Emergency Preparedness and Resilience and Response

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Background

Under the Civil Contingencies Act 2004, an Acute Trust is a Category 1 NHS responder. The Emergency Department is usually the receiving system for patients involved in a major incident or CBRN incident and lead on decontamination (where appropriate), triage and initial clinical management of these patients.

NHS England hold overall responsibility for the health response to a major incident or CBRNE incident in England and have a number of useful documents on their website in relation to these. Each ICB has a EPRR lead to co-ordinate local responses and communications.

In Wales, this responsibility is held by Public Health Wales. **Emergency preparedness Leaflet..pdf** In Northern Ireland, this is held by the Department of Health. **Emergency planning and response | Department of Health**

In Scotland, overall responsibility for health EPRR falls under the Scottish government directorate: Chief Operations Officer, NHS Scotland. This department provides emergency planning guidance to Scottish Emergency Departments, which falls into one of the 14 Territorial Health Boards (CCA cat. 1 responders). It also provides guidance to other key EPRR CCA cat. 1 responders, including NHS Scottish Ambulance Service, NHS24 & Scottish National Blood Transfusion Service including **Preparing for Emergencies Guidance - gov.scot**

Standards

1. Role cards must be available staff working in the ED to define actions in the event of a major incident.

NHS England » Summary of published key guidance for health, emergency preparedness, resilience and response (EPRR)

Preparing for Emergencies Guidance - gov.scot

Recommendations

Education

1. HMIMMS or similar course, completion (selected senior ED staff and managers)

2. Training in EPRR to be part of all appropriate specialty's departmental training programs

3. Training programme in major incident management at the appropriate level for all ED clinicians.

4. Mandatory EPRR training or assurance of EPRR knowledge specific to their clinical or operational or management role for all staff from senior managers to appropriate clinicians.

5. CBRN response requires a whole hospital response, not solely the Emergency Department. The aim is that the emergency department can continue to provide business as usual care alongside a CBRN response.

Clinical EPRR Lead roles in ED

1. Separate MI and CBRN Medical and Nurse Lead roles in ED, with time assigned in job plans to deliver EPRR.
2. Systems and education to encourage further involvement of/development of ED SAS EPRR leads to support ED QIPs related to EPRR.
3. National support for further information sharing with ED SAS and other middle grade doctors, as OOH in many EDs they will be the first senior doctor to lead in the initial stages of a major incident or CBRN incident alongside senior nursing colleagues.

Governance

1. EPRR should be a standing items on ED governance meetings and on Trust committees and Board updates.
2. ED Clinical (medical and nursing) and operational leads should have authorities to comment on provide assurance on and attend Business Continuity planning meetings, Acute Services executive and nonexecutive led committees, and Trust Board to share expertise.
3. There should be systems to “close the loops on EPRR system assessments using audit and other evaluations and feedback systems to and from clinical staff.
4. Regular, funded, multiagency exercises should be undertaken by NHS systems as defined by external criteria, audit outcomes and internal requirements.
5. ED staff should have protected SPA or studyleave time to take part in CBRN or major incident exercises and also to attend debrief/learning events in order to participate on system quality improvement.

EPRR Equipment

1. Clear systems for supply and rapid resupply (internally and through procurement contracts) of adult and paediatric equipment likely to be needed in a major or CBRNE incident. This might include centralising and standardising major incident stores.
2. Financial planning for capital programmes to replace out of date or damaged EPRR equipment.

Cross Regional

1. Rapid roll out of the Ten Second Triage Tool (TST) and the Major Incident Triage Tool (MITT) to all EDs by December 2025, monitored through NHSE regional and national systems with quarterly reporting to NHSE EPRR CAG.

2. Local and regional agreements between Acute Trusts and Ambulance Trusts, to agree arrangements if a TU is overwhelmed by self-presenters. To support transfers to other sites and increase expert capacity once the scene is stood down.

3. Local leads linked into regional trauma and critical care transfer networks, smaller TUs need to be ready to assess and stabilise P1 patients, before transfer to tertiary centres.

4. Time for participation in ICB or NHSE regional EPRR exercises.

References

Civil contingencies Act.

1. *NHSE. NHS EPRR Framework. Available at: https://www.england.nhs.uk/publication/?filter-category=eprr Summary of published key strategic guidance for health emergency preparedness, resilience and response (EPRR) Accessed 11.11.24*

2. *NHSE. Clinical guidelines for major incidents Accessed 11. 11.24*

3. *NHSE. NHS England » Summary of published key strategic guidance for health Emergency Preparedness, Resilience and Response (EPRR) Accessed 11.11.24*

Civil Contingencies Act: Cat 1 responder?

1. *NHSE. 2019. Guidance for the initial management of self presenters from incidents involving hazardous materials https://www.england.nhs.uk/wp-content/uploads/2019/03/guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials.pdf*

2. *NHSE. 2020. Clinical Guidelines for Major Incidents and Mass Casualty Events B0128-clinical-guidelines-for-use-in-a-major-incident-v2-2020.pdf (england.nhs.uk)*