, the CCG On-call Director will ensure that all appropriate elements of the local response are stood down. This may be a staged process. It is important to ensure that where communication channels have been specially created for the incident, forwarding mechanisms are in place to ensure that no information is lost.

16. Records management

16.1. All logs, records and other details from the incident will be collected and handed to the CCG EPRR lead. These will form the definitive record of the response and may be required at a future date as part of an inquiry process (judicial, technical, inquest or others). Such records are also invaluable in identifying lessons that would improve a future response. The Incident Director is formally responsible for signing off the decision log and all briefing papers and documents relating to the incident.

17. Debriefs and reports

17.1. A hot de-brief will be held within 24 hours of stand down. A full debrief will be held within 14 working days of the incident. A report will be produced to identify any learning from the incident.

17.2. Structured debriefs should be held with involved staff as soon as possible after de-escalation and stand down. Participants must be given every opportunity to contribute their observations freely and honestly.

17.3. As part of the debriefing process a post incident report will be produced to identify learning from the incident. Typically this will include:

- Nature of incident
- What went well?
- What could be improved?
- Action plan

17.4. This report may also contribute to a wider post-incident debrief, generally coordinated by NHS England.

17.5. The CCG Incident Director is responsible for activating the lessons identified process and may delegate the responsibility for lessons identified to the CCG EPRR lead.

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Appendix 1: Action cards

ACTION CARD	INCIDENT DIRECTOR 'STAND BY'
Accountable to	**NHS England Incident Director**
Responsible for: assessing the initial information received in respect of a potential or actual major incident and escalating to the NHS England On-call Director	
1	Start a personal log detailing information received and actions taken. Copies of the log book can be found in the on call pack. Ensure formal logging of your actions/decisions is in place as soon as possible.
2	If necessary, verify the information received by contacting the initial caller, the police, the local authority or other appropriate agency.
3	Obtain as much information about the incident as possible (METHANE) and begin to complete the log, including any specific or urgent actions required from the NHS.
4	Assess the severity of the situation and consider the potential impact on the local health economy. Conduct a risk assessment (see Health Community Response Plan).
5	If it is a potential or actual incident for the NHS, or if incident standby or a major incident has been declared by a partner agency, notify the NHS England On-call.
6	In liaison with the NHS England On-call, assess the information received and consider action to be taken.
7	On **activation** of the Incident Response Plan notify relevant personnel. Contact numbers for these can be found in the On-call pack. **SEE ACTION CARD 'ACTIVATE THE PLAN- INCIDENT DIRECTOR'**
8	**If this is NOT a potential or actual major incident:** • If no further action is required, complete the log • If it can be dealt with using normal resources, notify the appropriate personnel and maintain a watching brief • Continue to reassess the situation as further information becomes available and determine if any additional action is required In the event of any increase in the scale / impact of the incident reassess the risk and re escalate as needed.

ACTION CARD	INCIDENT DIRECTOR 'ACTIVATE THE PLAN'
Accountable to	**NHS England Incident Director**

Responsible for: Supporting NHS England On-call staff in managing the Health response to the incident. If a Tactical Control Group is called the CCG Incident Director may be asked by NHS England to attend on behalf of the local NHS.

1	Establish liaison with the appropriate personnel from PHE, NHS Trusts and partner agencies.
2	Confirm that the relevant command and control structures have been implemented across the local health economy.
3	Confirm that all relevant personnel internally, at NHS England and externally have been informed.
4	Confirm with NHS England the aim and objectives for responding to the incident, and the strategy to achieve these.
5	The following actions are incident dependent: • A meeting will be set up ASAP with key involved NHS organisations (plus PHE as indicated) (teleconference/face to face) • Briefing out to local NHS trusts, clinical networks Situation Report to be provided to NHS England as requested: email DCIOSATICC@nhs.net
6	Identify battle rhythm dependant on: • TCG and SCG meetings (if called) • NHS external teleconferences/meetings • Reporting requirements.
7	If support is needed to undertake the role, consider establishing an **Incident Management Team** and brief the membership. This will depend on the incident but, as a minimum, should include: • CCG On-Call • Communications lead • Administrator • Loggist In some incidents the IMT may include a Public Health England (PHE) liaison and a representative from the Public Health team.

8	Establish an **Incident Control Room** if indicated, tasking specific staff.
9	Where indicated by the type of incident, establish broader membership consisting of all responding organisations. Request attendance of a liaison person (by teleconference or in person) from each responding organisation including the appropriate network (Critical Care, Trauma, Burns). If this is not possible, confirm a single contact name and contact details.
10	If requested by NHS England, implement a media strategy and identify an appropriate person to represent the NHS at any press conferences / media interviews.
11	Ensure close communication and full two way briefings before and after each TCG meeting.
12	Ensure response to all TCG determined actions.
13	In consultation with the NHS England, determine when the stand down should be declared (taking advice from partners as necessary) and inform the appropriate personnel/agencies of this.

ACTION CARD	INCIDENT DIRECTOR 'STAND DOWN'
Accountable to	**NHS England Incident Director**
When the 'Stand Down' command is given by NHS England the Incident Director will:	
1	Ensure a process is in place for an appropriate return to business as usual internally and externally across the local NHS. (Resourcing, coordination of recovery across providers and integration with social care and any opportunities for improved practice).
2	Support the multi-agency recovery phase if required.
3	Agree when staff involved in the incident should return to their normal duties.
4	Debrief the staff working in the incident room ("hot debrief").
5	Complete and sign off the incident log and ensure all relevant documentation is secured.
6	Ensure a formal report is prepared, highlighting any good practice or issues identified.

ACTION CARD	LOGGIST
Accountable to	**Incident Director**
Responsible for: Recording and documenting all issues/actions/decisions made by the Incident Director. If the Incident Director attends the TCG they will be accompanied by a loggist if possible.	
1	The loggist must use the log book provided.
2	On arrival all staff must wear Identification Badges. If the badges are unclear the loggist must ask for clarification of who is present within the room and their title.
3	The log must be clearly written, dated and initialled by the loggist and include the location.
4	All persons in attendance to be recorded in the log.
5	The log must be a complete and a continuous record of all issues/ decisions /actions as directed by the Incident Director.
6	Timings have to be accurate and recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented. When the task is completed this must also be documented.
7	If notes or maps are utilised these must be noted within the log.
8	At the end of each session a score and signature to be added underneath the documentation so no alterations can be made at a later date.
9	All documentation is to be kept safe (passed to the CCG EPRR lead) and retained for evidence for any future proceedings.
10	Where something is written in error changes must be made by a single line scored through the word and the amendment made.

The loggist MUST NOT:

- **Take minutes;**
- **Record for more than one decision maker;**
- **Keep a separate chronological log;**
- **Have responsibility for the decision/action**

The log and all paper work becomes legal documentation and could be used at a later date in a public enquiry or other legal proceedings.

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ACTION CARD	COMMUNICATIONS LEAD
Accountable to	**Incident Director**
Responsible for: Providing communication, co-ordination, advice and support to the Incident Director	
1	Confirm with the Incident Director that an incident is taking place.
2	Contact the NHS England Communications team and agree who will be leading on communications.
3	Commence personal log.
4	Issue pre-arranged public health / safety messages where required.
5	If requested to do so by the NHS England Communications lead, assume responsibility for managing all public information and media communications.
6	Rapidly formulate and implement an integrated media handling strategy on behalf of the local NHS response. Agree health spokespeople. If no SCG/TCG established, advise media (& stakeholders) on the timing of future media updates.
7	Alert communications network of incident and advise of media handling strategy. Brief the Out of Hours/111 provider on the information / advice to be given to the public.
8	Deal with all media enquiries/draft statements/organise press conferences and interviews as agreed in media handling strategy.
9	If a TCG or SCG is established, they will control messages about the overall incident and its health impact, to the media. Therefore it is vital that communications leads from local health organisations act as one to advise the TCG and SCG.
10	Identify communications officer/ admin support to log media calls and develop rolling question and answer brief.
11	Identify communications officer/ admin support to liaise with local NHS communications network to ensure urgent cascade of information / coordinated internal communications / messages for staff. This should continue as appropriate throughout the incident.
12	Provide regular updates to the NHS England Communications lead and stakeholders' communications teams on the NHS response and key health messages. This should continue as appropriate throughout the incident.
13	On stand down, ensure that all original documentation (including notes, flip charts, e-mails etc.) are kept. Close personal log.
14	Attend Hot and Formal debriefs.
15	Manage any on-going media interest in the NHS response, including social media.

Appendix 2: Risk assessment

Questions to consider
What is the size and nature of the incident?
Area and population likely to be affected - restricted or widespread
Level and immediacy of potential danger - to public and response personnel
Timing - has the incident already occurred or is it likely to happen?
What is the status of the incident?
Under control
Contained but possibility of escalation
Out of control and threatening
Unknown and undetermined
What is the likely impact?
On people involved, the surrounding area
On property, the environment, transport, communications
On external interests - media, relatives, adjacent areas and partner organisations
What specific assistance is being requested from the NHS?
Increased capacity - hospital, primary care, community
Treatment - serious casualties, minor casualties, worried well
Public information
Support for rest centres, evacuees
Expert advice, environmental sampling, laboratory testing, disease control
Social/psychological care
How urgently is assistance required?
Immediate Within a few hours Standby situation

Appendix 3: NHS England Situation Report (SITREP)

OFFICIAL - SENSITIVE

NHS Incident Situation Report (SitRep)

Note: Please complete all fields. If there is nothing to report, or the information requested is not applicable, please insert NIL or N/A
Instructions for completion are provided at the end of the template
This template will be customised by NHS England as soon as practicable for use during an incident however initial reporting should be done on the generic template
For second and subsequent SitRep reports highlight new information in yellow

The source, time and assessed quality of information should be reported. Uncertainties and working assumptions must be clearly identified

Organisation Name:				
Date:		dd/month/yyyy	**Time:**	hh:mm
Completed by:	Name			
	Title			
Telephone number:				
Email address:				
Authorised for release by:	Name			
	Title			

Exact location of Incident/s				
NHS Incident	Business Continuity Incident ☐	Critical Incident ☐	Major Incident ☐	
Type of Incident/s	Big Bang ☐	Rising Tide ☐	Cloud on the Horizon ☐	Headline News ☐
	Internal Incident ☐	CBRNe ☐	HAZMAT ☐	Mass Casualties ☐
	Extreme Weather ☐	Flooding ☐	Infectious Disease ☐	Other ☐
	Specify Other			
Description of Incident				
Resources Deployed				

Actual impact on Critical Functions and/or services and/or patients	
Potential impact on Critical Functions and/or services and/or patients	
Capacity Issues	
Capability Issues	
Impact on business as normal	
Mitigating actions taken/planned	

Mutual Aid Request Made	Yes ☐ No ☐ Details
Current media interest and messages	
Potential media interest and messages	
Media lead (Name) **Email/ Telephone number**	
Other Information/Context Other Key information that you deem relevant for NHS England to be aware of	
Key risks and mitigating actions	
Key risks for escalation	

Incident Specific Information and Questions	*Insert any specific information/questions related to the incident*			
Forward Look	Next 12/ 24/ 48 hours/ Next week			
Recovery Actions Including any issues				
Next SitRep Due **Battle Rhythm**	**Date:** dd/month/yyyy **Time:** hh:mm			
Return to	**Email:**		**Contact Tel. No.**	

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Appendix 4: Pre-ratification checklist

For use by ratifying bodies. To be attached to a policy or similar document when submitted to the appropriate committee/group/individual for consideration and ratification.

	Title of document being reviewed	Yes/No	Comments
1.	**Title**		
•	Is the title clear and unambiguous?	Choose an item.	
2.	**Purpose**		
•	Is the reason for the document stated?	Choose an item.	
3.	**Development process**		
•	Has a reasonable attempt been made to ensure relevant expertise has been included?	Choose an item.	
•	Is there evidence of consultation with stakeholders and users?	Choose an item.	
•	If appropriate, has there been clinical input?	Choose an item.	
•	If appropriate, has the Joint Partnership Committee been consulted?	Choose an item.	
•	If appropriate, has the Counter Fraud Specialist been consulted?	Choose an item.	
4	**Content**		
•	Are the objectives and intended outcomes clear?	Choose an item.	
•	Is the target audience clear and unambiguous?	Choose an item.	

	Title of document being reviewed	Yes/No	Comments
5	**Evidence base**		
•	Are key references cited, if appropriate?	Choose an item.	
•	Are the references cited in full, if appropriate?	Choose an item.	
•	Are supporting documents cross referenced?	Choose an item.	
6	**Ratification**		
•	Does the document identify which committee will be asked to ratify it?	Choose an item.	
7	**Dissemination and implementation**		
•	Is there an outline plan to identify how this will be done?	Choose an item.	
•	Does this include training/support to ensure compliance?	Choose an item.	
•	Is it clear whether the document can be published on the organisational website? If it cannot, is a clear, valid reason given for this?	Choose an item.	
9	**Process for review and monitoring compliance**		
•	Is a review date identified?	Choose an item.	
•	Is the frequency of review identified? If so, is it reasonable?	Choose an item.	
•	Is there a plan to review or audit compliance with the document?	Choose an item.	
11	**Overall responsibility for the document**		
•	Is it clear who will be responsible for coordinating the	Choose	

	Title of document being reviewed	Yes/No	Comments
	dissemination, implementation and review of the documentation?	an item.	

NHS
Kernow
Clinical Commissioning Group

Appendix 5: Equality Impact Assessment

Equality Impact Assessment

Kernow Clinical Commissioning Group

Name of policy to be assessed	NHS Kernow Incident Response Plan		
Section	Click here to enter text.	**Date of Assessment**	21/08/2018
Officer responsible for the assessment	Drew Wallbank	**Is this a new or existing policy?**	Existing

1. Describe the aims, objectives and purpose of the policy.

Gives procedural guidance to On call staff in the event of a major incident

2. Are there any associated objectives of the policy? Please explain.

No

3. Who is intended to benefit from this policy, and in what way?

Staff – it provides clear guidance on role and responsibilities.

4. What outcomes are wanted from this policy?

Mobilisation, co-ordination of response and stand down in the event of a major incident.

5. What factors/ forces could contribute/ detract from the outcomes?

Failure to follow plan.

6. Who are the main stakeholders in relation to the policy?

NHS Kernow CCG On-call staff and Incident Commanders.

7. Who implements the policy, and who is responsible for the policy?
On-call staff, as written by EPRR Lead.
8. What is the impact on people from Black and Minority Ethnic Groups (BME) (positive or negative)?
Consider relevance to eliminating unlawful discrimination, promoting equality of opportunity and promoting good race relations between people of different racial groups. Issues to consider include people's race, colour and nationality, Gypsy, Roma, Traveller communities, employment issues relating to refugees, asylum seekers, ethnic minorities, language barriers, providing translation and interpreting services, cultural issues and customs, access to services.
None. The plan provides guidance to staff regardless of BME status.
How will any negative impact be mitigated?
Click here to enter text.
9. What is the differential impact for male or female people (positive or negative)?
Consider what issues there are for men and women e.g. responsibilities for dependants, issues for carers, access to training and employment issues, attitudes towards accessing healthcare.
None. The plan provides guidance to staff regardless of gender.
How will any negative impact be mitigated?
Click here to enter text.
10. What is the differential impact on disabled people (positive or negative)?
Consider what issues there are around each of the disabilities e.g. access to building and services, how we provide services and the way we do this, producing information in alternative formats and employment issues. Consider the requirements of the NHS

Accessible Information Standard. Consider attitudinal, physical and social barriers. This can include physical disability, learning disability, people with long term conditions, communication needs arising from a disability.
None. The plan provides guidance to staff regardless of disability.
How will any negative impact be mitigated?
Click here to enter text.
11. What is the differential impact on sexual orientation?
Consider what issues there are for the employment process and training and differential health outcomes amongst lesbian and gay people. Also consider provision of services for e.g. older and younger people from lesbian, gay, bi-sexual. Consider heterosexual people as well as lesbian, gay and bisexual people.
None. The plan provides guidance to staff regardless of sexual orientation.
How will any negative impact be mitigated?
Click here to enter text.
12. What is the differential impact on people of different ages (positive or negative)?
Consider what issues there are for the employment process and training. Some of our services impact on our community in relation to age e.g. how do we engage with older and younger people about access to our services? Consider safeguarding, consent and child welfare.
None. The plan provides guidance to staff regardless of age.
How will any negative impact be mitigated?
Click here to enter text.
13. What differential impact will there be due religion or belief (positive or negative)?

Consider what issues there are for the employment process and training. Also consider the likely impact around the way services are provided e.g. dietary issues, religious holidays, days associated with religious observance, cultural issues and customs, places to worship.
None. The plan provides guidance to staff regardless of religion or belief.
How will any negative impact be mitigated?
Click here to enter text.
14. What is the impact on marriage of civil partnership (positive or negative)? NB: this is particularly relevant for employment policies
This characteristic is relevant in law only to employment, however, NHS Kernow will strive to consider this characteristic in all aspects of its work. Consider what issues there may be for someone who is married or in a civil partnership. Are they likely to be different to those faced by a single person? What, if any are the likely implications for employment and does it differ according to marital status?
None. The plan provides guidance to staff regardless of status.
How will any negative be mitigated?
Click here to enter text.
15. What is the differential impact who have gone through or are going through gender reassignment, or who identify as transgender?
Consider what issues there are for people who have been through or a going through transition from one sex to another. How is this going to affect their access to services and their treatment when receiving NHS care? What are the likely implications for employment of a transgender person? This can include issues such as privacy of data and harassment.
None. The plan provides guidance to staff regardless of this.
How will any negative impact be mitigated?

Click here to enter text.
16. What is the differential impact on people who are pregnant or breast feeding mothers, or those on maternity leave?
This characteristic applies to pregnant and breast feeding mothers with babies of up to six months, in employment and when accessing services. When developing a policy or services consider how a nursing mother will be able to nurse her baby in a particular facility and what staff may need to do to enable the baby to be nursed. Consider working arrangements, part-time working, infant caring responsibilities.
None. The plan provides guidance to staff regardless of this.
How will any negative impact be mitigated?
Click here to enter text.
17. Other identified groups:
Consider carers, veterans, different socio-economic groups, people living in poverty, area inequality, income, resident status (migrants), people who are homeless, long-term unemployed, people who are geographically isolated, people who misuse drugs, those who are in stigmatised occupations, people with limited family or social networks, and other groups experiencing disadvantage and barriers to access.
None. The plan provides guidance to staff regardless of this.
How will any negative impact be mitigated?
Click here to enter text.
18. How have the Core Human Rights Values been considered in the formulation of this policy/strategy? If they haven't please reconsider the document and amend to incorporate these values. • **Fairness;**

• **Respect;** • **Equality;** • **Dignity;** • **Autonomy**
The plan gives guidance to staff in implementing the Incident Response Plan and in support these values.
19. Which of the Human Rights Articles does this document impact?

The right:	**Yes / No:**
• To life	No
• Not to be tortured or treated in an inhuman or degrading way	No
• To liberty and security	No
• To a fair trial	No
• To respect for home and family life, and correspondence	No
• To freedom of thought, conscience and religion	No
• To freedom of expression	No
• To freedom of assembly and association	No
• To marry and found a family	No
• Not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention	No
• To peaceful enjoyment of possessions	No

a) What existing evidence (either presumed or otherwise) do you have for this?
The plan gives guidance to staff in implementing Incident Response Plan and in support these values.

20. How will you ensure that those responsible for implementing the Policy are aware of the Human Rights implications and equipped to deal with them?
Plan gives guidance for staff.
21. Describe how the policy contributes towards eliminating discrimination, harassment and victimisation.
Plan gives guidance to staff
22. Describe how the policy contributes towards advancing equality of opportunity.
Plan gives guidance to staff
23. Describe how the policy contributes towards promoting good relations between people with protected characteristics.
Plan gives guidance to staff
24. If the differential impacts identified are positive, explain how this policy is legitimate positive action and will improve outcomes, services or the working environment for that group of people.
n/a
25. Explain what amendments have been made to the policy or mitigating actions have been taken, and when they were made.
n/a
26. If the negative impacts identified have been unable to be mitigated through amendment to the policy or mitigating actions, explain what your next steps are.
n/a

Signed (completing officer): .....

Date: 30/2/18

Signed (Head of Section): ..... J Carson .....

Date: ..... 30/8/18 .....

Please ensure that a signed copy of this form is sent to both the Policies Officer with the policy and the Equality and Diversity lead.