HSC Public Health Agency

HSC Health and Social Care Board

HSC Business Services Organisation

Public Health Agency (PHA)

Health and Social Care Board (HSCB)

Business Services Organisations (BSO)

Joint Response Emergency Plan

April 2018

Table of Contents

Version Control

Controlled Document

This is a controlled document. This document and subsequent amendments will be issued by the Emergency Preparedness & Environmental Hazards (EmPEnH) Team with the PHA to the persons detailed in the distribution table. Any copy not in the possession of the names person or post may not have the current issue.

All amendments should be recorded and initialled below.

No.	Date	Amendment	Initial
1.	30th November 2010	First draft	JMD
2	20th December 2010	Second draft	EAW
3.	10th March 2011	Third draft	EAW
4.	16th May 2011	Fourth draft	EAW/JD
5.	3rd Nov 2011	Fifth draft	CH/JD/EAW
6.	31st Oct 2012 – issued Dec 2012	Sixth draft	JD/EAW
7.	20th October 2014	Seventh draft	JD
8.	20th October 2015	Eighth draft	JD
9.	December 2015	V1	EAW/ JD
10.	April 2018	V2	MC

Validation and Review

The EmPEnH Team will be responsible for a corporate review of the plan on an annual base or in the aftermath of an exercise or response to a real incident. Individual Directorates will be expected to review and amend their individual plans annually. This will include ensuring that contact details are accurate. Any changes, etc. should be communicated to the EmPEnH Team to ensure that the Joint Response Plan remains accurate and fit for purpose.

Glossary of Terms and Acronyms

Glossary of Terms

Battle Rhythm	Is the synchronised working of staff at all levels to achieve a common goal
Body Holding Area	An area, under the control of the Police, where the dead can be held temporarily until transferred to a mortuary
Capability	A demonstrable capacity to respond to and recover from a particular threat or hazard
Cascade	A succession of stages or procedures
Casualty	A person directly involved in or affected by the incident (injured, uninjured, deceased or evacuee)

Casualty Bureau	Central information and contact point, operated by the police, for all those seeking or providing information
Casualty Clearing Station (CCS)	An area established by the Ambulance Service, where casualties are triaged, treated and prepared for evacuation
Command	The authority for an agency to direct the actions of its own resources (both personnel and equipment).
Control	The authority to direct strategic and tactical operations in order to complete an assigned function and includes the ability to direct the activities of other agencies engaged in the completion of that function
Controlled Area	The area contained
Co-ordination	The harmonious integration of the expertise of all the agencies involved with the object of effectively and efficiently bringing the incident to a successful conclusion
Cordons	Designated perimeters of an emergency site
Friends and Relatives Reception Centre (FRRC)	A secure area provided for friends and relatives arriving at or near the scene
Hazard	An accidental or naturally occurring event or situation with the potential to cause physical (or psychological) harm
Health Silver	HSCB, the PHA and BSO (Health Silver) will provide strategic health and social care advice and direction in response to the health consequences of a Significant (Level 1) emergency whenever two or more Health and Social Care (HSC) Trusts are responding to the emergency, including the response to CBRN. Also see Tactical Level
Incident Officer	An Officer at the scene who commands the tactical response of his/her respective service
Integrated Emergency Management	The process of emergency management carried out across partner bodies so that arrangements are coherent and support each other
Lead Organisation	Organisation appointed by a group of organisations to speak or act on their behalf or to take the lead in a given situation, with the other organisations' support
Major Incident	Any emergency that requires the implementation of special arrangements by one or more of the emergency services, the NHS or the local authority
Mass Casualty Incident	An incident (or series of incidents)causing casualties on the scale that is beyond the normal resources of the emergency and healthcare services' ability to manage. A mass casualty incident may involve hundreds or

	thousands of casualties with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures to cope and require further measures to appropriately deal with casualty numbers.
Media Centre	Central contact point for media enquiries, providing communications and conference facilities and staffed by press officers from all organisations
METHANE Report	A mnemonic used by the emergency services to report the details of an incident
Met Office	Meteorological Office
MoD	Ministry of Defence
Mutual Aid	The provision of services and assistance by one organisation to another
Operational Level (Bronze)	The level at which the management of hands-on work is undertaken at the incident site
Public Health Duty Room	Point of contact for emerging Health Protection issues (business hours)
Receiving Hospital	A hospital designated to be the principal location to which casualties are sent
Recovery	The process of restoring and rebuilding the community, and supporting groups particularly affected, in the aftermath of an emergency
Emergency Support Centre (ESC)	Premises where persons evacuated during an emergency are provided with appropriate welfare and shelter
Risk Assessment	A structured and auditable process of identifying hazards and threats, assessing their likelihood and impacts, and then combining these to provide an overall assessment of risk, as a basis for further decisions and action
Senior Investigating Officer	Police senior detective officer appointed by gold to assume responsibility for all aspects of the police investigation
SitRep	Situation report
Strategic Level (Gold)	The level of management which is concerned with the broader and long-term implications of the emergency
Survivors	Those in the immediate vicinity of, and who are directly affected by, an emergency, possibly as wounded casualties
Survivor Reception Centre	Secure location to which survivors, not requiring hospital treatment, can be taken for shelter, first aid, interview and documentation
Tactical Level (Silver)	The level at which the emergency is managed, including issues such as, allocation of resources, the procurement of additional resources, and the planning and co-ordination of ongoing operations
Temporary Mortuary	A building of vehicle adapted for temporary use as

	a mortuary
Triage	A process of assessing casualties and deciding the priority of their treatment and / or evacuation
Warn and Inform the Public	Establishing arrangements to warn the public when an emergency is likely to occur or has occurred and to provide them with information and advice subsequently.

Acronyms

AD	Assistant Director
BSO	Business Services Organisation
BT	British Telecom
BTS	Blood Transfusion Service
CBRN	Chemical, Biological, Radiological & Nuclear
C&C	Command & Control
CCA	Civil Contingencies Act 2004
CCF	Civil Contingencies Framework
CCGNI	Civil Contingencies Group Northern Ireland
CCPB	Civil Contingencies Policy Branch
CHaPD	Chemical Hazards and Poisons Division
CMG	Crisis Management Group
CRIP	Common Recognised Information Picture
CX	Chief Executive
DoH (NI)	Department of Health (Northern Ireland)
DPH	Director of Public Health
DSCC	Directorate Social Care & Children
ED	Emergency Department
EmPEnH	Emergency Planning & Environmental Hazards Team within the Public Health Agency
EOC	Emergency Operations Centre

ESC	Emergency Support Centre
ETA	Estimated Time of Arrival
ETD	Estimated Time of Departure
GAC	Governance & Audit Committee
HP	Health Protection
HPA	Health Protection Agency
HR	Human Resources
HSC	Health & Social Care
HSCB	Health & Social Care Board
HSE	Health & Safety Executive
ICT	Incident Control Team (Silver)
IT	Information Technology
JR	Joint Response
LA	Local Authority
LGEMG	Local Government Emergency Management Group
MA	Multi Agency
MCA	Maritime and Coastguard Agency
ME	Major Emergency
MMMF	Man Made Mineral Fibres
MOU	Memorandum of Understanding
N&AHP	Nursing & Allied Health Professionals
NHS	National Health Service
NIAS	Northern Ireland Ambulance Service
NICCF	Northern Ireland Civil Contingencies Framework
NICCMA	Northern Ireland Central Crisis Management Arrangements

NIE	Northern Ireland Electricity
NIEA	Northern Ireland Environment Agency
NIFRS	Northern Ireland Fire & Rescue Service
NIO	Northern Ireland Office
NIOBR	Northern Ireland Office Briefing Room
OFMDFM	Office of the First Minister, Deputy First Minister
PA	Personal Assistant
PDCM	Performance Director Corporate Management
PHA	Public Health Agency
PHE	Public Health England – established 1st April 2013
PMSI	Performance Management & Service Improvement
PR	Public Relations
PSNI	Police Service of Northern Ireland
RHCC	Regional Health Command Centre
RNLI	Royal National Lifeboat Institution
RPA	Review of Public Administration
RVP	Rendezvous Point
SAR	Search and Rescue
SITREP	Situation Report
SPOC	Single Point Of Contact
STAC	Scientific & Technical Advice Cell
SOP	Standard Operating Procedure

Foreword

The overall aim of this joint emergency plan is to outline the main arrangements for a joint response by the Public Health Agency (PHA), the Health & Social Care Board (HSCB) and the Business Services Organisation (BSO) in an emergency, thereby ensuring that the response of the 3 regional HSC organisations is co-ordinated and effectively managed.

The objectives of the Emergency Plan are to:-

- Rapidly mobilise sufficient staff and resources to deal with the emergency;
- Establish and maintain good communications internal and external to the organisations;
- Ensure good coordination exists within the HSC in the event of an emergency occurring;
- Ensure expert advice and guidance is available in a timely manner in the event of an emergency.
- To provide an overview of the regional Mass Casualty Incident (MCI) co-ordination arrangements by HSC 'Silver'.

This document is intended as a guideline to aid an effective response to an incident irrespective of its cause. It has also been designed to comply with the requirements set out in the Northern Ireland Civil Contingencies Framework and to have interoperability with other HSC emergency plans.

This plan will be reviewed and updated, on an annual basis, or more regularly if circumstances change, i.e. a major emergency occurs.

Ms Name Redacted **- Chief Executive Public Health Agency and Health & Social Care Board**
Mr Name Redacted **- Chief Executive Business Services Organisation**

Section 1

Introduction to Plan

Scope of Plan

Purpose of Plan

Roles and Responsibilities

Introduction to Plan

1.1. Scope of Plan

Within the NHS a major emergency is defined as: - "*any occurrence which presents serious threat to 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 implanted by hospitals, ambulance trusts or primary care organisations.*" Source: NHS Guidance on Major Emergencies 2005.

For the NHS, this will include any event as defined as follows:

(a) An event or situation which threatens serious damage to human welfare in a place in the united Kingdom
(b) An event or situation which threatens serious damage to the environment of a place in the United Kingdom
(c) War, or terrorism, which threatens serious damage to the security of the United Kingdom.
(Section 1, CCA 2004)

NB The term 'Incident' can be used interchangeably with the term 'Emergency'. However, it must be noted that some incidents are of such a scale that from the outset they will be declared an emergency and the plan activated. In contrast other incidents may develop more slowly over time for example as in a severe weather event where service continuity issues (being dealt with by one of the three organisations) grow over time in magnitude and geographical spread to become an emergency. In the case of the latter the senior officers from the three organisations will be contacted and jointly agree when this point occurs, the emergency declared and the joint response plan activated. It is important to note that the good practice principal of activating high and standing down low should be followed in each situation.

This plan is designed to be sufficiently flexible to respond to any type of incident irrespective of how the emergency might originate or progress and hence in the document the term emergency and the term incident are used interchangeably.

1.2. Purpose of Plan

The PHA / HSCB / BSO may be involved in responding to a range of incidents that have the potential to impact on the wider health and wellbeing of the public. The main types of emergency are categorised as follows:-

EXTERNAL INCIDENTS (arising external to HSC)
Sudden Event ('Big Bang')

The classic example of this type of incident would be a sudden, major transport or industrial accident with a large number of casualties.

The Ambulance Service and other emergency services will be First Responders with receiving hospitals directly involved in the incident response. The wider public health implications of this type of event may not be immediately evident.

Gradual Development ('Rising Tide')

Communicable disease outbreaks, epidemics and hospital bed availability problems along with severe weather disruptions are all examples of this type of incident. The incident may have no clearly defined starting point and the exact point at which the incident becomes an Emergency may only be clear in retrospect.

Incident Elsewhere ('Cloud on the Horizon')

In this scenario an event in one location has a major impact in another location. The threat may even occur overseas e.g. a chemical or radioactive release. Normally the progress of the threat can be observed and predicted – not unlike a flu epidemic.

Public or media alarm

An Emergency may result from alarm over a perceived threat rising from a health issue. The alarm may be due to the public's perception of an issue or may be media driven and fears may be unfounded. Examples of this type of incident might include drug recalls, endoscope decontamination or malpractice.

INTERNAL INCIDENTS (arising within the HSC)

Events within the HSC itself may seriously impair the provision of health services e.g. fire, equipment failure, healthcare-acquired infection, staffing crisis or violent crime.

An emergency of the types listed above could occur at any time and it is essential that the PHA/HSCB/BSO have robust but flexible plans in place to ensure that a coordinated and timely response can be achieved. The PHA/HSCB and BSO have drafted this plan to help ensure that this can be achieved.

The PHA/HSCB and BSO have also completed Business Continuity Plans. These plans are compliant with the standards that are set out in the ISO 22301.

This plan has been put in place in line with each organisation's statutory responsibilities and follow recognised good practice within the area of emergency preparedness and response (Appendix A).

1.3. Roles and Responsibilities

This section outlines the roles and responsibilities of the Public Health Agency (PHA); the Health & Social Care Board (HSCB); the Business Services Organisation (BSO); Trusts and the DOH (NI) in relation to emergency preparedness and response as set out in DOH (NI) Policy Circular 2010 Emergency Preparedness for Health and Social Care Organisations). This document may be subject to review following implementation of the revised Performance Framework (22June 2017).

Responsibilities
DoH (NI)

In relation to responding to emergencies the DoH (NI) is responsible for leading and co-ordinating the health response when an emergency has been categorised as serious or catastrophic **and requires a cross-departmental or cross-governmental response**. In such scenarios the Department will be supported by PHA, HSCB and BSO. The severity and complexity of an emergency will dictate the level of involvement of the Department in the health response to it. If required the DoH (NI) will activate its emergency response facility, the Regional Health Command Centre (RHCC) and its Emergency Response Plan.

Public Health Agency (PHA)

The three core functions of the PHA are health protection, health improvement and commissioning support to the Health and Social Care Board. The statutory health protection function of the Director of Public Health (DPH) include emergency preparedness, the development of Public Health emergency plans and support to Trusts and other HSC and non-HSC organisations as required. In adherence to the Performance Management Framework (22 June 2017),the PHA will provide professional advice to the Department with regards performance (and financial) management, and support to Trusts within an overall cycle of continuous engagement and improvement on any given service or care area.

This JREP should also be read in conjunction with the PHA's Outbreak Plan that will be used in the event of a complex/major communicable disease outbreak. The Outbreak Plan is linked in Appendix J on Page 198.

Health and Social Care Board (HSCB)

The three core functions of the HSCB are finance; commissioning; and performance management and service improvement. The HSCB and PHA will work closely in reviewing performance in those areas for which the PHA is the lead organisation (such as health protection, including emergency preparedness) and any escalation of performance risks in these areas will be jointly agreed by HSCB and PHA. HSCB will also work with DOH (NI) and the PHA to secure funding and resources required to deliver health protection services to required standards including emergency preparedness and response. Where business cases are required the HSCB will work with PHA and DOH (NI) to develop these.

Business Services Organisation (BSO)

Through provision of its business support functions, such as procurement, logistics and human resources, across the HSC sector, the BSO will contribute to an integrated approach to ensuring an effective emergency response.

HSC Trusts

Trusts are to ensure compliance with contractual arrangements and DoH (NI) emergency preparedness guidance by developing comprehensive, robust and flexible emergency preparedness plans to address a range of emergency situations. In addition, when an incident is confined to one Trust, that Trust should lead the health response, drawing on support from PHA and HSCB as required. As a minimum, the Trust should keep the PHA informed of the progress and conclusion of its response to the incident.

Roles

When responding to an emergency or incident, regardless of the cause of the emergency, the HSC family is called upon to deliver on one or more of three functions:

(a) Provider response. This role falls mainly to the staff within the ambulance service in relation to pre-hospital care and to Trust staff in terms of acute clinical care of casualties. Social care staff within Trusts also have a provider role as they fulfil their responsibilities in relation to the setting up and running of Emergency Support Centres (ESC) in collaboration with local council staff and others.
(b) HSC co-ordination. The HSCB along with the PHA jointly lead the coordination of the HSC response when an incident or emergency involves more than one Trust, but does not require cross-department or cross-government coordination i.e. when an emergency is categorised as significant or serious. This includes the setting up and running of an Emergency Operations Centre (EOC) where necessary. The PHA/HSCB/BSO balance of the decision making team and chair will be dependent on the specifics of the incident;
(c) PH advice. In fulfilling their role of 'protecting the health of the local population' the Director of Public Health (DPH) is identified as being responsible for ensuring robust local arrangements are in place 24/7 to provide an early assessment of the actual or likely impact an incident may have on public health and public safety.

As per the DOH (NI) Policy Circular HSC (PHD) Communication 1/2010, and the Chief Medical Officer's report *"Northern Ireland Public Health Emergency Preparedness Audit 2008"*, The Public Health Advisor acts as the focal point in the provision of health, public health, health protection and other scientific advice as part of the incident management process.

The Public Health Agency is a multi-disciplinary, multi-professional body with a strong regional and local presence. The PHA has statutory responsibility for public health protection in Northern Ireland. In relation to emergency preparedness, CBRN/HazMat incidents the Agency is responsible for:

i. Responding to public health emergencies (including CBRN/HazMat) through the provision of robust local arrangements 24/7.
ii. Providing an early risk assessment of the actual or likely impact the incident may have on public health or public safety.

iii. To provide public health advice which includes where appropriate public health advice on:
   a. The health effects of exposure to the hazard,
   b. The need for decontamination (humans and the environment),
   c. The use and level of PPE worn by healthcare staff,
   d. The risk to vulnerable people,
   e. The clean-up (in relation to ongoing risk to the public),
   f. Post mortem and disposal of the body.

iv. Establishing, running and contributing to a Scientific and Technical Advice Cell (STAC) as and when required.

v. Participating in multi-agency emergency preparedness and response as set out within the Civil Contingencies Framework for Northern Ireland.

vi. Working within the resources available to provide HSC organisations with emergency preparedness guidance, advice and training as required.

In Northern Ireland the Health Protection Service within the PHA would fulfil this role of providing 24/7 public health advice into an unfolding emergency situation.

In an unfolding emergency any combination of the three roles may be required. When the response to an incident involves more than one Trust or a regional response is required following a MCI, the responsibility for the co-ordination of the HSC 'silver' response falls to the HSCB with support from PHA and the BSO.

In the event of a CBRN incident, the PHA (Health Protection) will lead on the co-ordination of HSC response with support from the HSCB and BSO. In this scenario the PHA Health Protection will also have lead responsibility for establishing a Strategic Technical Advisory Cell (STAC). Please refer to the Public Health CBRN (e):HAZMAT Incident Response Plan and STAC Plan for additional guidance.

Where the incident is of such a size that a joint incident team is required, HSC Silver will be established as depicted in Table 1. See the matrix on page **25** for further detail.

Section 2

Activation Procedure

Step 1 – Notification and Recording of the Incident

Step 2 – Initial Assessment of the Level of Joint Response Required

Step 3 – Cascade of Information through the three Organisations

Step 4 – Joint Decision Making

Step 5 – Immediate Actions

Activation Procedure

The activation process that leads into the activation of the Joint Response plan at one of the 4 levels of joint response involves several steps outlined in the following pages.

The activation steps should be followed in every incident /emergency regardless of the type of incident. In each situation whether it is a Major Incident, MCI or CBRN incident that clearly requires a joint response from the three organisations OR a slower onset incident that turns into an emergency over a period of hours or days (such as a severe weather incident or a complex/major communicable disease outbreak) the five steps outlined below should be applied. The steps are:

- Notification and recording of the incident (2.1),
- Initial assessment of the level of joint response required (2.2),
- Cascade of information through the three organisations (2.3)
- Joint Decision making (2.4), and
- Immediate public health +/- service continuity actions (2.5)

2.1. Step 1 – Notification and Recording of the Incident

The majority of unfolding emergencies will be notified to the PHA by the Northern Ireland Ambulance Service (NIAS). Notification, however, may come from a range of other organisations within the Health & Social Care (HSC) family (including the HSCB and the BSO) or alternatively from one of our partner organisations outside the HSC family such as the Northern Ireland Fire & Rescue Service (NIFRS) or one of the local councils.

Although there are potentially a number of sources of notification of an unfolding emergency for record management purposes every incident should be routed through the only one Single Point of Contact (SPOC) for receipt and recording of the tactical level (PHA/HSCB and BSO) notification and that SPOC is within the PHA as follows:

- **During office hours** ~ to alert the PHA/HSCB and BSO the notifying organisation/ agency should contact the Public Health Duty Room
- **Out of Hours** through the Public Health Doctor on call.

(Note: The Public Health Agency operates a 24/7 acute response health protection service 365 days per year staffed by Public Health Doctors and Nurses. The initial notification of a potential incident will be via this service. During office hours (Monday – Friday; 9am to 5pm) the Health Protection Duty Room in Linenhall Street will receive the notification. Out of hours and on public holiday's notification will be via the PH doctor on call rota activated by the Northern Ireland Ambulance Service (NIAS).

All Health & Social Care Trusts are required from April 2010 to notify the PHA if they have activated their Major Emergency Plan.

It is very important that information pertaining to the incident being notified is recorded in a consistent and complete manner. As set out in the individual directorate section (page 55) the Health Protection Consultant whether in hours or out of hours will note the details of the incident including contact details of the caller, and give immediate public health advice as required Proforma A & B (page 112).

2.2. Step 2 – Initial Assessment of the Level of Joint Response Required

Once the call is made to public health either directly from an external source or as noted above (page 21) indirectly from within HSC in a service continuity incident that over time has become an emergency the following aspects of the incident must be considered in making the initial assessment of the level of joint PHA:HSCB:BSO response required:

- Public Health impact/consequences;
- HSC service continuity impact / consequences;
- Complexity of the incident;
- Geographical spread of the incident;
- Competencies within PHA/HSCB/BSO needed for handling it;
- Potential duration of the incident;
- Impact on PHA/HSCB/BSO business continuity;
- Public perception (positive and negative), local and national
- Media attention local and national
- Potential malicious incident / act of terrorism, deliberate release

This initial assessment of the level of joint response required should take place as soon as possible and be communicated early within each of the three organisations. As noted above if the HSCB or the BSO are involved in a service continuity issue within the service (beyond that which they would normally deal with on a day to day basis) **and** it has the potential to escalate into an emergency (e.g. severe weather event) the senior officer dealing with the issue should notify the PHA as above. In this way a joint assessment as to the need to activate the emergency plan can be carried out i.e. step 2 of the plan activation process described here. In effect the HP duty room (out of hours HP on-call) consultant when contacted by HSCB or BSO in such a scenario would contact the Assistant Director Public Health (Health Protection) and the DPH, link with the HSCB and BSO senior officers and conduct the assessment.

NB The actual level of response required during an incident may change over time as new information becomes available. It is therefore important that following the initial assessment regular joint review assessments should be carried out and documented as the incident progresses. In this way the level of joint response can be escalated or de-escalated as appropriate.

Escalation and De-escalation

Criteria for Escalation	Criteria for De-escalation
• Increased geographic area or population affected	• Reduction in incident resource requirements

• The need for additional internal or external resources • Increased severity of the incident • Increased demands from (NI) DoH, partner organisations or other responders in HSC • Heightened public or media interest • Establishment of (NI) DoH Gold or COBR • Increased UK threat level	• Reduced severity of the incident • Reduced demands from the (NI) DoH or from partner organisations or other responders. • Reduced public and media interest • Decrease in geographic areas or communities affected. • Decreased UK threat level.

Changes in incident level can only be authorised by the Director of PH (or nominated deputy) and the Director of Performance and Corporate Services, PMSI (or nominated deputy). All response level changes need to be communicated both internally and externally as appropriate.

Levels of Joint Response

The level of joint response (Table 1) required can range from a single person in one organisation giving advice on immediate actions to be taken, (such as health protection advice into a chemical incident OR HSCB service continuity advice into a major road traffic collision), to the full resources of all three organisations (PHA/HSCB/BSO) being committed over a protracted period of time as in a mass casualty CBRN (Chemical; Biological; Radiological; Nuclear) terrorist incident with very significant health protection and service continuity implications. Some incidents may also have major national and international implications whilst others would remain very local.

Four levels of joint PHA/HSCB/BSO response are outlined in the matrix (Table 1) and text below.

Table1. Levels of Joint (PHA; HSCB; BSO) Response on receiving notification of a Potential Major Incident –

Level of Joint Response (JR)	Public Health / Service Continuity Implications	Joint Response	Example
Level 1 JR	An Acute Incident with **no** Public Health or Service Continuity implications	**Noting** and Monitoring	A serious Road Traffic Collision (RTC) managed by single Trust

Level 2 JR	An Acute Incident with **potential** PH /+ Service Continuity implications	**Advice** from either PHA **or** HSCB or both	A fire in a plastics recycling plant with a toxic smoke plume (chemical incident) and potential evacuation of a health estate.
Level 3 JR	An Acute Incident with **definite** PH / + Service Continuity implications	**LOWER END OF SPECTRUM** **Action by an Incident Control Team**[1] of PHA and HSCB +/- BSO **HIGHER END OF SPECTRUM** **Action by an Incident Control Team**[2] of PHA and HSCB. This level may also include the setting up and running of an EOC / Information Hub	An acetylene gas tank incident at a hospital with subsequent horizontal evacuation of inpatients and cancellation of outpatient clinics. A fire at a COMAH site with significant numbers of casualties **OR** a plane crash with mass casualties and fire on board plane
Level 4 JR	An Acute Incident with **definite major** PH / + Service Continuity implications	**Action by Incident Control Team**[3] of PHA; HSCB & BSO. This level will include the setting up and running of an EOC/Information Hub	A large HAZMAT / CBRN terrorist incident with the setting up of a STAC (Scientific and Technical Advice Cell) **OR** a high mortality pandemic influenza. Mass Casualty Incident or MTFA with multiple casualties.

The four levels cover incidents that range from those that are entirely local in their management and impact, through to those which require NI wide intervention. The text below describes the arrangements within each level in more detail.

Level 1 JR (*An Acute Incident with **no** PH / Service Continuity implications*)

[1] This may in the initial stage be 3 senior officers, one from each of PHA, HSCB and BSO

[2] ICTeam (Silver) is a formal process with agendas; minutes and actions etc. and as a minimum will include Assistant Directors/ Directors or their nominated representatives from at least one organisation.

[3] This ICT (Silver) will include senior Management Team members from the three organisations

A Level 1 joint response does not require the active involvement of any of the agencies, beyond initial receipt, assessment and recording of the incident. If an incident such as this is notified to the PHA, either through the Duty Room or through the PH Doctor on call, then the full details of the incident are logged and filed in the appropriate section of the Notification and Assessment Proforma (Appendix B). A decision is also made as to the need to review the situation at a later date in case it escalates.

Level 2 JR (*An Acute Incident with **potential** PH/ Service Continuity implications requiring **advice**) (this may or may not require an Incident Control Team to be convened – if required likely to be a virtual team)*

A Level 2 joint response is a scenario that requires advice (and ongoing monitoring) from the PHA **and/or** the HSCB. The initial assessment of the incident will again be carried out by the PH Officer (Health Protection consultant in the duty room OR on-call) as in Level 1.

The HSCB and BSO will be informed by PHA of all Level 2 incidents (potential and actual) in order to assess any service continuity implications. Unlike Level 1, the initial assessment in a Level 2 incident would identify the need for further action and require a more specialised ongoing response. Specialised input may be sought from the Emergency Preparedness and Environmental Hazards (EmPEnH) Team members in the PHA **and/or** the relevant HSCB officer. The specialised advice may be in the form of specialised health protection advice e.g. chemical decontamination advice **or** in the case of service continuity advice it may relate to ambulance diverts and the regional unscheduled care escalation plan. This level of response may also require PHA/HSCB attendance at multi-agency co-ordination meetings. The Assistant Director Public Health (Health Protection), the health protection consultant, the HSCB officer and the BSO officer will agree who the most appropriate person is to attend these meetings. This will depend on the specifics of the incident.

All incidents requiring a level 2 Joint response and above once initiated will be communicated to nominated senior staff within the 3 organisations and further cascaded internally as appropriate.

Level 3 JR *(An Acute Incident with **definite** PH / Service Continuity implications requiring an **Active response by a Joint Team** (this may or may not require an Incident Control Team to be convened)*

A Level 3 joint response is an incident that requires ongoing action from the PHA and HSCB and possibly BSO that goes beyond that of simply offering advice. A range of incidents fall within this category of joint response from the not so complex, relatively short duration incident to the much longer more complex incident that may last for a number of days.

At the **lower** less complex end of the spectrum of JR3 incidents a core incident control team from both the PHA and HSCB +/-BSO will be involved (a minimum of one person from each ~ the Health Protection Consultant from the PHA and a Senior Officer from the HSCB) may be required for a few hours. At least one meeting (real or via teleconference) of the core team will be held to:

- agree the level of joint organisational response from PHA; HSCB and BSO,
- agree and implement the immediate joint health protection and service continuity actions required,
- contact the relevant staff within the PHA;HSCB;BSO (as per action cards)
- Agree the appropriate staff member to attend Trust Incident team meetings or multi-agency command meetings as necessary. This will again depend on the specifics of the incident.

At the **higher** end of the spectrum of JR3 incidents there would be scenarios that are more complex and have wider implications on health protection and / or service continuity. These incidents would require an incident control team (IC Team - Silver) with wider membership from both organisations.

NB: It is important to note that the actual numbers and specialities of the specific senior officers from each organisation involved in the IC Team (Silver) will be dependent on the incident itself and needs to be flexible enough to cover a range of incidents.

The appropriate chair of the IC Team (Silver) will also be incident dependent and will be confirmed at the first meeting. A core team will include:

From PHA:

- Director of Public Health (or their nominated representative)
- Assistant Director Public Health - Health Protection (or their nominated representative),
- the Emergency Preparedness Lead OR the EmpEnH team lead
- Public Relations / media representation

From HSCB:

- Director on Call or Director of Finance/Deputy Chief Executive as appropriate
- Director of Performance or nominated representative.
- Director of Corporate Services
- Director of Commissioning
- Director of Integrated Care (or their nominated representative)
- Director of Social Care and Children (or their nominated representative)
- Public Relations / media representation
- Emergency Planning HSCB
- Unscheduled Care Lead
- IT and Performance

From BSO

- Chief Executive BSO
- Procurement and Logistics (PaLS)
- Human Resources (HR)
- Information Technology (IT)

Level 4 JR *(An Acute Incident with* ***major*** *PH/Service Continuity implications requiring* ***a high level Incident Control Team [chief executive or their representative from each of the three organisations] and an EOC/Information Hub***.

This is a mass casualty high profile major emergency that would be of a scale and nature that would have major implications for health protection, the HSC and the wider community in NI. In instances such as these all three organisations, i.e. PHA/HSCB and BSO will have a significant role to play in the management of the HSC response. The ICT Team (Silver) and EOC/Information Hub would be fully established and functioning for incidents such as these.

Examples of Joint Levels of Response

- An example of an incident requiring a Level 1 response would be an acetylene gas tank explosion near a residential area with no injuries or a small number of casualties with minor injuries only. This scenario may also require some localised evacuation of residents. The incident would be managed by local emergency services, District Councils and the local HSC Trust, in particular social services staff and as such should be notified to PHA/HSCB/BSO for information.
- An example of an incident requiring a Level 2 PHA/HSCB/BSO response would be a chemical incident such as a fire in a plastics recycling plant with a toxic smoke plume requiring specialised health protection advice, and the service continuity issues that arose in relation to the potential evacuation of vulnerable patients from inpatient facilities on a health estate.

A Health Protection consultant would give advice into the emergency response via the NIAS / NIFRS / PSNI or Local Council (This has to be available to the Multi Agency (MA) commander within 15 minutes and **if the incident escalates** a STAC may have to be set up within 1-2 hours. (This falls within National Guidance and the responsibility of the Regional Director of Public Health.)

Where service continuity issues are evident the senior officer from the HSCB would liaise with the relevant service provider (e.g. Trust or Primary Care) to give advice. This may relate to the activation of the regional escalation protocol recently developed.

- An example of this lower end JR3 incident would be an acetylene gas tank incident at a hospital with subsequent horizontal evacuation of inpatients and cancellation of outpatient clinics, OR a prolonged severe weather incident with service continuity and public health implications.
- An example of an incident requiring a high end JR3 PHA/HSCB/BSO response
  (a) with a balance of PHA senior staff on the IC Team (Silver) and chaired by PHA would be a fire at a COMAH (Control of Major Accident Hazards Regulations) site where there would be significant health protection issues in relation to the toxic chemicals on site and service

continuity issues in relation to casualties or complex/major communicable disease outbreak.

(b) with a balance of HSCB senior staff on the IC Team (Silver) and chaired by HSCB would be a mass casualty incident (e.g. plane crash and fire on board) where two or more HSC Trusts had activated their Major Emergency Plans in view of the number of casualties being managed and health protection issues in relation to MMMF[4] and the fire on board the plane.

The high end JR3 response may or may not require an EOC/Information Hub to be established and hence the involvement of the BSO staff if not already involved.

- An example of an incident requiring a Level 4 PHA/HSCB/BSO response would be a Mass Casualty Incident (MCI) and/or Marauding Terrorist Firearms Attack (MTFA) or a large HAZMAT / CBRN (Hazardous Materials/Chemical, Biological, Radioactive, Nuclear) terrorist incident, with the setting up of a STAC (Scientific and Technical Advice Cell) or a high mortality influenza pandemic.

It is noted that the DoH (NI) also has the Emergency Response Plan. The decision to activate and the specific level of activation will be a decision of Departmental colleagues, however, it is noted that if both JREP and ERP are activated both HSC Gold and Silver will be regular and agreed communication.

2.3. Step 3 – Cascade of Information through the three Organisations

All incidents that are notified and assessed as requiring a joint response above level 1 i.e. JR Levels 2-4 should be notified by PHA to HSCB and BSO. The protocols for doing this in hour and out of hours are available in **Appendix B.** The communications cascade will be tested every six months as a requirement of the Emergency Planning Controls Assurance Standard.
Once JREP activated HSC Trusts and DOH (NI) will be informed of this and agreed level and if they are required to participate in any meetings/teleconferences, etc.

2.4. Step 4 – Joint Decision Making

(a) Structure (Command & Control)

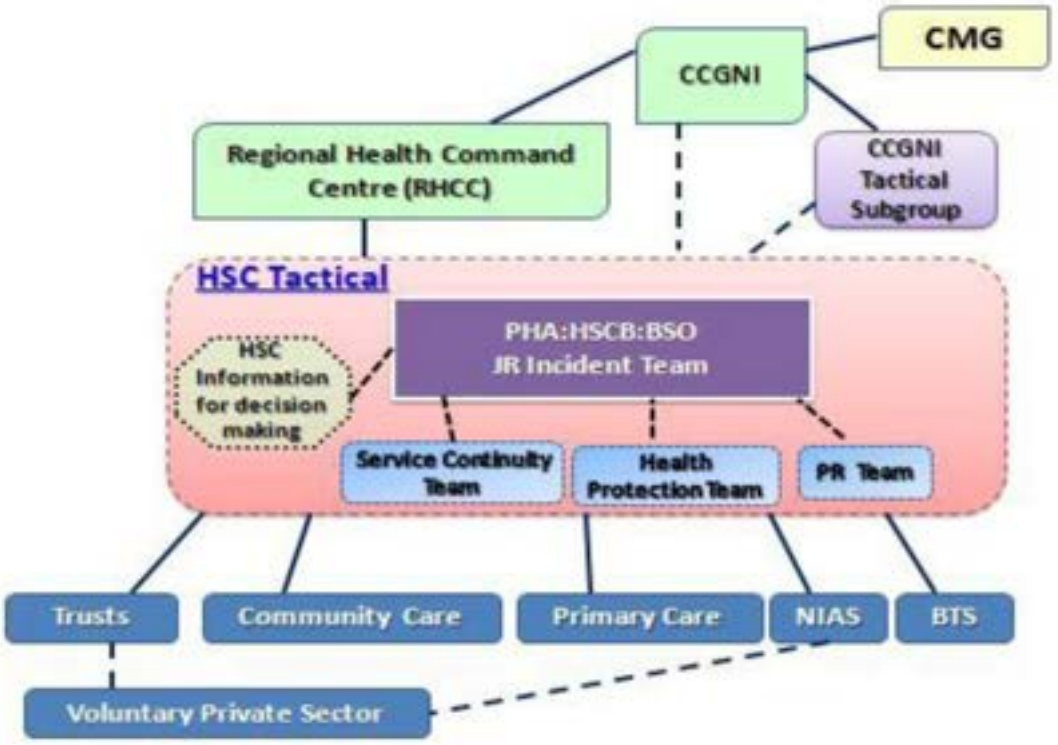
The joint decision making structure that would be set up in an incident will be dictated by the specifics of the incident itself. Some incidents will require the full structures to be set up (Fig 1) whereas others may only require several joint meetings between the three organisations and linkages with the service and therefore partial setting up of the structures (Fig 2).

A CBRN or MCI would require a level 4 Joint Response and therefore have **the full range** of command and control structures established within the HSC as shown in Figure 1. At the other end of the spectrum a level 2 joint response may only require officers from PHA: HSCB +/-BSO to liaise on a few occasions (either face to face or via conference call) and as would only require **partial** setting up of the structure (fig

[4] Man-Made Mineral Fibres

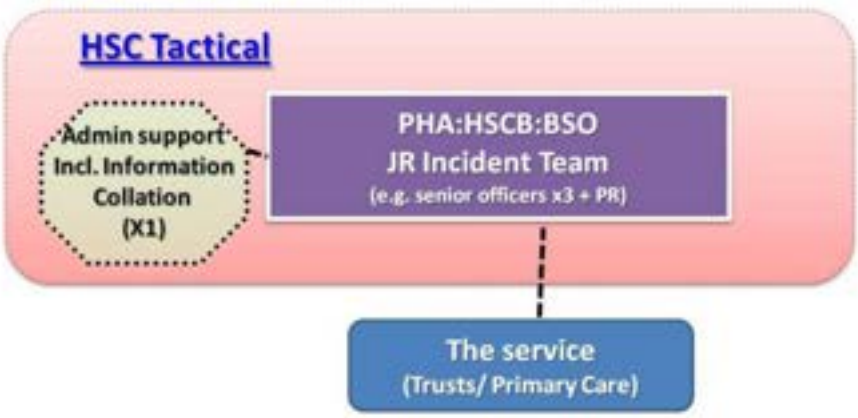
2). The initial step would be to jointly review the risk assessment and agree the level of joint response required and hence the decision making structure needed.

Fig 1: Full Decision making structures within HSC (Command and Control)



CMG:	Crisis Management Group
CCGNI:	Civil Contingencies Group Northern Ireland
BTS:	Blood Transfusion Service
NIAS:	Northern Ireland Ambulance Service
OCT:	(please see Fig 3 on page 45) regarding structures for Outbreak Control Team.

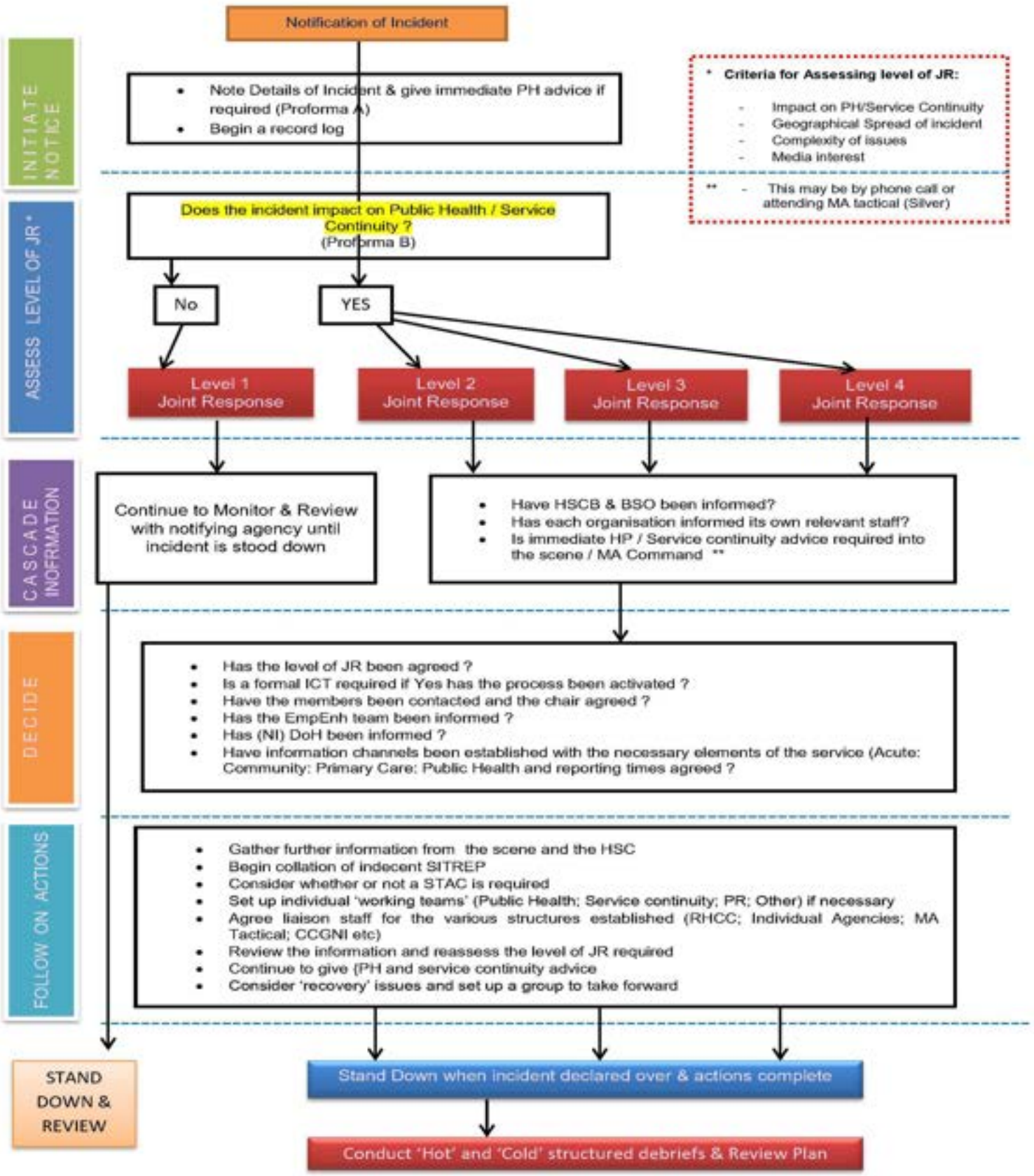
Fig 2: Partial Decision making structures within HSC (Command and Control)



(b) Decision Tree

Figure 3 below sets out the different stages in the decision making processes that need to be followed by PHA: HSCB: BSO: when notified of an incident.

Fig 3: Decision Making Tree for Joint Response



2.5. Step 5 – Immediate Actions (See Fig 2)

PHA Immediate Action

The following immediate actions need to be taken by the HP Consultant:-

1. **During office hours:** if the incident is assessed as a Level 2 or above by the HP Consultant, he/she should contact the Assistant Director (Health Protection). The Assistant Director (Health Protection) will then contact the HSCB Director on call.

   Out of hours: the HP Consultant will contact the DPH or designated deputy to confirm the level of Joint Response required. The DPH will then contact the HSCB Director on call and if Level 3 or above a senior officer in BSO.

2. Link to scene/Multi Agency (MA) Command centre
   a. gather further information
   b. review the public health risk assessment
3. Notify the EmPEnH team if available.
4. Maintain an incident and decision log throughout and input where necessary at Multi-Agency or Trust Command.
5. Liaise with PHE (PHE) (CHaPD) where required.
6. Liaise with relevant agencies as necessary.
7. The HSCB Director on call will access facilities as outlined in the Emergency Operations Centre (EOC) plan.
8. Contact the PHA Communications Manager if the incident is a Level 2 or above. There are on-call PR arrangements in place also.

HSCB Immediate Action

As stated above the PHA will contact the HSCB through the agreed point of contact if an incident appears to be a Level 2 or above.

During office hours the first point of contact is the Director of Performance or designated deputy, Emergency Planning/Business Continuity Manager if unavailable. Outside office hours the first point of contact is the HSCB Director on call.

However, if none of these officers are available any Director within HSCB may be tasked with the responsibilities below. Cascade contact should follow the order set out in Annex 2.

The HSCB officer notified in hours or out of hours will:

1. Agree with notifying person from PHA the level of response required;
2. Assess situation and determine which Directorate(s) within HSCB need to be notified to take forward HSCB response;

3. Advise Chief Executive, if during office hours.
4. Chief Executive/ Director of Performance will contact other relevant Directors in HSCB re nature of incident and required response. This should follow the order set out in Annex 2;
5. HSCB Director (or deputy) will contact their PR Manager (or deputy);
6. Agree with PHA senior officer the level of information and administration support required and the staff member(s) who will be responsible. In a lower level joint response this would require a senior administration support officer to keep notes of meetings and actions taken to a higher level of joint response requiring an HSC wide situation report (SITREP) and hence a group of information staff may be needed to process larger volumes of information.
7. Dependent upon the nature and scale of the incident, during office hours the HSCB Director will liaise with Corporate Business Manager or deputy in order to initiate facilities requirements, support to setting up of EOC (refer to EOC operational plan)
8. Complete log of action taken, who communicated with, etc;
9. Determine and agree Directorate representative on Incident Control Team
10. Determine and agree Directorate representation/support to EOC.

The PHA will subsequently coordinate and command the joint response if the incident is assessed as being primarily a Public Health incident.

Alternatively, HSCB will subsequently coordinate and command the joint response if the incident is assessed as being primarily a service continuity incident.

BSO Immediate Action

As stated above the PHA DPH or designated deputy will contact the BSO through the agreed point of contact if an incident appears to be a Level 3 or above. **During office hours the first point of contact is the Chief Executive's Office OR Director of Human Resources Office. Outside office hours the first point of contact is the Chief Executive mobile numbers.**

The BSO officer notified in hours or out of hours will:

Initial notification of an incident (In Hours)

1. Agree with notifying person from PHA the level of response required. Agree if it is likely to require incident group (Incident Control Team) and/or agree timescale for feeding back to agreed PHA contact;
2. Advise Chief Executive, if during office hours. Outside office hours first point of contact should normally be Chief Executive;
3. Assess situation and determine which Directorate(s) within BSO need to be notified to take forward BSO response. Agree method of internal discussions require to take place to enable feedback to PHA/HSCB;

4. Chief Executive(or nominated deputy)/DHRCS will contact the relevant Director in BSO regarding the nature of incident and required response and agree timescale for feedback of actions, etc. to PHA/HSCB;
5. DHRCS will contact all Directors to ensure all informed;
6. Dependent upon nature and scale of incident DHRCS or Administrative Services manager will initiate facilities requirements, support to setting up of EOC, etc.
7. Complete appropriate log of action taken, who communicated with, etc;
8. Determine and agree Directorate representative on Incident Team if required
9. Determine and agree Directorate representation/support to EOC if required.

Initial Notification (Out of Hours)

1. Agree with notifying person from PHA the level of BSO response required. Agree if it is likely to require incident group (Incident Control Team) and/or agree timescale for feeding back to agreed PHA/HSCB contact;
2. Advise Chief Executive, if during office hours. Outside office hours first point of contact should normally be Chief Executive;
3. Assess the situation and determine which Directorate within BSO needs to be notified re incident and required response, and agree timescale for feedback of actions, etc. to PHA/HSCB;
4. Contact relevant Director in BSO re nature of incident and required response, including agreed timescale for feedback if required;
5. Contact HSCB (who will contact)/Communications/PR Manager;
6. DHRCS will contact all Directors for information purposes;
7. Complete log of action taken and who communicated with;
8. DHRCS will, dependent upon nature and scale of incident liaise with HSCB in order to initiate facility access, security, etc. and support to setting up of EOC, etc.;

Section 3

Emergency Response

Establishing an Incident Control Team

Working of IC Team (Silver)

Location of IC Team (Silver)

Establishment of an EOC/Information Hub

Information Flows & Situation Reports (SITREPS)

Location of the EOC/Information Hub

Call Out of Staff

Staff Muster Point

Support Staff Requirements & Staff Flexibility Requirements

Communications & IT Requirements

Scientific & Technical Advice Cell

Creation of Helpline

Dealing with the Media

Emergency Response

The range, complexity and scale of incidents that the joint PHA/HSCB/BSO emergency response arrangements have to be capable of dealing with are potentially large and unpredictable. For this reason the plan has to be flexible. The following sections set out in Part A are the **cross cutting areas** that need to be considered as to whether or not they are required in a particular unfolding scenario. Part B goes into more detail on the **individual directorate operational procedures.**

Joint Response Cross cutting areas / themes

3.1. Establishing an Incident Control Team

Once the initial alert has been received and an assessment of the level of joint response required the decision must be made as to whether or not to formally establish an Incident Control Team (IC Team -Silver).

It must be noted that in the early stages of a major emergency the IC Team (Silver) may not physically meet as especially out of hours it may take time to establish meeting rooms and muster staff. In these early stages an IC Team (Silver) may still meet in virtual form with a few core members with the use of telecommunications. In these early stages senior staff from PHA and HSCB should continue to individually record all decisions and actions and file these within the Incident File.

The decision to establish an IC Team (Silver) will be judged on the scale of the incident in accordance with the action cards in Appendix C but in general the following should act as a guide:-

JR Level 1
No Requirement for an IC Team (Silver) or EOC/Information Hub

JR Level 2
Unlikely that an IC Team (Silver) or EOC will be required however virtual IC Team (Silver) may be convened between senior officers from HSCB and PHA.

The need to establish a subsequent IC Team (Silver) and EOC if the incident escalates needs to be kept under review.

JR Level 3
Likely that IC Team (Silver) and or EOC will be established.

JR Level 4
IC Team (Silver) and EOC will be established.

3.2. Working of the IC Team (Silver)

Timing and Duration

Incident Control Team meetings should be short (approx. 20-30 mins) and very focused and their frequency may range from 2 hourly in a 'big bang' incident such as an explosion in a chemical plant to daily meetings in a 'rising tide' incident such as a severe weather incident or complex/major communicable disease outbreak. Where teleconferencing is used refer to guidance (Appendix I)

Strategic Objectives of IC Team (Silver)

The strategic objectives of the team are to:

- Protect the health and wellbeing of the public of Northern Ireland
- Provide public health advice to:
  - The public
  - Professionals within the HSC (e.g. Hospitals; Community Care; GPs; Dentists; Pharmacists; Optometrists)
  - Other agencies
  - First Responders (through their occupational health staff)
- Maintain service continuity within the HSC through the co-ordination of actions across Trusts.
- Monitor and conduct surveillance on the impact of the incident on the health and wellbeing of the public.
- Monitor the effectiveness of the response and make adjustments as necessary

Membership of IC Team (Silver)

The Incident Control Team will vary in size and representation. The exact makeup will depend on the nature and scale of the emergency itself and the balance of public health and service continuity issues to be managed. However, senior decision makers from PHA, HSCB and BSO are the key officers who will sit on the IC Team (Silver).

The chair of the incident team (**Chief Executive** or their nominated representative) will depend on the incident itself and be agreed by PHA;
HSCB; BSO senior officers at the first meeting. The following general principle will apply:

- **The PHA will coordinate and lead the response if the incident is assessed as being predominantly a Public Health incident, for example a complex/major communicable disease outbreak.**
- **Alternatively, HSCB will coordinate and lead the incident if it is predominantly a service continuity incident, for example a mass casualty incident.**

Roles within the Incident Control Team
Chair

As stated at 3.2.3 the chair of the Incident Control Team will be dependent on the incident itself, i.e. a public health incident or service continuity incident. This decision will be made at the time of the incident after initial discussion between senior staff in both HSCB and PHA.

When the decision is made to establish an Incident Control Team the Chair, who will either be a senior officer from PHA (normally Director of Public Health or designated deputy) or senior officer from HSCB (normally Director of PMSI or designated deputy) should use the following as a guide to actions:-

PHA LED INCIDENT - DPH OR DESIGNATED DEPUTY
Key Roles:-

1. Obtain a briefing on all relevant details of incident from the HP Consultant on call or A/D Health Protection **and record**.
2. Where necessary, liaise and review with all relevant PHA officers, the Public Health Risk Assessment (this is one of the first steps that should have been taken by the PHA officer receiving the initial notification).
3. Agree the Level of PHA/HSCB/BSO response required (as per matrix) in discussion with HSCB & if required, BSO relevant senior management.
4. Where necessary, review the joint risk assessment in relation to public health and service continuity impacts
5. Where necessary convene a Health Protection Team, Service Continuity Team to assist HSCB response and Support Team.
6. Confirm that DoH (NI) has been informed of the incident
7. Approve a holding media statement, if required
8. Where necessary liaise further with other relevant agencies, HSC Trusts, NIFRS, PSNI, NIAS, etc. at appropriate level and where appropriate recommend multi-agency meeting be convened.
9. Nominate appropriate members of staff to act as Liaison Officers into Trust; DOH (NI); and Multi-agency meetings where necessary
10. Consider the need for a STAC
11. If following risk assessment and discussion the incident is deemed serious enough , i.e. a Level 3 or 4 major emergency as per Matrix ensure an EOC/Information Hub and Incident Control Team is set up and chair the first meeting.
12. When required, ensure that organisations activate plans for recovery and eventual return to normal

NOTE: If incident is HSCB-led, DPH or designated deputy will be member of Incident Control Team and lead public health response but senior officer from HSCB will chair ICT. Above actions may still be relevant.

HSCB LED INCIDENT

1. Obtain a briefing on all relevant details of incident from the PHA **and record**;

2. Confirm with the PHA, BSO and HSCB lead director or nominated deputy the level of response required.
3. Contact, inform and assemble incident team members
4. Ensure incident room is set up and distribute action cards
5. Develop/approve a media holding statement (joint statement)
6. Arrange for the relevant information to be gathered
7. Inform relevant organisation(s) of arrangements for contacting the incident team (phone, e-mail, web)
8. Inform other relevant local agencies
9. Identify any business/service continuity needs & coordinate actions across Trusts where necessary to ensure business continuity
10. Provide agreed regular updates to the DOH (NI) lead director
11. Confirm arrangements for co-ordinating and producing the INCIDENT SITREP.
12. Agree frequency and times of meetings
13. When the incident is stood down ensure the message is communicated to relevant parties.

Public Health Lead

Where an incident is service continuity led there will be a requirement for public health input on medical issues that may be impacted upon when service continuity disruptions occur.

In these circumstances a consultant from Service Development and Screening from the Directorate of Public Health will be required to be on the Incident Control Team. Their specific role will be to gather public health intelligence regarding the incident and to feed relevant information to the ICT Chair, (Proforma D1 Checklist). A specific PH Service continuity team may also be convened to assist with clinical service issues.

Service Continuity Lead

Where an incident is public health led there will be a requirement for service continuity input to the Incident Control Team that may be impacted upon when a public health emergency occurs.

In these circumstances a senior officer from the PMSI Directorate, normally the Director or Assistant Director, will be the representative. Their specific role will be to gather service continuity intelligence and feed relevant information to the ICT Chair.

Other Directorates (where applicable)

Other Directorates from BSO/PHA or HSCB may be represented on the Incident Control Team. This will vary and are incident dependent, e.g. if the incident has social care implications the HSCB Directorate of Social Care and Children will be represented, etc.

These representatives will be responsible for ensuring issues related to their directorates are fed to the ICT for consideration. More specific detail on this is contained within the Directorate Plans.

PR/Communications Lead

The role of dealing with the media is crucial during the emergency. It will be essential that a senior officer from PR/Communications is represented on the Incident Control Team. Their role will be to ensure that the designated spokesperson is well briefed in dealing with the media. They will also assist the remainder of the Incident Control Team by keeping them informed of media developments.

Dependent on the size and scale of the incident there may be a need to establish a PR Team. Their role will be to assist with the coordination of the HSC media response and to ensure that a good liaison exists between the ICT and media. See Communications Plan (appendix G).

Role of Spokesperson

This should be a senior member of staff and if possible a member of the Incident Control Team. Their role will be to act as the joint PHA:HSCB:BSO spokesperson. They will act as the single conduit of information from the three organisations. However, it is most likely that they will come from either the HSCB or PHA.

The designated spokesperson will be dependent on the incident type; i.e. PHA if the incident is public health related and HSCB if the incident is service continuity related.

Loggist

As decisions made within the ICT are legally discoverable in any subsequent inquiry it is essential that an accurate record is kept of the various discussions and actions that emerge from each ICT meeting.

It will therefore be necessary to have a trained loggist as a member of the team. These trained officers will be from an administrative background and will note all key discussions and actions agreed.

At the end of each meeting the notes must be agreed by the ICT and signed off by the Chair of the Team and the Loggist.

Agenda and Running of meetings

In relation to the overall HSC response the purpose of the joint Incident Control Meetings are two-fold. Firstly it is to gain an understanding of the impact of the incident on the public and the service (including the impact on the PHA, HSCB and the BSO). Secondly, it is to identify and take the necessary actions (immediate and long term) in relation to public health actions and service continuity co-ordination as is required by the Silver (tactical) level.

Using a pre-agreed meeting agenda template (Appendix D) and recognised good emergency planning practice record keeping processes (Decision logs and Action Logs – see appendix F) lends itself to more effective meetings. As the dynamics of an incident can change dramatically over short periods of time it is important that the chairperson keeps a tight control of what is brought to the IC Team (Silver) table. These should only be:-

(a) An update from each functional area i.e. public health; acute hospital service continuity; community care service continuity; and service continuity in primary care;
(b) cross-cutting issues which the team needs to be informed of such as cancellation of electives with the knock-on impact in primary care OR requests for media interviews to individual organisations, and
(c) Those issues that need a joint team decision.

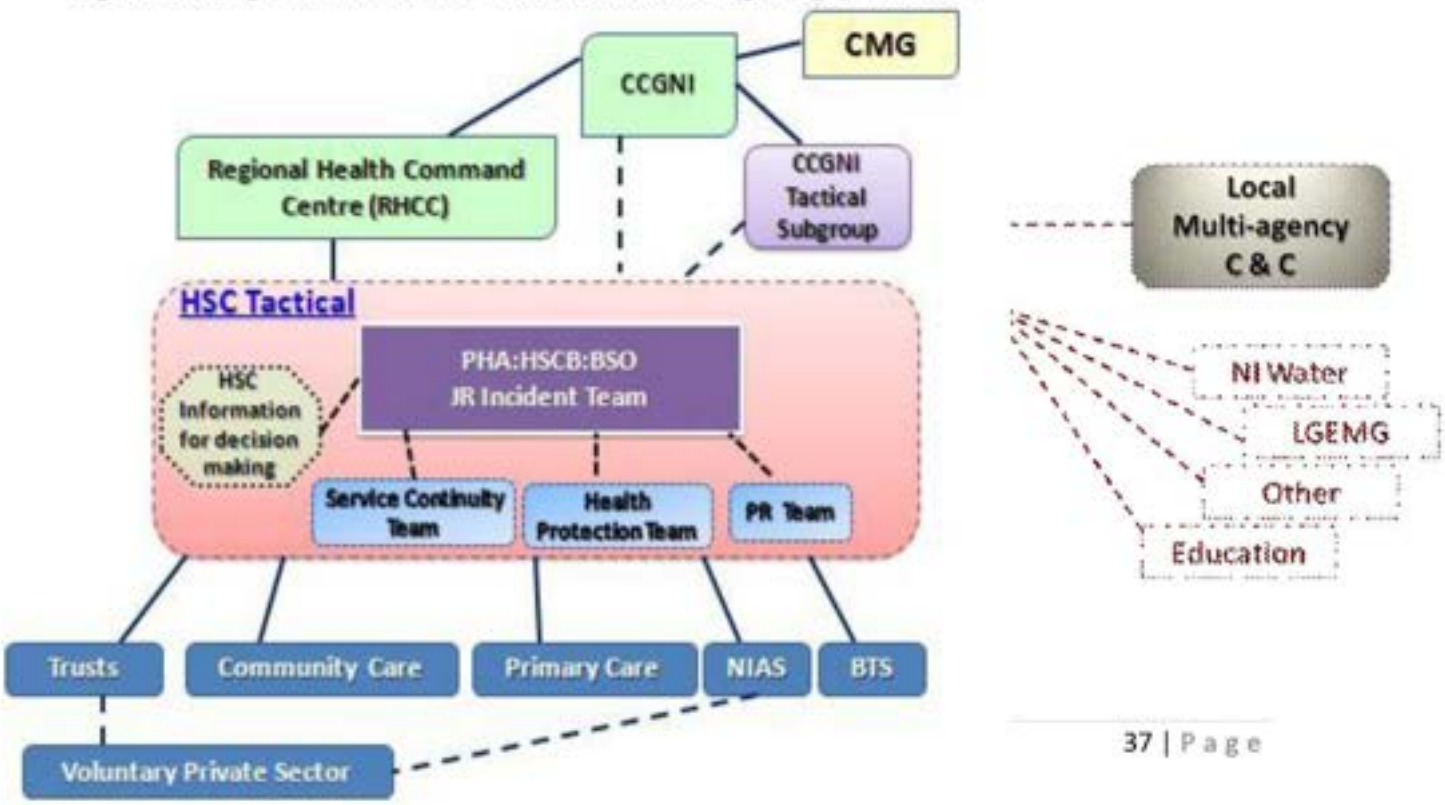
It is also important that the record keeping of team meetings follows the recognised good practice in relation to the keeping of a central log; individual member logs; a Decision Log and an Action Log. The IC Team (Silver) meetings should be intricately linked to the EOC / Information hub when it has been established.

Linkages / liaison with Trusts and Primary Care (Fig 3)

To be effective a key role of the Joint Response Incident Control Team is to liaise with and coordinate the wider HSC response. This will include communication within the HSC family with BRONZE level Trusts and GOLD level DOH (NI) structures.

The key to an effective joint response to an unfolding incident is robust liaison between the JR team and the appropriate staff in the relevant organisations inside and outside the HSC. The diagram below depicts how these interact.

Fig 3: Linkages across HSC and with Multi-agency partners



CMG:	Crisis Management Group
CCGNI:	Civil Contingencies Group Northern Ireland
BTS:	Blood Transfusion Service
NIAS:	Northern Ireland Ambulance Service
LGEMG:	Local Government Emergency Management Group
OCT:	Local Multi-Agency C & C will act as OCT in complex/major communicable disease outbreak. This is chaired by PHA

NB: The linkages to multi-agency Command and Control structures during an incident and the specific steps to alert, activate and manage a multi-agency response are outlined from Appendix K.

Once an IC Team (Silver) has been established Trusts, primary care and the DOH (NI) will be informed and a process for ongoing engagement with HSC partners will be established. This may take the form of regular SITREPS produced by the EOC/Information Hub and populated by information from across the whole service (acute, community, primary care and public health). A SITREP template is attached within the appendices. More formal communication may be necessary with conference calling on a regular basis or face to face liaison meetings. It must be kept in mind that the timing of the Trust liaison process needs to feed into the joint incident team and any multi-agency meetings. For this reason a 'battle rhythm' of meetings needs to be established early and reviewed regularly.

Linkages / liaison with Multi-agency partners (Fig 3)

At all levels of joint response a link to the multi-agency command structures is essential. Lower level incidents may simply involve linking by telephone to the senior commander at scene of the incident (usually NIAS but on occasions this may be NIFRS). In higher level more complex incidents Multi-agency SILVER (Tactical) level and possibly GOLD (Strategic) will be established by the Lead Organisation. On occasions the expertise within PHA:HSCB:BSO will also be required at multi-agency gold level (e.g. the output of a STAC although initially feeding into tactical may also be required at strategic level) and as such the PHA and HSCB would be required to send representatives to these Multi-agency meetings.

When the emergency requires a cross-governmental response the DOH (NI) will be leading the co-ordination of the HSC response and as such will set up the Regional Health Command & Control centre (RHCC). In these scenarios the department will look to PHA; HSCB and BSO to support their response. For community wide incidents the Northern Ireland Central Crisis Management Arrangements (NICCMA) may also be activated. In effect two further groups may be established Civil Contingencies Group NI (CCGNI) and Crisis Management Group (CMG).

NB. As well as linking into the overarching multi-agency arrangements it may be necessary for the joint response to have more direct liaison with specific agencies IF one or more key agencies are at the centre of the response as was the experience with NI Water and LGEMG (Local Government Emergency Management Group) in the previous severe weather incidents. In these instances direct contact points between PHA; HSCB; BSO and the lead agency need to be established early in the

response and individual staff within PHA:HSCB:BSO nominated to act as the main point of two-way contact for that agency.

Given the range of groups to potentially be serviced by PHA;HSCB;BSO staff it is important that the chair of the PHA;HSCB;BSO Joint Response incident team identifies representation at these groups early and that the two way information flow/ feedback mechanism for these meetings is robust.

The wide range of multi-agency partners potentially involved in the response is listed in appendix B (proforma E) and should be used as a check list to consider when the first IC Team (Silver) is established.

Note: Procedures to alert and escalate a response to a formal multi-agency response and guidance on how to coordinate and who chairs the various, local and regional groups can be seen in appendix G-J.

ICT (Silver) members are asked to familiarise themselves with documentation, in particular the flow diagrams on escalation and coordination.

3.3. Location of IC Team (Silver)

As already noted in the early stages of a response the IC Team (Silver) may meet virtually by means of teleconference facilities. However when face to face meetings are to be arranged and as the majority of senior staff who would populate an incident team work out of Linenhall Street, the IC Team (Silver) in the majority of scenarios would meet in Linenhall Street. Please refer to appendix O for access arrangement for the contingency locations.

3.4. Establishment of an EOC/Information Hub

When the decision to establish an EOC/Information Hub has been made; the Director of Performance within HSCB is responsible for setting up the facility requirements for an IC Team (Silver) and EOC. This will be completed in adherence to the EOC Operational Plan (Appendix O).

Officers from BSO are also critical for the setting up and maintaining of specific Information Technology requirements within the EOC.

3.5 Information Flows and Situation Reports (SITREPS)

Data Analysis from Trusts Primary Care and Social Services as well as Health Protection.

Clear, timely and accurate information is fundamental to effective decision making and management of the response to any emergency. The demand for information during a Major Emergency can be high both from within HSC and from outside HSC. Building on the learning from the recent incidents and exercises regular two-way situation reporting will be required throughout the duration of an emergency.

In order to conduct an effective joint response at PHA:HSCB:BSO level, information from several HSC operational areas need to be compiled into an overarching SITREP / CRIP. This information will be incident specific however it will usually contain information from the following areas:

- **Public health** information (e.g. if a chemical incident the numbers of people having received OR requiring decontamination and longer term health surveillance).
- **acute hospital** information (e.g. in a mass casualty incident the numbers of P1 i.e. life threatening; P2 critical but not life threatening; P3 walking wounded;
- **Social care** information (e.g. in an incident requiring evacuation the numbers being managed by social care in the Emergency Response Centres)
- **Integrated Care** information (e.g. in a large water borne incident the numbers presenting to general practice with diarrhoea and vomiting)

The role of gathering information, i.e. data analysis, from the wider service will fall to the HSCB wherein lies the day to day responsibility for acute services, social services and integrated care. In collating and analysing the information for the SITREP /CRIP normal reporting mechanisms and structures will be built upon to ensure staff are confident in the actions that will be required of them in an emergency situation.

It must be noted that in order to avoid confusion and duplication it is essential to ensure that whatever system is established the principle of having only one line of main two-way communication should exist between the Trust command and control arrangements (Bronze) and the tactical command and control (Silver) Joint Response.

See appendix H for a copy of existing information reports.

3.6 Location of the EOC/Information Hub

The main EOC / Information hub will also be located in the Linenhall Street offices. Contingency arrangements are also in place in the event that Linenhall Street is not available due to the nature of the incident. Please refer to the EOC Operational Plan for access arrangement for the contingency locations

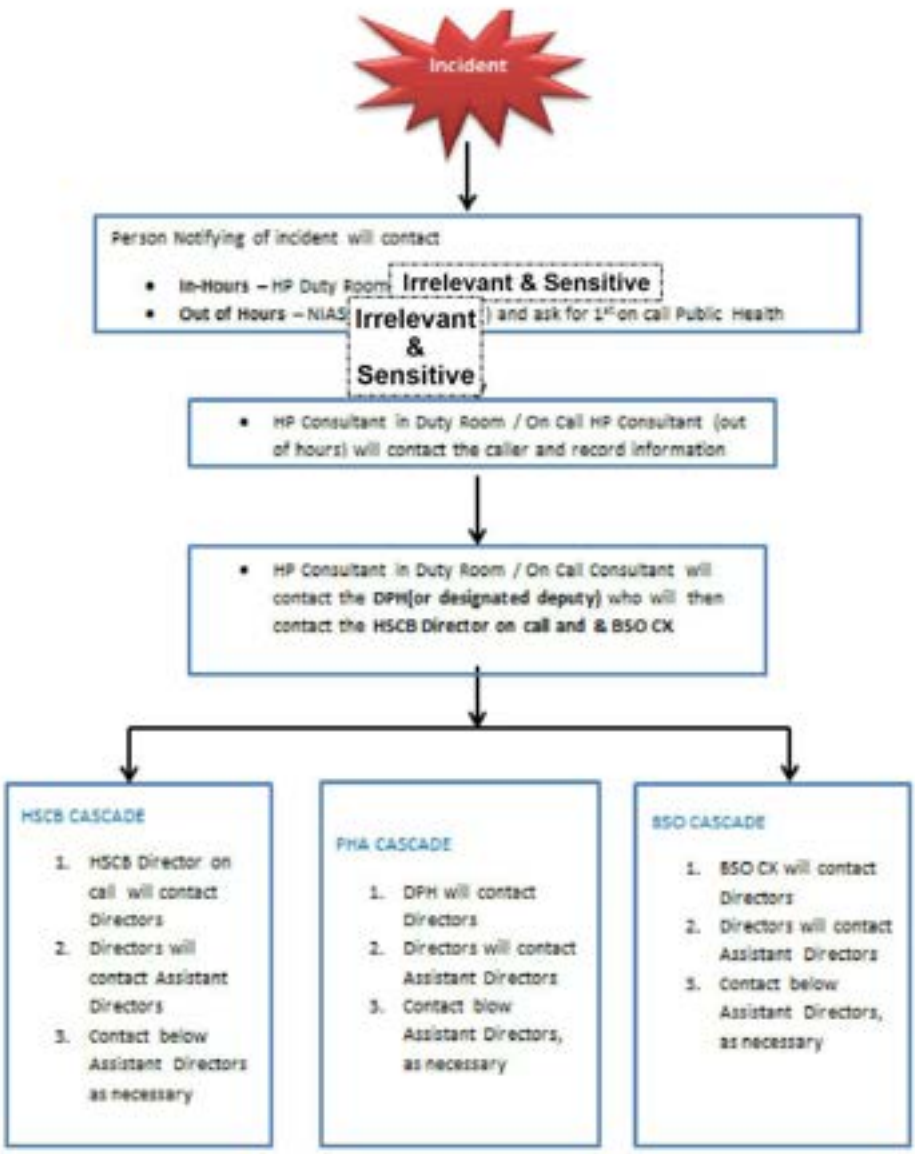
3.7 Call out of Staff

Inside office hours, when the level of incident dictates that a decision is made to call out staff this may result in staff being diverted from their normal day to day duties. In such instances PHA/HSCB/BSO Directorate plans will be reviewed and activated where appropriate in order to free up staff to support the joint response.

Outside office hours, as per the communication cascade protocol and figure 4 below the HP consultant will contact the on-call DPH who will liaise with the director on call for the HSCB and the BSO (Chief Executive or Director covering),to agree and initiate the call in of appropriate staff as per the Directorate plans. The PHA on-call rota takes account of the need to have health protection surge capacity available in emergencies. Other staff may also be required in some incidents; activation of this

would be done through PHA and HSCB Chief Executive and Directors. The assessed level and specifics of the incident would dictate the numbers; type and duration of staff required.

Fig 4: Notification Cascade diagram



3.8 Staff Muster Point

Staff are likely to be called to their normal area of work if they are called into deal with a major emergency. Other staff may be required to work within the EOC and Incident Control Team. This will be outlined at the time of the incident and will also be detailed within the EOC plan.

3.9 Support Staff Requirements and Staff Flexibility Requirements

Staff in the HSCB Corporate Services Directorate are responsible for ensuring support staff arrangements are updated and included in the response. Staff will be gathered from the wider HSCB pool and if the incident is of such a size or duration (e.g. Level 4 Joint response) it will include PHA and BSO support staff.
The support staff are essential to enabling an effective joint response takes place and as such will be deployed in areas such as records management; running of the EOC/Information Hub; security, catering and other facilities. Corporate Services within HSCB will also be supported by the Operations Directorate from within PHA when supplying staff to assist with a major emergency, in particular when servicing the EOC.

The Incident Control Team will have to consider issues on a graduated response to dealing with a prolonged incident. This should include adequate rest breaks; shift changes and also achieving a graduated response in the event that an incident escalates.

3.10 Communication and IT Requirements

As stated above the role of communications and IT will be crucial within the effective running of the EOC and IC Team (Silver). HSCB staff will liaise with facilities management on the communication requirements needed for the specific incident and this will be included within the EOC /Information Sub-Group plan.

BSO will have a key role to play in providing staff and IT equipment within the EOC. This is outlined within the EOC plan and also within the BSO Directorate plan.

3.11 Scientific and Technical Advice Cell (STAC)

With reference to section 1.3 (Roles and Responsibilities) the Public Health Advisor acts as the focal point in the provision of health, public health, health protection and other scientific advice as part of the incident management process. This may include the setting up and running of a STAC (Scientific and Technical Advice Cell) which links into the local multi-agency command and control arrangements in an incident.

In Northern Ireland the Health Protection Service within the PHA would fulfil this role of providing 24/7 immediate public health advice into an unfolding emergency situation. Should ongoing scientific advice from a range of agencies be required a STAC would be established.

The responsibility for the setting up and running of a STAC within 1-2 hours of notification of an incident falls to the Director of Public Health. (See separate STAC Plan).

3.12 Creation of Helpline

Members of the public may want to ask specific questions about the effects of the emergency on local services and a telephone enquiry line will help to channel

enquiries and prevent floods of calls to individual services that are busy responding directly to the emergency itself. It may be useful to consider the establishment of a dedicated help-line facility.

This decision as to whether or not a help line is required will be taken by the Joint Response Incident Control Team (IC Team) Silver. The details of how such a help line would be run and who would staff the phones would also be decided by the JR IC Team (Silver) at the time and would be incident specific. A protocol to assist with the creation and effective running of a helpline is included at Appendix E.

The Helpline will also take account of the enhanced arrangements approved by the OFMDFM. The IC Team (Silver) will use the internal Helpline in the first instance and request additional support from CCGNI if the incident response requires. A copy of the helpline arrangements from OFMDFM are attached as Appendix O.

3.13 Dealing with the Media

There will always be high media interest in a major emergency. Whilst media interest is likely to be concentrated on the scene of any major emergency or at any hospital involved there will be the requirement for having an area for dealing with media enquiries.

The IC Team (Silver) will identify a lead press officer (from within HSCB and PHA) to liaise with the media and this will be in keeping with the PR media operational procedures set out in this plan. Regular bulletins will be issued to the press, as information becomes available.

A designated spokesperson will be identified by the JR IC Team (Silver) at the outset and will be a senior officer from one of the three organisations.

Again the specifics of the incident will dictate the most appropriate person and it will depend on balance of the public health and service continuity impacts. Senior members of staff potentially involved in giving such media interviews will have received prior media training, be adequately briefed on the incident before the interview and follow pre-set PR messages agreed by the JR IC Team (Silver).

The media plan will also look closely at inter-agency working and a representative from PHA: HSCB: BSO public relations will link into the multi-agency media process. In many major emergencies the media response is usually led by the PSNI. In these circumstances it will be essential that the Joint Response Plan takes account of this. The media plan will also need to liaise closely with all other HSC colleagues to ensure a holistic response from the HSC family.

All staff when approached by the media must take care. Any requests for interview must be cleared with the JR IC Team (Silver). Please see separate Communications Plan which is included within the appendices.

Section 3 (Continued)

Directorate Plans

Public Health Agency

Emergency Preparedness Response

Public Health Directorate

1. Areas of responsibility

The Directorate of Public Health (DPH) has four key areas of responsibility:-

These are:

- Service Development and Screening;
- Health Protection;
- Health & Social Wellbeing Improvement and;
- Health & Social Care Research & Development.

Responsibility in relation to Emergency preparedness and response lies within the Director of Public Health's statutory health protection duty in the form of protecting the health and wellbeing of the public through the development of public health emergency plans and support to Trusts and other Health Social Care (HSC) and non-HSC organisations as required. More specifically the role of public health includes:

- Responding to public health emergencies (including complex/major communicable disease outbreaks and chemical and biological emergencies) through the provision of robust local arrangements 24/7.
- Providing an early risk assessment of the actual or likely impact the incident may have on public health or public safety.
- Ensuring that an effective ongoing public health response/advice is provided to chemical contamination or other pollution incidents, which would impact upon the health of the population.
- Ensuring that out of hours contact and 'on-call' arrangements are maintained and that the providers of a 24/7 public health advice is sufficient during an emergency response.
- Establishing, running and contributing to a Scientific and Technical Advice Cell (STAC) as and when required.
- Along with the HSCB jointly leading the co-ordination of the HSC response when an incident or emergency involves more than one Trust, but does not require cross-department or cross-government co-ordination i.e. when an emergency is categorised as significant.
- Providing professional advice to the DoH (NI).
- Working within the resources available facilitating training of, and emergency preparedness exercises for, relevant staff across the HSC system and DoH (NI) including promotion of training initiatives.
- Participating in multi-agency emergency preparedness and response as set out within the Civil Contingencies Framework, as required.
- Working with the resources available to provide HSC organisations with emergency preparedness guidance, advice and training as required.

2. Response

As noted within this document one of the three roles of the HSC family is the provision of immediate public health advice into an incident. Health Protection staff within the Directorate of Public Health provide this specialist health protection advice into an unfolding incident such as a chemical, biological or radiological incident

following a public health risk assessment of the potential and actual impact on the health of the public.

Public Health also has a role along with HSC colleagues to jointly lead the co-ordination of the HSC response when an incident or emergency involves more than one trust, but does not require cross-department co-ordination. The JREP and Outbreak Control Plan will also be activated when a communicable disease outbreak involves more than one Trust.

Staff within the Health Protection division of the public health directorate, have specialist training and knowledge in the area of emergency preparedness and response. As such they have responsibility for leading on emergency preparedness within the Public Health Agency and advising officers in the HSCB, BSO and Trusts as they fulfil their emergency preparedness and response responsibilities.

Notification

As previously set out officers within Health Protection act as the first **and** single point of contact for the PHA, HSCB and BSO in the event of a major emergency occurring. This is a 24 hour 7 day per week service activated either through the Duty Room or the Public Health Doctor on call.

As noted above from within this document notification of the incident will be made via the Duty Room or through the Public Health Doctor on call.
If the incident is deemed to be an acute major incident that requires immediate action the information will be recorded and passed to the HP Consultant on Call.

Public Health Actions

The HP Consultant working will follow the checklist below as a guide to initial actions. Following the setting up of a Public Health Team (NB. This team is distinct from the overarching Joint Response Incident Control Team) tasks will be allocated to members of the team. The Public Health Team, with other key specialised membership may also act as the regional outbreak control team in the event of a regional communicable disease outbreak.

Tasks will be allocated to the public health team lead who will chair the public health team. The chair of the team will also be responsible for ensuring that information on the unfolding incident is cascaded to relevant staff within the PHA (incident dependent). In the early stages (and in particular out-of hours) much of the work will be conducted by teleconference. And meetings will be arranged as soon as possible in the offices of Linenhall Street.

Specific Role of the PH Team

Should an incident be of such a size that a number of staff within public health are involved in the response a full public health team will be established. Depending on the specifics of the incident this team may consist of three distinct groupings:-

1. Health Protection Team

2. Service Continuity Team with staff from, service development and screening, nursing and allied professions. These incidents will be led overall by HSCB but this team will aid the response by giving clinical public health advice.
3. Support Team (including EOC/Information Hub) with staff potentially from Health Protection health improvement, operations and PR, etc.

Where the incident is a communicable disease outbreak the membership of the Multi Agency Command & Control Team, chaired by PHA will act as the Outbreak Control Team

This team's specific role will be to:

- risk assess the incident in relation to the actual or potential public health impact,
- collate the relevant public health information for the PH response and feeding into the joint response,
- Based on the information agree and implement the necessary public health actions e.g. advice / guidance to the public and the HSC, advice in relation to communicable disease, toxic chemicals, etc. where relevant, liaison with PHE;
- liaise with NIAS to advise on decontamination of casualties,
- where appropriate set up and run a STAC (Scientific and Technical Advisory Cell)
- conduct mid-long term health surveillance and follow-up,
- participate (and where appropriate chair) the Joint Incident Control Team (Silver) and
- participate where relevant in the multi-agency response

The Director of Public Health or their nominated representative would be the chair of this public health team. However, in reality the Director of Public Health is likely to be a member of the overall Incident Control Team. Therefore, the Public Health Team would be chaired by one of the Assistant Directors Public Health - most likely Health Protection. However, depending on the incident and availability it would be chaired by or one of the other Assistant Directors.

Alternatively, dependent on the incident the Team may be chaired by the Director of Nursing and Allied Health Professionals or the Director of Operations.

3. Internal Directorate Communications

Based on the assessed level of Joint Response relevant staff within each directorate of the PHA will be notified by the Director/nominated deputy and actions as required will be delegated.
On activating a joint response, media enquires will be managed jointly by the PHA, HSCB and BSO and respective organisations will adhere to communications procedures as set out previously.

4. Infrastructure Requirements

The Directorate of Public Health is located across four geographical localities. These are as follows:

Eastern Office
Northern Office
Southern Office
Western Office

Irrelevant & Sensitive

To facilitate a geographical response to an incident, the Director of Public Health (or nominated deputy) may require access to telephones and IT equipment in one or more of the respective local offices. Contact details of key holders and the Business Support Managers for the respective local offices are identified within the EOC Operational Plan.

Arrangements are set out within the overall Joint Response Emergency Plan on accessing any of the HSC buildings listed out of hours. Ensuring access to buildings will be done simultaneously by colleagues within HSCB.

5. Action Cards/Updates

Action cards:

- Director of Public Health - [an action card for the DPH separate to the action card for the ICT Chair]
- First on Call -
- HP Consultant -
- Non HP Consultant
- HP Lead Assistant Director (HP)
- Assistant Director (Service Development and Screening)

6. Access to facilities

Arrangements are set out within the overall Joint Response Plan on accessing any of the HSC buildings out of hours. Ensuring access to buildings will be done simultaneously by colleagues within HSCB.

Public Health Agency

Emergency Preparedness Response

Nursing and Allied Health Professionals Directorate

1. Areas of responsibility

The main area of responsibility of the Nursing and Allied Health Professionals (N&AHPs) directorate in the context of emergency preparedness is to ensure the service continuity of a safe service which meets patient needs and to ensure that accurate and timely information continues to be available in order to:

- Deal effectively with issues of patient and client safety;
- Communicate with appropriate external bodies ie Trusts, independent employers (nursing homes) etc;
- alert the Board to pressures within the service that require escalation (in line with the Regional Escalation Policy);
- provide assurance to the Department and Minister that services continue to be provided to an acceptable standard;
- along with HSC Board and BSO colleagues meet the information needs of the Emergency Operations Centre (EOC) and the decision making Incident Control Team (Silver).

The N&AHP directorate will be responsible (through the mechanism of the IC Team (Silver) if and when it is established) for providing regular updates in respect of service continuity issues on the basis of the analysis of information made available by service providers.

2. Response

The level of response will be determined centrally by the PHA 24/7 health protection service/ duty room or on call professional officers who will assess and consider the real and potential consequences of the situation and inform the directorate via the Director of N & AHPs or designated deputy.

Level 2 or above incidents:

The N & AHPs directorate is to be informed by the duty officers. The Response may include watchful waiting as well as action.

- During normal working hours:
  - The initial contact should be with the Director of Nursing and AHPs (or nominated deputy) who will assess the situation and the level of response.
  - The relevant members of staff in the directorate will then be notified by the Director/nominated deputy and actions as required will be delegated.
- Out of hours:
  - Contact will be via the Director or other senior N&AHP team as listed in the contact list for Nursing and AHPs.
  - This person will then be responsible for contacting other N&AHP team members and delegating actions according to the needs of the incident.
  - This person will also liaise with PHA to assess the situation.

Mass Vaccination programme:

- The N & AHP directorate via the Director will support the Health Protection team in organising and administering a mass vaccination programme:

Public Helpline

The N & AHP directorate will be advised by the Incident Control Team, when it is necessary to establish an incident specific public help phone line. Appendix E outlines the process for establishing a helpline and N & AHP may facilitate this. CCGNI have published further guidance on establishing a public helpline. This is contained at Appendix O. Guidance on establishing a helpline as part of the JREP is also included at Appendix E.

3. Internal Directorate Communications

During normal working hours

The initial contact should be with the Director of N & AHPs or Assistant Director of N & AHPs who will assess the situation and determine the level of response for the directorate.

The relevant members of staff in the directorate will then be notified by the Director/nominated deputy and actions as required will be delegated.

Outside normal working hours

Contact will be via the Director or Assistant Director of N & AHPs. If neither is available, the next most senior member of the directorate on the Emergency Preparedness contact list (see action plan contact list) is to be contacted.

This individual will then be responsible for assessing the situation and level of response and contact the other members of the directorate as required depending on the needs of the incident.

Incident Control Team or Multi Agency Meetings

The N & AHP director or nominated deputy will attend and contribute to these meetings.
The nominated person will update the senior N & AHP team.

4. Infrastructure and Staffing Requirements

- Access to telephones, blackberries and IT equipment (with remote access) and assistance (including internet and video conferencing) is essential for an efficient and effective response.
  This will include the potential requirements for the establishment of a Public Help Phone line (incident specific).
- Nursing staff from the Board, BSO and PHA may be required to use their expertise to assist on the Public Help Phone line. Director of the HSC Board,

BSO and PHA should agree to release staff if requested by the Director or Assistant Director of N & AHPs.

- Procurement of additional nursing staff for the Public Help Phone line should also be considered if internal capacity is inadequate. This may involve the use of agency staff.

5. Action Cards

A range of action cards will need to be developed outlining specific staff responsibilities.

Generic Action Cards will be available for staff involved in specific Incident Control Teams providing input to an EOC/Information hub (the latter will form part of the protocol for the establishment of an EOC).

In terms of the N & AHP directorate responding to specific incidents, the following action cards are required:

- Action card for notification of SMT in N & AHP directorate (contact phone list)
- Action card for Initial contact within the directorate
- Action card for 2nd contact in N&AHP
- Action card for Lead N&AHP Incident Officer

6. Access to facilities

Please refer to EOC Operational Plan.

Public Health Agency

Emergency Preparedness Response

Operations Directorate

1. Areas of Responsibility

The key areas of responsibility for the Operations Directorate are:

- Lead the PR response, in partnership with HSCB PR;
- Work with HSCB Corporate Services to ensure that appropriate facilities related arrangements are in place;
- Co-ordinate PHA administrative support for the EOC (in partnership with HSCB and BSO)
- Ensure effective and robust IT support
- Ensure PHA public communications are robust and effective, particularly through the PHA website

Practical/Response

In practical terms:-

- The co-ordination of contact arrangements for senior Operations Directorate officers (including PR) in hours and out of hours, ensuring that these are reviewed, updated and communicated within the Directorate and wider as required.
- The establishment of the Emergency Operations Centre is reliant on the HSCB in terms of facilities, accessing equipment, etc and the relevant supporting mechanisms i.e. security, catering, cleaning, confidential waste management, power, etc. PHA Operations Directorate will work with HSCB Corporate Services to ensure that the EOC is operational.
- Operations Directorate will operate in conjunction with HSCB Public Relations to ensure a full 24/7 PR service including out of hours operation is provided
- Support the operation of the EOC through provision of administration support and health intelligence staff (both in partnership with HSCB and BSO)

2. Response

Contact details for in and out of hours are in place for senior Operations Directorate officers and PR officers. These details are reviewed and amended regularly.

Mechanisms are in place to gain electronic access to PR and other related resources. This information will be regularly updated.

Equipment is accessible to enable the setting up of an EOC within a short timeframe.

3. Internal Directorate Communications

In and out of hours contact arrangements are in place for Operations Directorate. The Emergency Plan is accessible to all key contacts identified in the Operations Directorate.

4. Infrastructure Requirements

Key Operations staff will be identified to receive general EP training and specifically on their role providing support within an EOC.

5. Action Cards

The following Key actions cards will be available

- Director of Operations on receiving notification of an incident (in hours and out of hours) and subsequent actions
- PR actions

Public Health Agency

Joint HSCB/PHA/BSO Emergency Preparedness

Communications Plan

1. Purpose

In the event of a major emergency, maintaining clear and effective communication will be key. The purpose of this joint HSCB/ PHA/ BSO communications plan is to set out how we will communicate amongst ourselves and across organisations within and external to the HSC to respond to a major emergency.

Definition of Lead Communications Officer

During office hours, the Lead Communications Officer(s) will be the Head of Communications/ Assistant Director of Communications and Knowledge Management or nominated Communications Manager(s). Out of hours, the Lead Communication Officer(s) will be the On-Call Communications Officer(s).

2. Alert and Activation of Joint Communications Strategy

In Office Hours
To trigger the joint Emergency Plan (EP) initial notification will be made by PHA and/ or HSCB senior management to both PHA and HSCB Lead Communications Officers.

Out of Hours
To trigger the joint Emergency Plan (EP) initial notification will be made by PHA and/ or HSCB senior management to both PHA and HSCB On-Call Communication Officers.

If Level 3 or above is activated out of hours, the on call Out of Hours Communication Officer(s) will inform their Head of Communications/ Assistant Director of Communications and Knowledge Management.

3. Communications Response

Following notification, an appropriate level of response will be initiated by the lead organisation. This will be decided at the time of the emergency through initial discussion by senior officers within PHA and HSCB.

If the incident is predominantly a public health emergency the PHA will take the lead in managing the response. If the incident is predominantly a service continuity incident the HSCB will lead the response.

However, both organisations will respond and assist and BSO will also be involved if the incident is Level 3 or 4 emergency.

In the event of the establishment of an Emergency Operations Centre (EOC) and/ or Incident Control Team (ICT), the Lead Communications Officer(s) or designated Communications Manager(s) will join the incident team at the EOC.

In other incidents that do not require the establishment of an EOC there may still be a requirement for media input. This may be through 'virtual' meetings, i.e. teleconferencing, etc.

Dependent on the level of response, the Lead Communications Officer(s) may contact members of the communications team(s) to seek / provide appropriate communications support. If in hours this will be initiated via email and telephone initially and if out of hours via email, WhatsApp and tele calls.

Level of Joint Response – Communications Support

Level 1 – An Acute Incident with no public health or service continuity implications.

Response: Business as usual.

Level 2 – An Acute Incident with potential public health or service continuity implications.

Response: If a decision is taken to establish an Incident Control Team (ICT), the Lead PHA/ HSCB organisation will invite their Lead Communications Officer(s)/ On-Call Communications Officer(s) to join the team to provide appropriate communications support and advice.
Once an appropriate level of staffing support is determined officers will then be designated specific tasks/roles, e.g. which may include setting up a media room and drafting holding lines / statements.

The Lead Communications Officer(s) will ensure communications colleagues in the Department of Health (DoH), Trusts and partner organisations are fully briefed and updated on the communications approach via email / Telecalls as per protocol. The Lead Communications Officer(s) will also feed in any key communications information from partner organisations to the Incident Control Team (ICT).
If a decision is taken not to establish an Incident Control Team (ICT), the Lead PHA/ HSCB organisation will advise their Lead Communications Officer/ On-Call Communications Officer(s) of the incident in the event of potential media interest.

The Lead officer in Silver will be the designated officer for approval of all information released publicity. DoH/HSC organisations will be kept briefed.

Level 3 and Level 4 – An Acute Incident with definite public health/ service continuity implications

Response: Both PHA and HSCB Lead Communication Officer(s)/ On-Call Communications Officer(s) will join the Incident Control Team (Silver) or Emergency Outbreak Control EOC/ Information Hub to provide appropriate communications support and advice.

The Lead Communications Officer(s)/ On Call Communications Officer(s) will decide if further communications staff is needed to provide additional support to the incident. They will be contacted as detailed above via email/ phone/ WhatsApp whether in or out of hours.
The Lead Communications Officer(s)/ On-Call Communications Officer(s) will advise on the communications approach.

Once an appropriate level of staffing support is determined officers will then be designated specific tasks/roles.

Communication activity may include, e.g. which may include developing short term communications plan to include but not limited to; developing public messaging; setting up a media room/rota, draft holding lines/key messages/statements for dissemination to the media, stakeholders and the wider public through a range of appropriate communications channels; updating websites, identifying spokespersons; media monitoring; social media monitoring/engagement; organising media briefings/press conference; attending Silver meetings/telecalls, being present at EOC or arranging Telecalls etc as appropriate.

The Lead officer in Silver will be the designated officer for approval of all information released publicly. DoH/HSC organisations will be kept briefed.

Communications with Trusts

The PHA/ HSCB will provide an overview of the incident, however, Trusts are likely to be approached by the media for comment at an operational level. The Lead Communications Officer(s)/On-Call Communications Officer(s), in conjunction with the DoH/ (On-Call EIS Press Officer) as appropriate, will establish a communications teleconference for DoH, HSCB, PHA and Trusts to ensure there is a consistent and joined up approach and clarity on roles and responsibilities

Communications with other partner organisations

The Lead Communications Officer(s)/ On-Call Communications Officer(s) will share joint media statements with the communication leads of any relevant partner organisation involved in managing the incident as appropriate.

4. Media room (if set up)

The media room will be equipped with

- telephone, computer, photocopier and internet access
- access to facilities for refreshments

The media room will be staffed by the Lead Communications Officer(s)/ On-Call Communications Officer(s) for the HSCB/ PHA and members of the Communications Team(s) as appropriate. Media enquiries should be directed to the media room and managed by the Lead Communications Officer(s) or nominated deputy.

5. Access to premises and facilities.

If necessary, access to premises and facilities will be arranged through the HSCB. It has been agreed that Corporate Services will facilitate access to the required HSC building and details on how this can be achieved is contained within the main Joint Response Major Emergency Plan.

6. Contacting other members of the Communications Teams

On determining the level of response required the Lead Communications Officer(s)/ On-Call Communications Officer(s) will contact members of the Communications Team both in and out of hours as appropriate. (Appendix 1)

(a) Action cards
Lead Communications Officer
Communications Officer

7. Staff requirements

The Lead Communications Officer(s)/On Call Communications Officer(s) will have to consider issues on a graduated response to dealing with a prolonged incident. This should include adequate rest breaks, shift changes and also achieving a graduated response in the event that an incident escalates.

8. Long term communications support

The communications support will be kept under regular review by the respective Heads of Communications/ Assistant Director of Communications and Knowledge Management within the PHA and HSCB to ensure that a sustainable level of support is provided throughout a major emergency event.

9. Decision Log and Action Log

Pre-agreed decision and action logs have been developed to ensure recognised good emergency planning practice record keeping.

Use template in Appendix F of PHA/ HSCB/ BSO Joint Response Emergency Plan

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Health and Social Care Board

Emergency Preparedness Response

Corporate Services Directorate

1. Areas of Responsibility

Governance

The Head of Corporate Services is the SMT Member with delegated responsibility for Emergency Preparedness. The key governance responsibilities are:-

- the co-ordination of the HSC Board's Emergency Preparedness response to support the Joint Emergency Response Plan;
- providing the evidence to meet the Controls Assurance Standards,
- ensuring SMT and Governance and Audit Committee (GAC) are updated as required and that the HSC Board meets its responsibilities in this regard,
- ensuring that processes are in place to inform verification by internal audit where appropriate

2. Practical/Response

In practical terms, ensuring:-

- the co-ordination of contact arrangements for Board officers in hours and out of hours, ensuring that these are reviewed, updated and communicated within the HSCB to SMT and PHA and BSO (and HSC Trusts) as required.
- access to facilities both in and out of hours.
- the establishment of the Emergency Operations Centre and accessibility/support to same, ie facilities, accessing equipment, security, catering, cleaning, confidential waste management, power, Board/PHA staffing support, etc.
- (with PHA) Corporate Services Communications staff providing the PR support to emergency situation/incident control team/EOC as appropriate;
- the co-ordination of the establishment and support mechanisms associated with an Incident Control Team where required, and will develop a mechanism to ensure Board staff are identified to provide administrative support as required;
- the co-ordination of the agreed mechanism for the HSCB/PHA and BSO to establish daily contact with HSC Trusts and DOH (NI) if required, via situation reports or via teleconferencing;

- the co-ordination of Emergency Preparedness Basic Awareness training for HSCB staff as part of an ongoing programme of mandatory operational policy and procedure training.

Corporate Services will take forward the arrangements to co-ordinate an EOC Sub Group to set in place an agreed procedure for the physical establishment of an EOC when required.

3. Response

Contact details for in and out of hours are in place for the Chief Executive and SMT. These include all necessary information relating to facilities and contacting PHA

(duty room) and BSO out of hours. These details are reviewed and amended regularly.

Mechanisms are in place to gain access to all HSC Board facilities in and out of hours. Please see EOC Operational Plan.

4. Internal Directorate Communications

In and out of hours contact arrangements are in place for Corporate Services across the HSCB.

Health and Social Care Board

Emergency Preparedness Response

Integrated Care Directorate

1. AREAS OF RESPONSIBILITY

The main area of responsibility for the Integrated Care Directorate in the context of emergency preparedness is the requirement to take the lead in co-ordinating emergency preparedness in Primary Care. (GPs, Dentists, Pharmacists and Optometrists). This involves encouraging practices to develop realistic and appropriate emergency preparedness plans which can be implemented should a major incident arise.

If an emergency were to happen involving primary care **the role of the Director of Integrated Care (or the nominated deputy) is to:**

- assess the level of risk and to co-ordinate information to and from Practices (regionally and locally) about potential incidents;
- co-ordinate the Integrated Care response as part of the joint HSCB /PHA incident team; and to,
- Maintain communication linkages with Trusts, Primary Care Practices and other agencies during an incident.

2. RESPONSE

In the event of an incident unfolding, notification will normally come via the HSCB nominated officer.

During normal working hours and out of hours, the initial contact should be communicated to the Director of Integrated Care (or nominated deputy).

Upon receipt of the information, **the Director of Integrated Care (or the nominated Deputy) has a responsibility 24hrs per day, every day of the year to assess the situation and decide upon the level of response necessary.**

If considered necessary the relevant members of staff within the Directorate of Integrated Care will be contacted by the Director (or nominated deputy) to take delegated actions or assist with the co-ordination of the response.

COMMUNICATIONS

In the event of a major incident maintaining clear and effective communication with Primary Care Practitioners, Trusts and other agencies such as the Police Service of Northern Ireland (PSNI) and the Northern Ireland Fire and Rescue Services (NIFRS) will be key. Depending on the nature of the incident, **the Director of Integrated Care (or nominated deputy) will communicate directly at local level or seek advice from the PHA.**

On activating a joint response, media enquiries will be managed jointly by the PHA, HSCB and BSO and respective organisations will adhere to corporate communications procedures. Depending on the nature of the incident, **the Director, in conjunction with the ICT and Comms colleagues will communicate with the media or assist with drafting press releases.**

The method of communication with Primary Care inside normal working hours will be actioned by local offices via telephone and existing communication processes. Outside normal working hours Primary Care Contractors will be contacted via the local out-of-hours service providers. Contact details are contained at the end of the plan.

3. INFRASTRUCTURE REQUIREMENTS

The Directorate of Integrated Care is located across four geographical localities. These are as follows:

Northern Office
Southern Office
Eastern Office
Western Office

Irrelevant & Sensitive

Depending on the incident, the main methods of communication will be via telephone and by email.

To facilitate a geographical response to an incident, the Integrated Care Director (or nominated deputy) may require access to telephones and IT equipment in one or more of the respective local offices. Contact details of key holders and the Business Support Managers for the respective local offices are identified in the EOC plan (see appendix P)

It is recognised that consultation with Trusts, Out of Hours Providers, GPC and other Primary Care Professional Bodies will be required to help design appropriate and robust communication arrangements. For example, Primary Care Practitioners will need to jointly agree the methods that the Integrated Care Directorate will use to communicate:

- notification of an incident
- guidance on what to do
- Specific contact details should a Primary Care Practitioner wish to speak to an expert.

4. ACTION CARDS/UPDATES

In the unlikely event of an incident, staff within the Directorate of Integrated Care should refer to action cards as per their designated role. Please see section on Action Cards.

Further action cards will follow subject to discussions with staff and consultation with GPC, Out of Hours Providers, Trusts and other Primary Care Professionals.

When action cards are produced, senior staff will receive emergency preparedness training and participate in exercises according to their role.

5. ACCESS TO FACILITIES

The Director of Integrated Care and his nominated deputies will be made aware of:

- contact details for key holders in the four local Integrated Care Offices
- Contact details for local Business Support Managers. These details are held at end of plan and within the Corporate Services Directorate.

Appropriate staff will be made aware of how to access local facilities and equipment out of hours.

Any changes regarding locations and access arrangements will be communicated to appropriate staff by email and emergency preparedness plans will be updated accordingly.

Health and Social Care Board

Emergency Preparedness Response

Performance Management & Services Improvement Directorate

1. Areas of responsibility

The main area of responsibility of the PMSI directorate in the context of emergency preparedness is the requirement to ensure service continuity and to ensure that accurate and timely information continues to be available in order to:

- alert the Board to pressures within the service that require escalation (in line with the Regional Escalation Policy);
- provide updates to the DoH (NI) and Minister on current service delivery/ or pressures identified.
- co-ordinate acute hospital provision across the region to support equalising pressures across the system;
- along with PHA and BSO colleagues meet the information needs of the Emergency Operations Centre (EOC) and the decision making Incident Team.

The PMSI directorate will be responsible (through the mechanism of the EOC when it is established) for providing regular updates to Incident Control Team (IC Team - Silver) in respect of service continuity issues on the basis of the analysis of information made available by service providers.

2. Response

The PMSI directorate will provide a central response via the Director (or nominated deputy) during normal working hours and via the directorate contact point out of hours.

The notification of incidents will normally be via the PHA 24/7 health protection service. At this point an assessment will be made as to the level of joint response required as per algorithm included in the Emergency Preparedness and Response interim arrangements. This will be kept under constant review during the period of the incident.
It is extremely important that records are kept of the details of each incident on the agreed recording templates.

Training will be provided to all relevant staff from the PMSI directorate on the potential roles to be undertaken during an incident.

3. Internal Directorate Communications

During normal working hours the initial contact should be with the Director of PMSI (or nominated deputy) who will assess the situation and level of response required. The relevant members of staff in the directorate will then be notified by the Director/nominated deputy and actions as required will be delegated.

Outside these hours contact will be via the nominated member of staff. This individual will then be responsible for liaising with the PHA to assess the situation and level of response and will contact other members of the directorate or other staff members from other Board directorates as required as per the needs of the incident.

4. Infrastructure Requirements

To allow the directorate to respond to the different levels/types of incident, the PMSI directorate will require access to phones and IT equipment (including access to the internet). Staff will require training on the Board's Emergency Preparedness and Response arrangements and the particular role to be played by the PMSI directorate within these arrangements.

Consultation is required with colleagues in Human Resources to ensure that the requirements of staff as set out in the Emergency Plan, particularly the out of hours arrangements are included in staff job descriptions.

5. Action Cards/Updates

The attached action cards set out the tasks that representatives from the PMSI directorate will be expected to follow as members as the initial point of contact for receipt of an incident report, as the lead incident control officer, as a member of a specific Incident Control Team (Silver) or providing supporting input to an EOC/Information Team.

6. Access to facilities

Refer to EOC Operational Plan

Health and Social Care Board

Emergency Preparedness Response

Commissioning Directorate

1. Areas of Responsibility

In the event of an incident, the Commissioning Directorate in conjunction with the Performance and Service Improvement Directorate has responsibility for ensuring arrangements are in place to respond to an incident and in conjunction with PMSI directorate, to ensure service continuity.

This will include-

- liaising with the Emergency Operations Centre and PHA, BSO and HSCB colleagues to clarify the responsibilities of PMSI and Commissioning with regard to each specific incident;
- working through agreed channels to gather information on Trust service provision;
- Co-ordinate acute hospital provision across the region in order to equalise pressures across the HSC system;
- Lead on commissioning issues and also lead HSCB response in the event that no senior officer from PMSI is available

2. Response (Central and Local)

Incidents will be notified to the HSC through the 24/7 PHA health protection service where the degree of response will be determined. A detailed record will be kept with regard to all information received and the response given. All action taken in relation to the incident should be recorded by the joint response team.

The need for a Commissioning Directorate response will be determined by the Head of Corporate Services/ Chief Executive or designated deputy who will contact the Director of Commissioning (or designated deputy) in the first instance. The Director of Commissioning will confirm with the Joint Commissioning team who is the incident lead for commissioning.

The contact details for the Director and Assistant Directors who may deputise are shown within the contacts section contained at the end of the plan.

3. Internal Directorate Communications – Normal Working Hours and Out of Hour (Central and Local)

The DoC has established a contact protocol for the Commissioning Directorate that will ensure a structured communication plan is in place in the event of an Emergency.
The Director of Commissioning (or designated Deputy) will be contactable in the first instance. During normal working hours this will be through the Director's PA. Outside of hours or if the Director cannot be contacted at HQ, a mobile number should be used.

Contact numbers for the Director's office, work mobile and personal mobile have been provided to meet the requirements during work hours and out of hours. A leave/absence protocol identifies the Director's Deputy. If necessary the Director will contact local Assistant Directors.

At a local level, all contact details for Assistant Directors during working hours and outside of working hours are available to the director and the Joint Team.
In the event that the Director or Deputy cannot be contacted, the incident's local AD should be contacted directly.

A list of the contact numbers is available in the Director's office, at HQ switchboard and a copy is held by each AD.

The above contact details will be reviewed and tested on a monthly basis by the Director's office.

Local Arrangements as established by corporate services are in place to ensure that access to facilities is prompt and appropriate.

4. Infrastructure requirements

Communication links are a critical element of the management of any major incident. In preparation for an incident, HQ staff and ADs s have ready access to live IT connections, hardware and networks at HQ and locally. This includes PCs, landline phones, mobile phones, fax, internet and email facilities. Refer to the EOC Operational Plan for access to facilities.

5. Action Cards/Updates

Action cards have been prepared for key officers within the Directorate

6. Access to Facilities – Local

If access is required to local facilities, the Joint Incident Control Team (Silver) will advise the incident lead for commissioning how this can be facilitated. Refer to the EOC Operational Plan for access to facilities.

Health and Social Care Board

Emergency Preparedness Response

Social Care and Children's Directorate

1. Areas of responsibility

The Directorate of Social Care and Children (DSCC) primary duty is to ensure the social welfare of the Board's population. This is achieved by the commissioning of services, mainly, from the Health and Social Care Trusts that meet the Statutory Duties of the Board which have been delegated to the Trusts.

These include:

- Family support and protection;
- Safeguarding vulnerable children and adults;
- Supporting older, disabled and isolated people;
- Supporting people with mental health problems or learning difficulties and their carers; and the,
- Regulation of Early Years facilities.

External stakeholders include: Northern Ireland Housing Executive and Housing Associations to provide accommodation for families with Children and Vulnerable Adults; Private sector providers for residential and Nursing beds for Adults.

2. Response

Staff within the DSCC would be available to give advice or approval when a Trust cannot meet its delegated statutory duties. This is more likely to occur in an escalating or gradually developing emergency.
During major or sudden events the Directorate role would be one of
Co-ordination to:

- Minimise the disruption of services;
- Assist with the relocation of populations;
- Provide access to financial resources for children and families;
- Ensure that any interim arrangements and use of volunteer or temporary staff do not breech safeguarding arrangements;
- Providing advice and guidance for other staff and agencies who are dealing with groups of vulnerable people.

The Director of Social Care & Children will provide a central response via the Director (or nominated deputy) during normal working hours.
Out of hours contact will be via the Director of Social Care and Children or their nominated deputy.

If considered necessary the relevant members of staff within the Directorate of Social Care & Children will be contacted by the Director (or nominated deputy) to take delegated actions or assist with the co-ordination of the response. See JERP contacts directory for relevant contact names and telephone numbers.

3. Internal Directorate Communications

During normal working hours the initial contact should be with the Director of SCC (or nominated deputy) who will assess the situation and level of response. The

relevant members of staff in the directorate will then be notified by the Director/nominated deputy and actions as required will be delegated.
Out of hours contact will be via the Director of Social Care and Children or their nominated deputy

In the event of a major incident maintaining clear and effective communication with, Trusts and other agencies such as the Police Service of Northern Ireland (PSNI) and the Northern Ireland Fire and Rescue Services (NIFRS) will be key. Depending on the nature of the incident, the Director of Social Care & Children (or nominated deputy) will communicate directly at local level or seek advice from the PHA.

On activating a joint response, media enquires will be managed jointly by the PHA, HSCB and BSO and respective organisations will adhere to
corporate communications procedures.

Depending on the nature of the incident, the Director of Social Care & Children (or nominated deputy), with the agreement of the IC Team – Silver and with support from PR/Communications colleagues may be required to take the lead on communicating with the media or assist with drafting press releases.

4. Infrastructure Requirements

The Directorate of Social Care & Children is located across four geographical localities. These are as follows:

Eastern Office
Northern Office
Southern Office
Western Office

Irrelevant & Sensitive

To facilitate a geographical response to an incident, the Director of Social Care & Children (or nominated deputy) may require access to telephones and IT equipment in one or more of the respective local offices. Contact details of key holders and the Business Support Managers for the respective local offices are identified in appendix P. DSCC staff will require access to phones and IT equipment (including access to the internet).

Consultation is required with colleagues in Human Resources to ensure that the requirements of staff as set out in the Emergency Plan, particularly any out of hours arrangements are addressed in staff job descriptions and contracts of employment.

5. Action Cards/Updates

Action cards have been prepared for:
Director of Social Care & Children

6. Access to facilities

The Director of Social Care & Children and his nominated deputies will be made aware of:

- contact details for access to the four local offices;
- contact details for local support staff .

These details are held in the EOC Operational Plan and JERP contacts directory.

Any changes regarding locations and access arrangements will be communicated to appropriate staff by email and emergency preparedness plans will be updated accordingly.

Health and Social Care Board

Emergency Preparedness Response

Finance Directorate

1. Areas of responsibility

The main area of responsibility of the Finance directorate in the context of emergency preparedness is the requirement to clarify financial queries to ensure service continuity and to ensure that accurate and timely financial information flows to and from HSC organisations and the DOH (NI) in order to:

- provide urgent financial projections to the Boards of the HSCB and PHA in order that prompt decisions can be made with regard to significant emerging pressures within the service;
- provide financial projections to the Department and Minister on the costs of continuing to provide services to an acceptable standard;
- co-ordinate financial monitoring across HSC organisations in order to provide options to the Board to equalise/prioritise financial pressures across the system;
- promptly communicate financial decisions to HSCB organisations on the approval status of pressures;
- In collaboration with PHA and BSO colleagues meet the financial information needs of the Emergency Operations Centre (EOC) and the decision making Incident Team;
- ensure that the necessary financial resources to ensure the smooth operation of the EOC are made available in a timely basis;
- liaise with the BSO to ensure that all financial processing continues to be provided in respect of staff, independent contractors, traders and 3rd Party providers are maintained; (need to link with BSO plans on this);
- Maintain adequate financial records in relation to all costs and funding approvals in relation to the emergency.

2. Response

The Finance directorate will provide a central response via the Director (or nominated deputy) during normal working hours and via the directorate contact point out of hours.

3. Internal Directorate Communications

During normal working hours the initial contact should be with the Director of Finance (or nominated deputy) who will assess the situation and level of response required by the Finance Directorate.
The relevant members of staff in the directorate will then be notified by the Director/nominated deputy and key actions delegated.

Out of hours, if required, the Director of Finance or nominated Deputy will assess the situation and level of response required from the Finance Directorate and make contact with other members of the HSCB as required to meet the needs of the incident.

4. Access to facilities

Please refer to EOC Operational plan.

Business Services Organisation

Emergency Preparedness Response

Procurement and Logistics Service (PaLS)

Directorate of Human Resources and Corporate Services

Information Technology Services

BSO Management Plan

Procurement and Logistics Service (PaLS).

1. Areas of Responsibility

BSO Governance

The Human Resources Director for BSO is the SMT Member with delegated responsibility for Emergency Preparedness. The key governance responsibilities are:-

- the co-ordination of the BSO's Emergency Preparedness response to support the integrated EP Plan;
- providing the evidence to meet the Controls Assurance Standards,
- ensuring SMT and the Board are updated as required and that the BSO Board meets its responsibilities in this regard, and
- Ensuring that processes are in place to inform the internal audit due to commence.

PaLS Practical/Response

In practical terms the PaLs response is coordinated by the Head of Logistics :-

- the co-ordination of contact arrangements for PaLS officers in hours and out of hours, ensuring that these are reviewed, updated and communicated within the BSO to SMT and others as required, to HSC,PHA and HSCB as required
- PaLS will ensure that a scalable response plan is in place (Business Continuity Plan) to deal with all eventualities.
- PaLS will also undertake Emergency Preparedness Awareness training for staff (as appropriate) as part of an ongoing programme of EP training.
- A protocol for the release of Emergency Planning goods and equipment is in place and maintained.

2. PaLS Response

Contact details for in and out of hours are in place for the PaLS Executive team and senior on call officers. These details are reviewed and amended regularly. (Emergency call out details are provided to all HSC Trusts as part of PaLS out of hours call out service)
Mechanisms are in place to gain access to all PaLS facilities and EP stores in and out of hours.

Equipment is accessible to enable the setting up of a PaLS Emergency Response Team (ERT) within a short timeframe.

Emergency Planning goods and equipment are released in accordance with an already established DOH (NI) protocol (if required).

3. Internal Directorate Communications

In and out of hours contact arrangements are in place for PaLS across the HSC.

4. Infrastructure Requirements

Key PaLS staff will be identified to receive general EP training and specifically their role providing support to an EOC.

5. Action Cards

Key actions cards covering the PaLS response.

BSO Emergency Planning template

1. Areas of Responsibility

Governance

The Director of Human Resources and Corporate Services (DHRCS) is the SMT Member with delegated responsibility for Emergency Preparedness. The key governance responsibilities are:-

- the co-ordination of the BSO Emergency Preparedness response to support the integrated EP Plan;
- providing the evidence to meet the Controls Assurance Standards,
- ensuring SMT and Board are updated as required and that the HSC Board meets its responsibilities in this regard, and
- Ensuring that processes are in place to inform verification by internal audit where appropriate

Practical/Response

In practical terms:-

- the co-ordination of contact arrangements for BSO officers in hours and out of hours, ensuring that these are reviewed, updated and communicated within the BSO to SMT and PHA HSCB and HSC Trusts as required.
- access to facilities both in and out of hours.
- HRCS will co-ordinate with HSCB and PHA Emergency Preparedness Basic Awareness training for HSCB staff as part of an ongoing programme of Corporate Training.
- Corporate Services will coordinate representation of the BSO on an EOC Sub Group to set in place an agreed procedure for the physical establishment of an EOC when required.

2. Response

- Contact details for in and out of hours are in place for the Chief Executive and SMT. These details are reviewed and amended regularly.
- Mechanisms are in place to gain access to all BSO facilities in and out of hours.

- Equipment is accessible to enable the setting up of an EOC within a short timeframe. (This is an interim arrangement which will be enhanced by an agreed procedure by EOC Sub Group).

3. Internal Directorate Communications

In and out of hours contact arrangements are in place for the BSO.

Information Technology Services (ITS)

Areas of Responsibility

BSO Governance
The Human Resources Director for BSO is the SMT Member with delegated responsibility for Emergency Preparedness. The key governance responsibilities are:-

- the co-ordination of the BSO's Emergency Preparedness response to support the integrated EP Plan;
- providing the evidence to meet the Controls Assurance Standards,
- ensuring SMT and Audit Committee are updated as required and that the BSO Board meets its responsibilities in this regard, and
- This year there is an added responsibility for ensuring that processes are in place to inform the internal audit due to commence.

ITS Practical/Response

In practical terms:-

- the co-ordination of contact arrangements for ITS officers in hours and out of hours, ensuring that these are reviewed, updated and communicated within the BSO to SMT and others as required, to HSC, PHA and HSCB as required.
- ITS will ensure that a scalable response plan for ITS services is in place (Business Continuity Plan) to deal with all emergencies.
- ITS will also undertake Emergency Preparedness Awareness training for staff (as appropriate) as part of an ongoing programme of EP training.

ITS Response

Contact details for in and out of hours are in place for the ITS Senior Management team as defined in the ITS Business Continuity Plan. These details are reviewed and amended regularly. Out of Hours on call details are provided to all HSC Trusts and other organisations as part of ITS out of hours call out service.

ITS has an offsite Business Continuity location as defined in its business continuity plan to enable the setting up of a ITS Emergency Response Team (ERT) within a short timeframe if its normal location is not accessible.

Internal Directorate Communications

In and out of hours contact arrangements are in place for ITS across the HSC. Emergency response will be enacted using ITS business continuity plan.

Infrastructure Requirements

Key ITS staff will be identified to receive general EP training and specifically their role providing support to an EOC.

Action Cards

Key actions cards covering the ITS response are included within the Action Cards section.

Section 4

Longer Term Response

Shift Patterns and Staffing Levels

Creation of Recovery Team if Required

Debriefing Arrangements

4.1 Shift Patterns and Staffing Levels

If the incident is a prolonged one, e.g. Pandemic, the IC Team (Silver) will ensure that adequate shift patterns are established to allow staff changeover, etc. in the EOC and Helpline (if applicable). The IC Team (Silver) must also ensure that adequate staffing levels to deal effectively with the major emergency are maintained.

HR will ensure measures are in place to compensate those staff who will be required to work out of hours when dealing with the incident.

4.2 Creation of Recovery Team if required

During the response phase to the Major Emergency the IC Team (Silver) must consider the need to establish a recovery team. This team will be chaired by a senior officer from within the PHA or HSCB depending on the incident. This team will recommend measures that will help the long term recovery of the PHA/HSCB and BSO. It will look at all issues such as logistical requirements, staff needs and returning the organisations to 'normal'.

This team may also need to liaise with any Recovery Teams that have been created in Trusts or with multi-agency partners.

4.3 Debriefing Arrangements

Building on existing good practice and processes adopted in legacy Health & Social Service Boards, formal debriefing sessions will be initiated following incidents and the format of these will be incident dependent. The outcomes of each incident debrief and lessons learned from an incident response will then feed into the ongoing dynamic review and revision of the joint PHA/HSCB/BSO arrangements.

The debrief into the emergency response will be led by the organisation that was responsible for leading the emergency response, i.e. if the emergency was as a result of a public health incident the PHA will lead and if the incident was more service continuity focused the debrief will be led by HSCB. However, each organisation may wish to have internal debrief arrangements in place also.

Section 5

Training, Exercising and Validation

TRAINING, EXERCISING & VALIDATION

Under RPA, the PHA has a role in *"facilitating training of, and emergency preparedness exercises for, relevant staff across the HSC system and DOH (NI)" (*DOH (NI) Policy Circular 2010 Emergency Preparedness for Health and Social Care Organisations*)*. This document may be subject to review following implementation of the revised Performance Framework (22June 2017).

Senior staff within PHA / HSCB /BSO receive induction training on the PHA/HSCB/BSO Joint Emergency Response Preparedness Plan. PHA work with colleagues in the other two organisations when organising events to train and exercise senior staff.

In line with the Emergency Planning Controls Assurance Standard exercising and subsequent validation of the plan will be carried out on a regular basis.

A communication call out test will be carried out every 6 months

A table top exercise will be carried out on an annual basis

A live exercise, possibly in partnership with Trusts, will be carried out once every 3 years.

Lessons from these exercises will be used to help review and amend the Joint Response Emergency Plan and will assist in increasing the organisations' emergency preparedness.

Section 6

Appendices

Appendix A - Emergency Preparedness Legislative Framework

The legislative basis for emergency preparedness and response within the HSC is spread across several documents and in recent years new legislation and guidance (Figure 5) in particular in relation to Civil Contingencies has been developed to meet the changing context within which organisations now prepare and plan. KKI

Fig 5 Emergency Preparedness and Response Legislative Basis and Good Practice Guidance

Legislation / Regulations / Guidance	Date Published
➢ TIG HSC Performance Management Framework	June 2017
➢ RPA Modernisation & Improvement Board Papers (MIPB 34/09) *Scope of the new Performance Management and Service Improvement Arrangements* (MIPB 159/08) *Health Protection* (MIPB 05/09) *Working relationship between RHSCB and the Regional Agency for Public Health and Social Well-being.* (MIPB 30/09) *RHSCB and RAPHSW- Working Together on a Daily Basis*	
➢ DOH (NI) Circular 2010..... *Emergency Preparedness for Health and Social Care Organisations*	2010
➢ DOH (NI) Modernisation and Improvement Programme (MIPB) Health Protection	2008
➢ The Public Health (Amendment) Act (Northern Ireland)	2008
➢ DOH (NI) Modernisation and Improvement Programme (MIPB) Proposed Performance and Service Improvement Arrangements for HSC	2008
➢ The Corporate Manslaughter and Corporate Homicide Act	2007
➢ The NHS Emergency Planning Guidance 2005 Department of Health Emergency Preparedness Division	2005
➢ The Controls Assurance Standard – Emergency Planning	2005
➢ The Northern Ireland Civil Contingencies Framework	2011
➢ A Guide to Risk Assessment in Northern Ireland V4	2005
➢ The Emergency Planning Functions Directions (N. Ireland)	2004
➢ A Guide to Emergency Planning Arrangements in N. Ireland	2004
➢ Health & Safety Legislation in relation to managing Chemical Incidents include: ➢ Control of Asbestos at Work Regulations ➢ Control of Asbestos in the Air Regulations ➢ Chemical Hazard Information and Packaging Regulations (CHIP) ➢ Control of Substances Hazardous to Health Regulations(COSHH) ➢ Control of Major Accident Hazards Regulations (COMAH)	 1987 1990 1994 1994 1999
➢ Duty of Care and Human Rights Legislation	1998
➢ The Emergency Powers Act	1972

Appendix B - Algorithm for Initial Actions

Proforma for Initial Actions

Once Notified of Potential Major Emergency

(Notification will be through the health protection 24/7 system)

- **Proforma A for initial Notification**
- Specific Proforma B for HAZMAT /CBRN incident
- **Proforma C for initial Assessment of level of JR**
- Proforma D - Checklist for initial actions by public health & service continuity
- Proforma E – Incident Lead Checklist – Immediate Actions
- Proforma F - Checklist of potential multi-agencies involved

HSC Public Health Agency | HSC Health and Social Care Board | HSC Business Services Organisation

Proforma (A) for initial Notification

Potential Major Emergency

On receiving a notification or an alert call of a potential incident (non-infectious disease) please complete the following.

Completed by: .....

Date & Time: .....

Caller Details:

Date : ---------- Time : ----------

Name and designation of caller: ----------

Caller Contact Details (Telephone / Mobile / Pager / Fax / e-mail) :

---------- ----------

---------- ----------

Incident Details:

Date : ---------- Time : ----------

Location : ----------

Current status of Incident (Chronic Environmental Hazard; Acute HP Incident with potential PH implications / Acute HP Incident with definite PH implications/Service Continuity Incident)

Nature of incident (e.g. Disease cluster/Land contamination/HAZMAT/ Flooding/Utility failure)

Hazards (Present / potential) ----------

Estimated number of unwell and nature of illness: (Categorise into P1: P2: P3 if appropriate).

PHA Actions to date ----------

Specific Proforma (B) IF INCIDENT RELATES TO HAZMAT OR CBRN INCIDENT

COMPLETE THE FOLLOWING HP RISK ASSESSMENT;

1. Hazard Identification: SOURCE!

- Hazard Details (Nature; quantity; proprietary and generic name)

- Physical State of Chemical(s) (solid, liquid, vapour / gas)

- Evidence of adverse effects ----------

---

2. Dose Response Assessment:

- Dose-response curve; threshold effects; LD50 etc: ----------

---

3. Exposure Assessment: PATHWAY & RECEPTOR(s)!

- Pathway of exposure (air; water; food; soil; other): ----------

---

- Route of Exposure (inhalation, dermal, ingestion, other):----------

---

- Identified Population at risk: ----------

- Estimate of number of persons exposed to hazard: ----------

---

- Duration of exposure ----------
- Frequency of exposure ----------

- Estimate of Dose exposed to ----------
- Decontamination carried out at incident site: Yes ∇ No
- Number of persons currently ill following exposure: ----------

---

- Details of any symptoms or signs: ----------

---

4. Risk Characterisation:

- Risk score (Low; Medium; High) ----------
- Recommendations for Risk Management:

  Immediate ----------

  Long term ----------

Health Protection Actions Taken Based on Risk Assessment:

HSC Public Health Agency | HSC Health and Social Care Board | HSC Business Services Organisation

Proforma (C) for initial Assessment of level of JR

Completed by: ---------- **Date & Time:** ----------

ASSESSMENT of LEVEL OF RESPONSE REQUIRED BY PHA/HSCB/BSO & ACTION(S) TAKEN TO DATE:

1. **Impact/Consequences for Public Health (Potential or Real):**

---

2. **Impact/Consequences for HSC Service Continuity (Potential or Real):**

---

3. **Impact/Consequences on PHA/HSCB/BSO:**

(e.g. advice only; active response; Incident Team etc)

---

4 **Potential duration of the incident**: (short; medium; prolonged[5])

---

5. **Level of media attention local and national** (nil; minimal; moderate; high)

---

6. **Potential Malicious incident / act of terrorism, deliberate release:**

YES NO

7. **Public Perception potential impact (positive and negative)**

ASSESSED LEVEL OF JOINT RESPONSE REQUIRED.

LEVEL 1 ☐ **LEVEL 3** ☐

LEVEL 2 ☐ **LEVEL 4** ☐

[5] Short = Hrs; Medium = Hrs – days; Prolonged = Days

Public Health Action Taken:

Date & Time	Action

Service Continuity Action Taken:

Date & Time	Action

- Further PH action required Yes ∇ No ∇

(if **No** close record; If **Yes** specify action required).

- Further Service Continuity action required Yes ∇ No ∇

(if **No** close record; If **Yes** specify action required).

HSC Public Health Agency | HSC Health and Social Care Board | HSC Business Services Organisation

Proforma (D) Checklist

Actions to be taken by PHA Officers on Notification of Potential Major Emergency

Completed by: ..... Date & Time: .....

	Assessment
1. Record information on Proforma A	
2. Give immediate PH advice	
3. Assess actual or potential impact on public health and service continuity (Proforma C)	
4. Decide Level of JR required	
5. If level 2 JR or above inform relevant staff DPH/Deputy DPH EmpEnH Team Member (if available) HSCB & BSO (DPH role) PHA PR	
6. Gather further info on incident from scene/multi-agency partners	
7. Review level of JR required and escalate or de-escalate as necessary	
8. Set up HP team if required	
9. Participate in JR Incident Control Team	
10. With HSCB and BSO Colleagues implement joint response	
11. Send rep to multi-agency command & control if required	
12. Identify staff and set up direct points of contact with agencies as necessary	

Proforma (D)1 Checklist – for use in service continuity incident

Actions to be Taken by PHA Officers on Notification of Potential Major Emergency

Completed by: ..... Date & Time: .....

	Assessment
1. Review information on Proforma A	
2. Give immediate PH advice & ensure HP resilience by assisting HP Consultant if required	
3. Assess actual or potential impact on public health and service continuity (Proforma C)	
4. Review strategic overview of incident and assess PH implications	
5 Liaise with DPH and via DPH HSCB +/- BSO to agree level of response	
6 If level 2 JR or above & service continuity implications:- a. Ensure PH implications are considered when decisions are being made b. Assist with clinician – clinician liaison through Control Team by discussing clinical issues with Trust & DOH (NI) senior clinicians	
7 Represent PH with emphasis on Screening & Commissioning	
8 Participate in JR Incident Control Team	
9 With HSCB and BSO Colleagues implement joint response	
10 Attend multi-agency command & control if required	
11 Identify staff and set up direct points of contact with agencies as necessary	

Proforma E

Major Incident Immediate Action Checklist

Actions to be taken by DPH/HSCB Senior Officer or deputy in event of Major Incident

Completed by: ..... Date & Time: .....

1. **INCIDENT OCCURS**

2. **INITIAL NOTIFICATION**

3.	Assess actual or potential impact on public health and service continuity	**YES/NO**
4.	Activate JREP and decide initial level of JR required	**YES/NO**
5.	If level 2 JR or above inform relevant staff & ESTABLISH SILVER a. DPH/Deputy DPH b. EmpEnH Team Member (if available) c. HSCB & BSO (DPH role) d. PHA PR e.	**YES/NO**
6.	If Level 3, ensure EOC established	**YES/NO**
7.	Inform Chief Executive	**YES/NO**
8.	Create HP Team – Environmental or Outbreak	**YES/NO**
9.	Create Service Team	**YES/NO**
10.	Set up PR team if required BUT ensure PR involvement	**YES/NO**
11.	Create Support Teams if possible	**YES/NO**
12.	Dynamically Assess Situation	**YES/NO**

- Environmental Health Officers — Yes / No
- Northern Ireland Water — Yes / No
- Rivers Agency — Yes / No
- NI Environment Agency — Yes / No
- Food Standards Agency — Yes / No
- NI Housing Executive — Yes / No
- Education & Library Board (N) — Yes / No
- Education & Library Board (S) — Yes / No
- Education & Library Board (E) — Yes / No
- Education & Library Board (W) — Yes / No
- LGEMG — Yes / No
- EPCO (Belfast) — Yes / No
- EPCO (Northern) — Yes / No
- EPCO (Southern) — Yes / No
- Utilities
  - BT — Yes / No
  - NIE — Yes / No
  - Phoenix Gas — Yes / No
- Translink — Yes / No
- Road Service — Yes / No
- PSNI — Yes / No
- NIFRS — Yes / No
- HSE — Yes / No
- CCaNNI — Yes / No
- NIBTS — Yes / No
- Others as this list is not exhaustive — Yes / No

(Please specify) ___________________________________

____

____

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Appendix C – Action Cards

Action Cards
Joint Response Incident Control Team

Action Card 1 – Incident Control Team Chair – Director of Public Health & HSCB Led)

Action Card 2 – Incident Control Team Member

Action Card 3 – First Responder Liaison Officer

Action Card 4 – Specialised Agency Liaison Officer

Action Card 5- Lead Communications Officer/On Call Communications Officer

Action Card 6- Communications Officers

Public Health Agency

Action Cards 1 – 8 Public Health Directorate including Chief Executive

Action Cards 9 - 11 Public Health Nursing & Allied Health Professionals

Action Cards 12 - 13 Public Health Operations

Health & Social Care Board

Acton Cards HSCB Corporate Services 1 -2

Action Cards HSCB Integrated Care 3 & 4

Action Cards HSCB PMSI & Commissioning 5&6

Action Cards HSCB Social Care & Children 7 & 8

Business Services Organisation

Acton Cards BSO Corporate Services 1 – 3

Acton Card BSO – PaLS – 4

Action Card Information Technology Services (ITS)-5

Joint Response Incident Control Team Action Cards

For use by PHA, HSCB and BSO

ACTION CARD 1 - INCIDENT TEAM CHAIR

When the decision is made to establish an Incident Control Team (Silver) the Chair, who will either be a senior officer from PHA (normally Director of Public Health or designated deputy if incident Public Health related) or HSCB director on call.

PHA LED INCIDENT - DPH OR DESIGNATED DEPUTY

Key Roles after notification and assessment:-

1. Where necessary, review the joint risk assessment in relation to public health and service continuity impacts

2. Confirm that DoH (NI) & Trusts have been informed of the incident

3. Approve a holding media statement, if required

4. Where necessary liaise further with other relevant agencies, HSC Trusts, NIFRS, PSNI, NIAS, etc. at appropriate level and where appropriate recommend multi-agency meeting be convened.

5. Nominate appropriate members of staff to act as Liaison Officers into Trust; DOH (NI); and Multi-agency meetings where necessary

6. Consider the need for a STAC

7. If following risk assessment and discussion the incident is deemed serious enough , i.e. a Level 3 or 4 major emergency as per Matrix ensure an EOC/Information Hub and Incident Control Team is set up and chair the first meeting. (See Appendix D on agenda for ICT)

8. Where required, contact, inform and assemble relevant incident team members including a Health Protection (HP).

9. When required, ensure that organisations activate plans for recovery and eventual return to normal

10. **NOTE: If incident is HSCB led DPH will be member of Incident Control Team and lead public health response but senior officer from HSCB will chair ICT. Above actions may still be relevant.**

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

HSCB LED INCIDENT Key Roles:-

1. Obtain a briefing on all relevant details of incident from the PHA **and record**;
2. Confirm with the PHA, BSO and HSCB lead director or nominated deputy the level of response required.
3. Contact, inform and assemble relevant incident team members
4. Ensure incident room is set up and distribute action cards
5. Develop/approve a media holding statement (joint statement)
6. Arrange for the relevant information to be gathered
7. Inform relevant organisation(s) of arrangements for contacting the incident team (phone, e-mail, web)
8. Inform other relevant local agencies
9. Identify any business/service continuity needs
10. Provide agreed regular updates to the DOH (NI) lead director
11. When required, ensure that organisations activate plans for recovery and eventual return to normal
12. Agree/confirm when & who produces INCIDENT SITREP
13. Agree frequency & times of meetings
14. When the incident is stood down ensure the message is communicated to relevant parties.

15. **NOTE: If incident is PHA led a HSCB Director will be member of Incident Control Team and lead Board response but senior officer from PHA will chair ICT. Above actions may still be relevant.**

(See Appendix D on agenda for ICT - Silver)

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 2 - INCIDENT TEAM MEMBER

When the decision is made to establish an Incident Control Team the Chair, who will either be a senior officer from PHA (normally Director of Public Health or designated deputy if incident Public Health related) or HSCB Director on call will convene the Incident Control Team (Silver). Membership may vary depending on availability, timescale of incident, i.e. shift pattern or the nature of emergency and will have membership from PHA: HSCB and BSO membership.

However, the key roles involved are generic and do not depend on incident type.

1. If required, prior to attending ICT (Silver) you may need to convene your Directorate Team and appoint chair;

Key Roles in ICT:-

2. Attend ICT meeting either remotely using teleconferencing or as directed to a HSC building, most incidents this will be Champion House, 12 – 22 Linenhall Street, Belfast.
3. Receive briefing on all relevant details of incident from the Incident Control Team Chair
4. Input as requested on the nature of incident and possible actions to take. You may be asked to comment specifically on issues that relate to your specific area of expertise or give a more corporate viewpoint. This could be from a public health perspective or service continuity perspective dependent on your background and expertise.
5. Assist with drafting any media statements that are required. You may be directed to act as spokesperson for joint response
6. As directed represent the HSC Silver Response at multi-agency tactical groups (See separate action cards)
7. At all times be aware that timely decisions will be required.
8. When required, ensure that organisations activate plans for recovery and eventual return to normal

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 3 – FIRST RESPONDER GROUP (MULTI-AGENCY TACTICAL) LIAISON OFFICER

This will normally be a senior officer from the PHA, i.e. Consultant or Assistant Director. They should have knowledge of emergency planning issues.

Key Roles:-

1. Attend multi-agency 'blue light' tactical meeting

2. Act as HSC Silver representative on group and when required make decisions accordingly

3. Act as conduit between Multi-Agency Command & Control Group and PHA:HSCB:BSO Joint Response ICT (Silver)

4. When required give immediate specific Public Health and/or Service Continuity advice from HSC Silver to chair of Multi-Agency Silver

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 4 – SPECIALISED AGENCY LIAISON OFFICER

This will normally be a senior officer from the PHA, i.e. Consultant or Assistant Director. They should have knowledge of emergency planning issues.

These groups will be incident specific and will be chaired by the organisation that has convened meeting. Examples include NI Water, Food Standards Agency, Northern Ireland Environment Agency, Health & Safety Executive, Councils, etc.

These groups are different from First Responder Group Multi-Agency Tactical Meetings.

Key Roles:-

1. Attend liaison meeting

2. Act as HSC Silver representative on group and when required make decisions accordingly

3. Act as conduit between Specialised Agency Group and PHA:HSCB:BSO Joint Response ICT

4. When required give immediate specific Public Health and/or Service Continuity advice from HSC Silver to chair of Group

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 5

Lead Communications Officer/On Call Communications Officer

Definition of Lead Communications Officer

During office hours, the Lead Communications Officer(s) will be the HSCB Head of Communications/ PHA Assistant Director of Communications and Knowledge Management or nominated Communications Manager.

Out of Hours, the Lead Communication Officer(s) may be the On Call Communications Officer(s) as appropriate.

Levels 2, 3 and 4

If the Lead Communication Officer(s) are not the Heads of Communications, they will be required to notify their respective Heads of Communications of the issue/incident.

The Lead Communications Officer(s)/On Call Communications Officer(s) will notify appropriate parties e.g. members of the HSCB/PHA Communications Teams and other relevant communications teams that an incident has occurred and will provide updates as well as respective Senior Management Teams/ Agency Management Team in both organisations.

The Lead Communications Officer(s)/On Call Communications Officer(s) will lead on implementing the relevant PHA/ HSCB aspects of the regional operational communications strategy, in line with direction from Health Gold and UK-wide policies and procedures as appropriate.

They will provide communications advice and support to the Incident Control Team (ICT) or Emergency Outbreak Team (EOC), including on appropriate public messaging, timing, channels, media management, internal communications etc.

ACTIONS

1. Upon being alerted of an incident, get key details and confirm handling arrangements.

2. If in-hours alert the Head of Communications/ Assistant Director of Communications and Knowledge Management and other appropriate communications members via phone/email initially.

3. If out of hours – send initial WhatsApp group message to HSCB/PHA Communications Teams as well as via phone/email.

4. Arrange urgent telecall with Head of Communications/ Assistant Director of Communications and Knowledge Management and other appropriate communications officers.

5. Send email alert to Department of Health/HSC Heads of Communications and set up a regional comms telecall as required

6. Attend/ dial in to Incident Control Team (ICT) or Emergency Outbreak Team (EOT) meeting (if one if set up), receive briefing and obtain a detailed understanding of the problem and its impact. Advise on approach to media activity, including media statements, holding lines, briefing materials, interviews etc.

7. If ICT or EOC has yet to be established it may be necessary to receive initial briefing by telephone.

8. If a decision is taken not to establish an Incident Control Team (ICT), the Lead Communications Officer(s)/ On-Call Communications Officer(s) of the incident will liaise with the Silver JEP lead within their respective organisation to agree approach.

9. If an ICT/ EOC is established, the Lead Communications Officer(s)/ On-Call Communications Officer(s) work with the ICT/ EOC to identify a lead Director/Designated Liaison from within the group who will act as the main point of contact between communications staff and senior/ clinical staff working directly on managing the incident. It will be the role of this person to keep abreast of developments and apprise themselves of the latest information and data so as to inform media activity. A key principle of this arrangement is that it will create a single point of contact between Corporate Communications and senior/ clinical staff to ensure that both teams can play their role in the management of the incident as efficiently and effectively as possible.

10. Working with the Lead Director/ Designated Liaison, the Lead Communications Officers will manage the relevant communications requirements around the incident, such as the frequency and timing of updates, the management of media interview requests and the general scale and form of engagement.

11. The Lead Communications Officers will work closely with the Lead Director/Designated Liaison to ensure strong synergy between the management of the incident and the communications activity relating to it, and

will advise senior/ clinical staff on key steps that may be recommended, such as arranging media briefings or the frequency of media updates.

12. Establish a communications teleconference with DoH/ HSC Trusts and other relevant organisations with the aim of coordinating the communication response and to share information. This will be done at least once daily, with ongoing e-mail and direct telephone contact in between. This will be kept under review. A joint email group should also be set up.

13. Maintain communication with communications leads from other organisations involved in the incident (PSNI, councils, NIFRS, etc)

14. Keep OWN timed log of actions taken/ decisions made

15. If necessary, establish a single media contact telephone number for the Incident room. Convene and manage HSCB/PHA Communications Team and establish shift patterns if necessary.

16. Establish holding lines and agree timetable for media briefings, releases and interviews as required.

17. Agree key messages and audiences with incident control team and senior management.

18. Ensure there are clear, quick and effective approval processes in place in relation to responses to media enquiries, statements, news releases, and in relation to facilitating interview bids. All proactive lines/ messaging and interview bids need to be cleared by the Incident Control Team (ICT) Chair.

19. Agree nominated spokesperson(s) with the Incident Control Team and senior management if different from Lead Director/ Designated Liaison (e.g. if enquiry relates to a very specific area of expertise) and provide appropriate support in relation to any media interviews

20. Set up and manage any press briefings/conferences as appropriate

21. Ensure effective use of social and digital media during the incident.

22. Manage and ensure all media and public relations activity is documented.

23. Maintain and keep records for purposes of debrief and potential Inquiry.

24. Ensure there are robust mechanisms in place to monitor media and social media coverage during the incident and post incident.

25. Brief replacement staff in the event of any handover.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

RECOVERY

The Lead Communications Officer(s) will review the communications support and incorporate lessons learnt from the incident into the Joint PHA/ HSCB/ BSO Emergency Preparedness Communications Plan.

ACTION CARD 6

COMMUNICATIONS OFFICER(S)

Levels 2, 3 and 4

The Communications Officers (HSCB/ PHA) will prepare and disseminate information to staff, the media and public once approved by Lead Communications Officer and ICT Chair.

The Communications Officers will act as first point of contact for media enquiries and provide support to ensure that all audiences get access to up to date information.

ACTIONS: On receiving notification of a major incident:

1. Proceed to the designated media room if one is established.

2. The Lead Communications Officer(s) will provide a briefing on communication roles and responsibilities.

3. Log all media requests (on usual logging systems) and develop responses in conjunction with the Lead Communications Officer(s) and appropriate communications staff.

4. Keep the Lead Communications Officer(s) informed of developments, progress and media interest, social media/online activity, and assist in progressing enquiries/bids as appropriate.

5. In conjunction with the Lead Communications Officer(s), assist in drafting responses to media enquiries, news releases, social media content, web updates, setting up and facilitating media interviews and arranging press conferences.

5. Monitor media and social media coverage of the incident.

6. Maintain and keep records for purposes of debrief and potential inquiry.

7. Brief replacement staff in the event of any handover.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

HSCB/PHA Joint Emergency Plan
Emergency Communications Pathway

Communications Lead/ On-Call Communications Officer alerted to incident

↓

Make contact with HSCB/PHA Communications Teams to alert re incident and request additional support, if necessary, via email/telephone or Whatsapp **

↓

Alert Heads of Comms/ On-Call Communications Officers in each HSC Trust/ DoH (via e-mail or telephone)

↓

Liaise with key point of contact on ICT/ Emergency Operation Centre to ascertain details and arrangements for handling and approval processes (both at Silver and Gold level)

↓

Keep HSCB/PHA Senior Management Team/Agency Management Team informed as appropriate

↓

Participate in ICT/ EOC telecalls/briefings as required and advise on communications activity, such as drafting holding lines, key messages, comms channels, agreeing timing of statements/briefings, agree spokespeople, need for media room/rotas etc

↓

Brief HSCB/ PHA communications colleagues as required on individual roles and actions

↓

Liaise regularly with DoH/HSC Trusts Heads of Communication, setting up regular telecalls as required, and ensuring there is a co-ordinated response/sharing of information and clarity on roles and responsibilities

↓

Set up group email list to be used for all communications to ensure consistency of approach and message.

↓

Designated communications officer within team creates a media log to record all media enquiries and store holding lines, and action log to record all activity of the team

↓

Ensure communications team keeps itself abreast of progress and developments, and of media/public interest, and manages workload and activity appropriately

↓

Communications team monitors mainstream and social media activity throughout incident

↓

Communications team agrees and implements handover process to ensure seamless and appropriate communications handling over a prolonged period

↓

Ensure appropriate statement/releases are cleared by ICT Chair and Spokespersons are briefed

↓

Debrief Communications Team

↓

Evaluation / lessons learned

Public Health Agency

Action Cards for

PH Directorate

PH ACTION CARD 1

CHIEF EXECUTIVE

This action card should be read in conjunction with ICT (Silver) Action Card 1 – Incident Control Team Chair – DPH and ICT (Silver) Action Card 2

Notification

The Chief Executive will be notified immediately about the activation of the Joint Emergency Response Plan at Level 2 or above. Notification will come from the DPH or designated deputy.

If Incident is PHA led the Chief Executive may chair the Incident Control Team (Silver). If incident is HSCB led the Chief Executive may act as PHA lead officer on the Incident Control Team (Silver).

Alternatively, the Chief Executive may delegate this role to the DPH or designated deputy.

Main actions – if not chairing ICT and not doing actions linked to ICT itself:

1. During incident, lead PHA and ensure 'normal business' can be maintained as much as possible
2. Ensure PHA Board members are updated on incident
3. Liaise with DoH (NI) and Minister and other elected representatives and other VIPs if required
4. Act as spokesperson for PHA and 'public face' of Agency when ICT is in session
5. When incident is over, ensure adequate recovery mechanisms are in place for the staff and resources within organisation and that organisation can return to normal as soon as possible

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PH ACTION CARD 2

Director of Public Health (PHA) or designated deputy. For use in-hours and out of hours.

NOTIFICATION & ASSESSMENT– DPH or Designated Deputy (in & out of hours)

This will come from Assistant Director Health Protection or designated deputy **during hours** and the on-call Health Protection Consultant **out of hours**.

Jointly assess level (as per matrix) and action required, i.e. health protection or service continuity and level of response to health protection incident.

1. If incident has service continuity implications contact HSCB, as per Annex 1 & 2 in JREP and assess what level of public health support is required.

2. If the incident is assessed as being a Level 2 or above incident contact the PHA Chief Executive.

3. Where an Emergency Operations Centre is required contact the BSO Chief Executive as per the Contact Arrangements contained in Annex 2

4. If incident PHA Led see Action Card 1 – Incident Team Chair for key actions

5. If HSCB Led Incident See Action Card 2 – Incident Team Member for key actions

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASON

PH ACTION CARD 3

DUTY OFFICER in HEALTH PROTECTION DUTY ROOM
(HP Nurse OR SpR)

- Inside office hours the initial call will come into the HP Duty room in PHA Headquarters, Linenhall Street. As such the call will be passed by the administration staff directly to the Duty Officer (Specialist Registrar/ HP Nurse)

PH Dr 1st On-Call

- Out of Hours the call will come via NIAS to the 1st On-call PH doctor

In both these situations the individual receiving the call should take basic details as per Proforma A including a contact number from the person notifying the potential MI and IMMEDIATELY inform the Consultant in Health Protection (In-hours this will be the HP consultant covering the duty room and out-of hours this will be the HP consultant 2nd on-call) who will make the initial assessment if the incident is Health Protection focussed or Service Continuity focussed and respond accordingly.

1. Complete notification Proforma A
2. Contact HP Consultant immediately and pass on information.
3. Inform member of Emergency Preparedness Environmental Hazards Team if available.
4. Assist in the joint response as per HP Consultant/Non HP Consultant, e.g. communication cascade, assist with creation of PH response teams, etc.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PH ACTION CARD 4

PH ACTION CARD 2 - HEALTH PROTECTION CONSULTANT

1. Upon receipt of call from 1st on call (Duty room during office hours) ensure Proforma A is complete then assess level of Joint Response required (Proforma C), i.e. the health protection and/or HSC Service Continuity implications.

a. In-hours - Contact Assistant Director (A/D Health Protection) or designated deputy;

b. Out of hours – Contact on-call DPH to review the risk assessment and discuss action required, i.e. health protection or service continuity.

2. HP Consultant, AD and DPH agree the level of joint response required. DPH contacts HSCB/BSO per communication lines if there are service continuity issues.(This action card should be read in conjunction with Action Card 3)

If incident mainly health protection incident +/- some service continuity implications:-

3. Ensure relevant staff are notified.
4. Review D (Checklist of actions) and ensure key actions have been completed
5. Give health protection advice into the incident as required.
6. Where appropriate, liaise with PHE(CHaPD) on health protection issues.
7. Carry out further health protection actions as necessary (incident specific)
8. Liaise with the relevant agencies responding to the incident.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PH ACTION CARD 5 - PUBLIC HEALTH (NON HP CONSULTANT)

Involvement from the Non-HP Consultant may be required when the incident is Level 2 or above and has service continuity implications. The **HSCB** will lead such an incident and chair the ICT. This Action Card should be read in conjunction with Action Card 2.

In such incidents the DPH, or designated deputy will be on the ICT.

Upon notification and prior to the involvement of the Non HP Consultant steps 1 - 3 on Action Card 2 will have been completed.

Following the risk assessment by HP Consultant and DPH, if service continuity implications have been identified, the HSCB and Non HP Consultant may be contacted.

Once you have been informed of the level of response agreed your role may include:-

1. Where an incident is deemed a Health Protection incident, act as additional Health Protection resilience by assisting HP Consultant if required

2. In a mainly service continuity incident review the service continuity implications of the incident, i.e. review Proforma C and review D and D1 (Checklist of actions).

3. Where appropriate, give service continuity advice to the service continuity lead in the HSCB. This will continue throughout the incident.

4. Along with the DPH, review the strategic overview of incident and assess the public health implications of issues and decisions made.

5. Liaise with DPH and via DPH HSCB +/- BSO to agree level of response

6. Contribute to service continuity decisions led by HSCB by bringing public health knowledge to the decisions.

7. Represent the Public Health Directorate, with emphasis on screening and commissioning implications.

8. Assist with the liaison with clinicians who are involved in the incident through Control Team by discussing clinical issues with Trust & DOH (NI) senior clinicians

9. Assist with any other actions as deemed necessary by Incident Control Team Chair.

There may be the requirement to create a service continuity team in the event of a major incident that will support the overall response. This will be agreed upon at the time of the incident.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PH ACTION CARD 6 - PUBLIC HEALTH (HEALTH PROTECTION) LEAD

This will normally be the Assistant Director with responsibility for Health Protection or a designated deputy.

NOTIFICATION

This will come from HP Consultant in Duty Room during hours. Out of hours notification will come from DPH on call. If OOH, points 1 & 2 will have been completed before A/D informed.

1. Jointly assess action required, i.e. health protection or service continuity and level of response to health protection incident with Duty Room Consultant.
2. Inform DPH or designated deputy.
3. Chair Overall Incident Control Team if incident Public Health and DPH is not available and designate deputy to lead Health Protection Team

IF DPH IS CHAIRING ICT Key Roles:-

4. Assess incident for specific public health implications, e.g. infectious disease*, chemical incident and establish team based on assessment
5. Convene HP team at suitable location. This may be virtual or in reality
6. Gather public health intelligence on incident for use by ICT
7. Pass on all relevant details to ICT.
8. Act as Public Health expertise hub for ICT

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASON

PH ACTION CARD 7

ACTION CARD - PUBLIC HEALTH (SCREENING & COMMISSIONING) TEAM CHAIR

This will normally be the Assistant Director with responsibility for Screening & Commissioning or a designated deputy.

Key Roles:-

1. If required, nominate senior officer to act as representative on ICT (Silver). This may be the Assistant Director or a Consultant

2. Assess incident for specific public health concerns surrounding screening and commissioning implications and establish team based on assessment

3. Consider convening PH Screening & Commissioning team at suitable location using remote conferencing facilities as appropriate. This may be virtual or in reality

4. Gather public health intelligence on incident for use by ICT (Silver) through PH Screening & Commissioning team

5. Pass on all relevant details to ICT (Silver) through PH Screening & Commissioning team

6. Act as Public Health (Screening & Commissioning) expertise hub for ICT (Silver) through PH Screening & Commissioning team

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PH ACTION CARD 8

SETTING UP A STAC

(Scientific and Technical Advice Cell)

SEE SEPARATE STAC PLAN

Public Health Agency

Action Cards for

PH Nursing & Allied Professionals Directorate

PHA Nursing & Allied Health Professionals

ACTION CARD 9: Initial Contact in Nursing and AHP (N&AHP)

(Document all communications and actions)

(Hardback A5 notebooks are available in the LHS nursing office)

1. **KEEP A WRITTEN RECORD all communications and actions**

2. Confirm the name and designation of the person who has contacted you.

3. Confirm the initial level of response

4. Obtain as much information as possible about the event from the informer (using the METHANE mnemonic). **WRITE THIS INFORMATION DOWN**

   - **M has a major emergency been declared or alerted;**
   - **E exact location of the incident**
   - **T what type of incident is it, e.g. road traffic collision, chemical leak, rail crash, etc?**
   - **H hazards- are there any hazards that the Board/PHA should know, e.g. has the incident happened in proximity to hospital site**
   - **A access – are there any access issues – this is not as relevant to the Board/ PHA staff. However ask if there are any access issues in relation to attending any proposed meetings.**
   - **N number of casualties and how many are likely to be brought to hospitals?**
   - **E emergency services – what emergency services are in attendance at scene and are more expected at scene**

5. Is there is an incident meeting? (check time/venue/ WRITE THIS INFORMATION DOWN)
   a. If yes: decide who else needs to attend from N&AHP
   b. If no: consider if a directorate meeting/response is required. Liaise with the Emergency Planning lead to receive an update and share with the N & AHP team

6. Assess the duration of the incident.

7. Decide who you need to contact from the N&AHP team at this stage. If you determine that it will be an ongoing or prolonged incident. You will need to ensure that there will be appropriate cover from the N & AHP team for the potential duration of the incident.

8. Contact the Nursing and AHP team (using list provided).

- **If you are the Director or Assistant Director**
  - Contact other team members
- **If you are not the Director or Assistant Director**,
  - Your role will be to continue to try and contact them. **Until you do this you are the 'Lead' in the N&AHP directorate.**
  - Contact the next name on the list until you get someone.
  a. Give this person a direction to contact other team members. (and to follow action card 2 ie 2nd contact in N&AHP directorate)
  b. Remind them you will continue to contact Director and Assistant Director and will phone them back when you have been successful.

The N & AHP directorate lead (at this stage) should:

- **Give a brief overview** of the event and provide details of incident meeting (and who is expected to attend).
- **ASK** staff their current location and direct them to the nearest locality office.
- **ASK** them how long it will take them to get there. (document this information)

  OR
- **Give a detailed overview** of the event and ask the team members to remain on stand-by.
- **ASK** staff their current location. (document this information)

9. Document the details of your actions.

10. Link to the joint response incident control team (Silver).

11. If business continuity is likely to be affected: arrange an internal N&AHP team briefing.

12. Continually re-assess and monitor your response.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PHA Nursing & Allied Health Professionals

ACTION CARD 10: 2nd Contact in Nursing and AHP

(Document all communications and actions)

(Hardback A5 notebooks are available in the LHS nursing office)

1. KEEP A WRITTEN RECORD all communications and actions

2. The initial contact from the N&AHP team will give you an overview of event and the level of the response. **RECORD THIS INFORMATION.**

3. You will be asked to contact either specific staff or all staff from the N & AHP directorate (i.e. professional staff and/or administrative staff) (from the contact list).
    a. The initial contact (the person who contacted you) will contact the Director and Assistant Directors of N & AHPs.

4. When you contact staff you should:

    - **Give a brief overview** of event and provide details of incident meeting (and who is expected to attend). **Ask them to record this information.**
    - **ASK** staff their current location and direct them to the nearest locality office. (document this information)
    - **ASK** them how long it will take them to get there. (Document this information)

    OR

    - **Give a detailed overview** of the event and ask the team members to remain on stand-by.
    - **ASK** staff their current location. (Document this information)

5. Update the initial contact that you have completed the actions, and determine if further actions are required.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PHA Nursing & Allied Health Professionals

ACTION CARD 11: Lead N&AHP Incident Officer

(This refers to the most senior member of N & AHP directorate or nominated representative)

(Document all communications and actions)

(Hardback A5 notebooks are available in the LHS nursing office)

1. Liaise with and update the "Incident Director" in the control team

2. Attend Incident meetings, agree local strategy.

3. Provide regular updates to the N & AHP team. Remind staff to document all communications and actions in relation to this incident.

4. Convene incident N & AHP team meetings as required.

5. Consider how the incident will affect the Trusts/primary care/ independent organisations/neighbourhoods.

6. Maintain an accurate log of actions taken/decisions made.

7. Delegate team responsibilities :
   If you determine that it will be an ongoing or prolonged incident
   - You will need to ensure that there will be appropriate cover from the N & AHP team for the potential duration of the incident.

8. Prioritise existing work
   - Identify those responsible for continuity of normal operations.
   - Ensure that staff working as part of the incident team has their normal roles covered if required.

9. Agree business continuity requirements

10. Assess and monitor responses (or nominate this role to a senior team member).

11. Ensure staff welfare by allowing staff to take regular breaks and hand over to another member of staff.

12. Act as spokesperson for the team by communicating with incident control team- Silver (or nominate this role to a senior team member).

13. Ensure the 'stand-down' message is communicated to N & AHP team and create an opportunity for debriefing the team.

14. Compile a report on the incident, including lessons learnt.

On behalf of the "Incident Director", you are responsible for the N & AHP incident team, including delegation of tasks and staff welfare.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Public Health Agency

Action Cards for

PHA Operations Directorate

PHA Operations Directorate

ACTION CARD 12 for Director of Operations on receiving notification of an incident (out of hours)

- Director of Operations will contact Assistant Director of Communications and Knowledge Management and PR Manager (or deputy)
- Dependant upon nature and scale of incident Director of Operations will contact Assistant Director Planning & Corporate Services and liaise with HSCB Corporate Services in order to initiate facilities requirements, support to setting up of EOC, etc.
- Complete log of action taken, who communicated with, etc;
- Determine and agree Directorate representative on Incident Group
- Determine and agree Directorate representation/support to EOC.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

PHA Operations Directorate

ACTION CARD 13. Operations Directorate Representative working with HSCB to take forward facilities requirements, support to setting up of EOC, etc

- Working with HSCB and Emergency Preparedness lead to ascertain what is required in terms of access to facilities, security, catering, opening hours of building and potential establishment of EOC and make necessary arrangements;
- Liaise with PHA Incident Officer to assess ongoing requirements;
- Ongoing liaison with HSCB to ensure provision of security and catering, etc
- Work with HSCB regarding the logistical arrangements for the establishment of the EOC in terms of accommodation, equipment, facilities support, and health and safety issues.
- Working with HSCB colleagues identify the scale of administrative support required and co-ordinate the organisation of administrative support from PHA.
- Working with HSCB colleagues identify the scale of health intelligence support required and co-ordinate the organisation of health intelligence support from PHA.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Health & Social Care Board

Action Cards

Health & Social Care Board

Action Cards for

First Officers Contacted

HSCB ACTION CARD 1

Director on call

- Agree with notifying person from PHA the level of response required. Agree if it is likely to require incident control team and/or agree timescale for feeding back to agreed PHA contact;
- Advise Chief Executive (or nominated deputy);
- Assess situation and determine which Directorate(s) within HSCB need to be notified to take forward HSCB response. Agree method of internal discussions required to take place to enable feedback to PHA;
- The Director on call will contact relevant Director in HSCB re nature of incident and required response and agree timescale for feedback of actions, etc to PHA;
- The Director on call will contact;
    - PR Manager (or deputy);
    - All Directors to ensure all informed;
- Dependent upon nature and scale of incident the Director on call will liaise with Corporate Business Manager or deputy in order to initiate facilities requirements, support to setting up of EOC, etc.
- Complete log of action taken, who communicated with, etc;
- Determine and agree Directorate representative on Incident Group
- Determine and agree Directorate representation/support to EOC.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASON

HSCB ACTION CARD 2

Emergency Operations Centre (EOC) Lead Officer ACTION CARD

Corporate Business Manager/ Representative to take forward facilities requirements, support to setting up of EOC, etc

- Ascertain from the Director on call what is required in terms of access to facilities, security, catering, opening hours of building and potential establishment of EOC and make necessary arrangements;

- Liaise with HSCB Incident Officer to assess ongoing requirements;

- Ongoing liaison with Security and Catering, etc

- Make the logistical arrangements for the establishment of the EOC in terms of accommodation, equipment, facilities support, and health and safety issues etc;

Health & Social Care Board

Action Cards for

Integrated Care Directorate

INTEGRATED CARE ACTION CARD 3

DIRECTOR/ASSISTANT DIRECTOR OF INTEGRATED CARE

Following notification of an incident:

1. Assess the Level of Integrated Care Response required. Link with Incident Control and continually reassess the level of response required as the situation unfolds.

2. Contact relevant Assistant Directors / Business Support Managers to assist depending on the nature of the incident

3. Allocate tasks and agree devolved responsibility

4. Ensure the continuous information flow of relevant information to and from primary care during an incident.

5. Liaise with the relevant service providers responding to the incident.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

HSCB ACTION CARD 4

Integrated Care Directorate

BUSINESS SUPPORT MANAGER – INTEGRATED CARE DIRECTORATE

Following notification of an incident:

1. Undertake tasks and devolved responsibility assigned by the Director /Assistant Director.

2. Contact other staff to assist depending on the nature of the incident.

3. Assist with the processes to ensure the continuous information flow of relevant information to and from primary care during an incident.

4. Provide assistance as required to support the incident.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Health & Social Care Board

Action Cards for

Performance Management & Service Improvement Directorate

& Commissioning Directorate

ACTION CARD 5: PMSI/Commissioning Directorate

Performance Management and Service Improvement directorate Information Lead in gathering information and provision of information to support the management of an incident.

- Identify the information requirements as per the needs of the incident
- Communicate with the relevant organisation(s) with regard to the information needs and the method and timescales for providing the information required (e-mail, web download, fax etc)
- Agree in conjunction with the lead director whether a formal information team should be established and agree the level of staffing and hours of cover required
- Ensure that the receipt and distribution of information is recorded and logged on appropriate templates

At the end of your shift you should hand over to someone with similar skills. You should also ensure you hand over a progress report and management plan for the next shift.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 6: HSCB PMSI/Commissioning

PMSI/Commissioning directorate representative providing administrative support.

- Provide admin support to the incident team
- Start an incident log using the agreed template
- Ensure that you have a list of incident team members and the roles that they are performing
- Ensure you are clear about what you are expected to record or clarify with a member of the incident control team or chief incident officer if required
- Keep a record of the incident team meetings and agree with the Chief Incident officer who will minute the meetings
- Ensure papers with agreed action points etc are available for meetings
- Review documentation on a regular basis to ensure records are accurate and to avoid duplication or confusion

At the end of your shift you should hand over to someone with similar skills. You should also ensure you hand over a progress report and management plan for the next shift.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Health & Social Care Board

Action Cards for

Directorate of Social Care & Children

ACTION CARD 7: Director of Social Care & Children

Following notification of an incident:

- Assess the Level of HSCB Response required.
- Contact relevant Deputy Directors to assist depending on the nature of the incident.
- Contact additional Directorate professional and administrative staff as necessary.
- Allocate tasks and agree devolved responsibility.
- Ensure the continuous information flow of relevant information to and from Social Care during an incident.
- Liaise with the relevant service providers responding to the incident.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 8: Assistant Director of Social Care

Following notification of an incident:

1. Assess the Level of HSCB Response required.
2. Contact additional Directorate professional and administrative staff as necessary.
3. Allocate tasks and agree devolved responsibility.
4. Ensure the continuous information flow of relevant information to and from Social Care during an incident.
5. Liaise with the relevant service providers responding to the incident.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Business Services Organisation

Action Cards for

BSO HR & Corporate Services Directorate

PaLS

Information Technology Services (ITS)

ACTION CARD 1: Initial notification of an incident (in hours)

- Agree with notifying person from PHA the level of response required. Agree if it is likely to require incident group and/or agree timescale for feeding back to agreed PHA contact;

- Advise Chief Executive (or nominated deputy);

- Assess situation and determine which Directorate(s) within BSO need to be notified to take forward BSO response. Agree method of internal discussions required to take place to enable feedback to PHA/HSCB;

- Chief Executive(or nominated deputy)/DHRCS will contact the relevant Director in BSO regarding the nature of incident and required response and agree timescale for feedback of actions, etc to PHA/HSCB;

- DHRCS will contact all Directors to ensure all informed;

- Dependent upon nature and scale of incident DHRCS or Administrative Services manager will initiate facilities requirements, support to setting up of EOC, etc

- Complete appropriate log of action taken, who communicated with, etc;

- Determine and agree Directorate representative on IC Team (Silver) if required

- Determine and agree Directorate representation/support to EOC if required.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 2: Initial Notification (Out of Hours)

- Agree with notifying person from PHA the level of BSO response required. Agree if it is likely to require incident group and/or agree timescale for feeding back to agreed PHA/HSCB contact;

- Contact Chief Executive (if available);

- Assess the situation and determine which Directorate within BSO needs to be notified re incident and required response, and agree timescale for feedback of actions, etc to PHA/HSCB;

- Contact relevant Director in BSO re nature of incident and required response, including agreed timescale for feedback if required;

- Contact HSCB (who will contact)/Communications/PR Manager;

- DHRCS will contact all Directors for information purposes;

- Complete log of action taken and who communicated with;

- DHRCS will, dependent upon nature and scale of incident liaise with HSCB in order to initiate facility access, security, etc and support to setting up of EOC, etc;

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Action card 3 for BSO representative on Incident Control Team

- Ensure membership of ICT agreed;
- Ensure development of terms of reference;
- Carry out functions as agreed by chair of ICT (Silver)
- Ensure communications/clear record of discussions from ICT are circulated to relevant parties and actions followed up:
- Record the formal standing down of the ICT (Silver);
- Ensure clear records are maintained.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ACTION CARD 4: PaLS

PaLS Assistant Director/On Call Officer as initial contact receiving notification of an incident.

- Agree with notifying person from PHA the level of response required;
- Assess situation and determine if Business Continuity Plan should be actioned.
- Determine and agree PaLS representation/support to EOC (if required).

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

ITS – Action 5- Operations Direction Information Technology Services

Action Card

Initial notification (in hours)

ITS help desk making clear that this is an emergency and logged as critical

Follow up by call to AD, Head of Infrastructure, Head of Business Systems.

Initial notification (out of hours)

Out of hours on call contact numbers

(OST)

Follow up by call to AD, Head of Infrastructure, Head of Business Systems

Representative from BSO to lead on taking forward access arrangements/facility support and communication (public relation) arrangements;

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Appendix D – Sample Incident Control Team Agenda

INCIDENT CONTROL TEAM (ICT) SILVER SAMPLE AGENDA
Date:
Time:
Venue:
ICT (Silver) Chair:

1. **Agree chair**

2. **Actions/Decisions from previous ICT (Silver) Meeting**
   (If first meeting carry out impact analysis of incident on HSC ~ public health and service continuity)

3. **Review information available:**

   a. An update from each functional area i.e. public health; acute hospital service continuity; community care service continuity; and service continuity in primary care;
   b. cross-cutting issues which the team needs to be informed of such as cancellation of electives with the knock-on impact in primary care OR requests for media interviews to individual organisations, and
   c. Those issues that need a joint team decision.

Use following as intelligence to inform decisions

   d. Situation Reports from the scene & multi-agency partners
   e. Situation Reports from service (Bronze Level)
   f. Situation Reports from DOH (NI) and multi-agency (Gold)
   g. Situation Reports internally from PHA; HSCB;BSO

4. **Strategic objectives**

5. **Actions/Decisions required from JR Incident Team (Silver)**

6. **Delegate specific Joint Response tasks with timescales**

7. Agree appropriate **liaison officers** for multi-agency partners **and** the command & control structures established (Multiagency Silver / Gold; CCGNI main & Tactical; RHCC)

8. Agree **media strategy** (including press statement if required and spokesperson)

9. Agree time and frequency of **next meetings**

Signature of ICT (Silver) Chair and Loggist required on notes taken.
Record all actions and key notes from ICT (Silver) meeting.

These notes act as a legal record of all actions and decisions taken by HSC Silver and must be filed accordingly

Appendix E - Protocol for Establishment of a Helpline

Introduction

Members of the public may want to ask specific questions about the effects of the emergency on local services and a telephone enquiry line will help to channel enquiries and prevent floods of calls to individual services that are busy responding directly to the emergency itself. It may be useful to consider the establishment of a dedicated help-line facility.

STEP 1 - INCIDENT OCCURS

The decision to establish a Public Help phone line will be instigated from the Incident Control Senior Team (Silver Command Chair) or as a result of a specific request from the Minister for Health.

- The help line is an interagency response (HSCB, PHA, BSO) but will be led by a specific directorate.

The Directorate responsible for managing the helpline will be dictated by the situation. For example in a situation where:

1. There is a police and social care investigation following an allegation of sexual abuse which has occurred in a children's nursery provider who operates over several sites:
   The Directorate of Social Care and Children (supported by Nursing & AHP directorate) will be the lead directorate.
2. There has been a fire at a GP practice in Ballymena overnight, there are no injuries but all patient records have been destroyed.
   The Directorate of Integrated Care will be the lead directorate. They will manage any urgent medical problems, prescriptions and redirect patients to an alternative venue to see a GP.

STEP 2 - The Incident Control Senior Team lead (Silver Command Chair) will contact the designated Director to request the establishment of the helpline.
Upon notification: use the following (and see flow chart) as guide to actions:-

STEP 3 - Director Role:

1. **Establish a meeting within the directorate to discuss incident.**
   - **Appoint a 'lead' for managing the helpline**
   - **Consider requirement for in hours/ OOHs service.**
   - **Consider requirement for static helpline – could staff manage using mobiles (particularly for evenings/weekends)?**
   - **Consider 'expertise' required for the call handlers**
     - Professional call handlers, e.g. nurses, social workers, pharmacists, etc.
     - non-professional call handlers, other staff, e.g. administrative staff.
     - Triage system

- Non professional Call handler triages call, providing general advice and forwards details to 'relevant professional' (within the Directorate or EOC) when professional advice is required.

- **Direct staff to identify critical functions and stand down non essential work to provide support to helpline**

2. **Location:**

   - Identify where the 'public help phone line is to be established. (ie venue and location within the venue). Coordinate with Incident Control Team.
   - Inform contacts below of the designated room.

3. Request 'set up' of Technical requirements (phones, headsets, computer/internet access. Mobiles etc) and inform the contacts below of the designated room.

   - **Contact:**
     - Office hours: HSB In Hour's Contact list
     - OOHs: Out of Hour's Contact list

   - **Building Access:** see appendix P

4. If the location for the public helpline is unsuitable due to technical reasons, another venue will be suggested.

5. Communication with Senior Command Team (Silver Control chair)

6. Dissemination of phone number is integral in the role of the Designated Helpline Lead: see below for pathway

   - GPs : via integrated care
   - General Public: via PR
   - Internal (HSCB, PHA, BSO): via email

7. Identify financial resources. If required complete a business case.

   - In the longer term Agency staff may be required.

8. Direct stand down of public helpline:

   - Debrief staff
   - Reflect on the management of helpline with designated lead and identify learning
   -

STEP 4 - Helpline Lead Role:

- **this member of staff should be a senior officer from within the designated lead Directorate:**

1. Identify staff who will undertake the call handler roles and hold a briefing meeting

- Discuss agreement for OOHs and additional hrs. if required
- A template has been provided to capture the relevant information. Discuss with staff. Electronic collection of data is preferred.

2. **Establish a call handler rota**.
    - Initially staff within the directorate who should be used
        - If the public help line cannot be managed within the Directorate, contact relevant directors in HSCB, PHA, BSO and request additional staff. The help line is an interagency response.
        - In the longer term Agency staff may have to be employed. Director to contact HR.

3. **Communicate** with Director/Incident Control Team and Arrange dissemination of Helpline Phone number and start date:
    - GPs: via HSCB integrated care
    - General public: inform PR
    - Internally: via email
    - Other specific agencies that may have an input to the incident

4. **Daily briefings:** establish mechanisms to update call handlers of current situation and advice changes. (helpline lead has responsibility for the Quality Assurance of information to the public)

5. **Daily situation Report**: (SitRep) for all staff involved on the helpline.

6. **Audit** the contacts daily & weekly to assess capacity requirements.

HSC Public Health Agency | HSC Health and Social Care Board | HSC Business Services Organisation

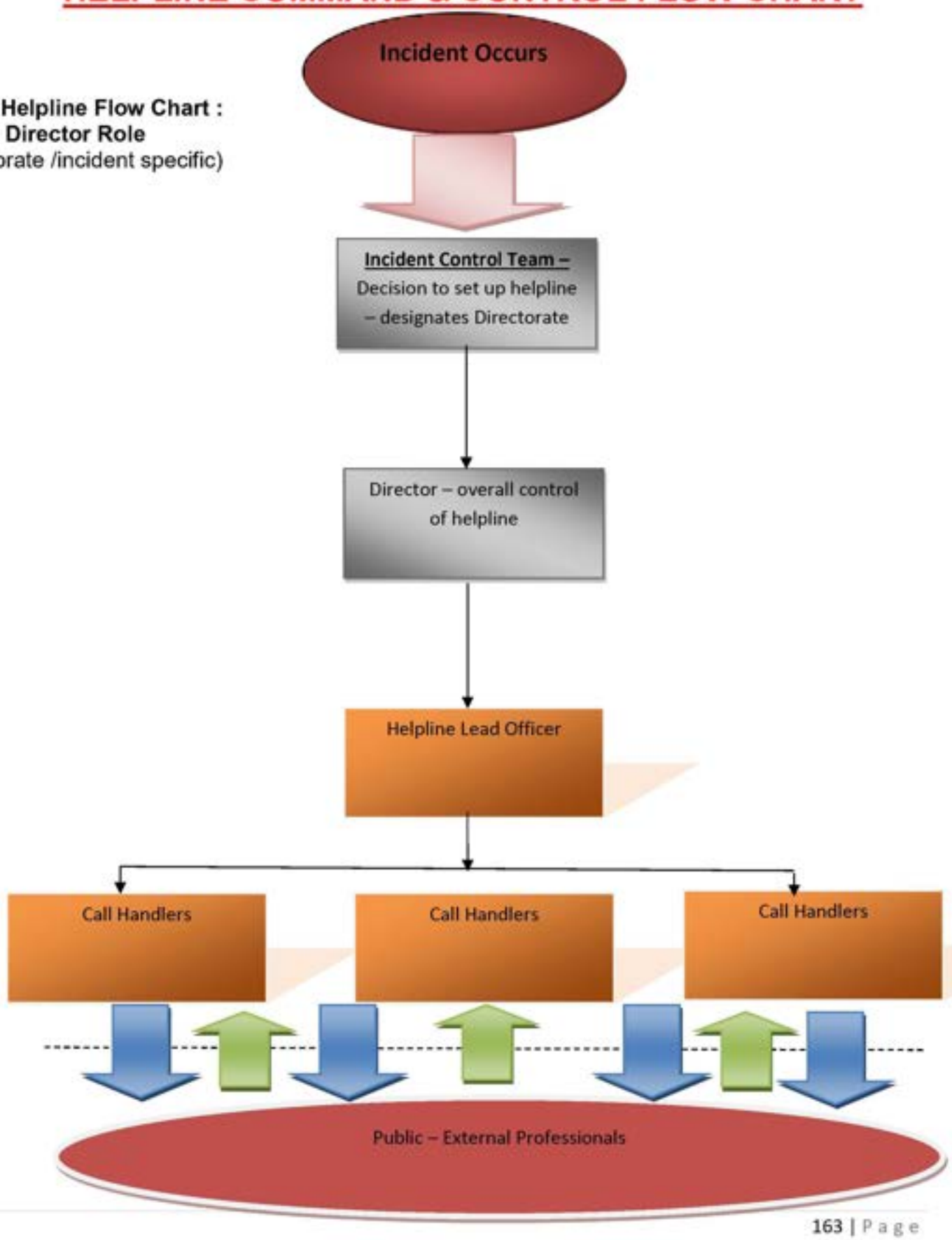
Emergency Helpline information template

Reference number:		
Date:	**Time of Call:**	
Call handled by:	**Other advice obtained from:**	
Caller Name:	**DOB:**	
Address		
Contact phone numbers: **Landline**	**mobile**	
Concern relates to a third party	**Y / N**	
Name:	**Age:**	**Relationship to caller**
Name:	**Age:**	**Relationship to caller**
Name:	**Age:**	**Relationship to caller**
Name:	**Age:**	**Relationship to caller**
Caller concerns:		
Advice Given:		

Follow up action:		
Referred for further advice: Y / N		
Referred to:		
Caller contacted by:	**Date:**	**Time:**
Advice given:		
Follow up action:		

HELPLINE COMMAND & CONTROL FLOW CHART

Public Helpline Flow Chart : Director Role
(Directorate /incident specific)



Decision to establish a helpline: made by Senior Control Team (Silver command chair)/ Minister. (helpline is a joint agency response but will be lead by a Directorate /incident specific)

↓

Senior control Team (Silver command chair) identifies 'lead' Directorate

↓

Decision communicated to Director

↓

Director Role:

1. Establish a meeting within the directorate
   - Appoint the lead for managing the helpline
   - Consider requirement for in hours/ OOHs service
   - Consider requirement for static helpline /helpline managed via mobiles (particularly for evenings/weekend)
   - Decide on 'experience' required for call handlers (professional/non professional/ triage system)
   - Direct staff to identify critical functions and stand down non essential work to provide support to helpline

2. Identify location and venue for helpline.

3. Request set up of technical requirements (phones, headsets, computer/internet access, mobiles etc) and inform contacts below of designated room
   - Office hours: Annex 1 (Contact list) in Joint Response Plan
   - OOHs: Annex 1 (Contact list) in Joint Response Plan

4. If the location for the public helpline is unsuitable due to technical reasons, another venue will be suggested.

5. Update Senior Control Team (Silver command chair) of progress

6. Identify financial resources. If required compile a business case.
   - In the longer term: if Agency staff are required inform HR.

7. Direct stand down of public helpline:
   - Debrief staff
   - Reflect on the management of helpline with designated lead and identify learning

Public Helpline flow Chart

Designated Helpline Lead Role:

1. Identify available staff to act as call handlers (initially within the Directorate).

2. Establish a briefing meeting with staff
   - Discuss Electronic template for use by 'call handlers'
   - Discuss agreement for OOOHs /additional hrs

3. Develop a staff rota for managing the helpline
   - initially staff within the directorate should be used.
   - If additional staff are required contact Directors from HSCB, PHA, BSO (helpline is a joint response)

4. Arrange dissemination of Phone number and Start date (coordinate with Director and Senior control team)
   - GPs: via integrated care
   - General public: inform PR
   - Internally: via email

5. Communicate with Senior Control Team for updates

6. Provide updates and daily situation reports to call handlers (responsibility for Quality Assurance is held by the 'lead')

7. Audit daily, weekly contacts (communicate with Director)

8. In the longer term agency staff may be required – inform Director.

9. When stand down of public helpline has been directed
   - Reflect on the management of helpline with Director and identify learning
   - Review documentation
   - Update Emergency plan

Appendix F – Template New Development/Key Decisions and Action Log

Incident Control Team (Silver)

New Developments (Date :)

New Developments

HSC Public Health Agency

HSC Health and Social Care Board

HSC Business Services Organisation

Key Decisions Log

Date and Time ……

Completed By

Decision Number	***Decision***	***Person Responsible***
1		
2		
3		

HSC Public Health Agency

HSC Health and Social Care Board

HSC Business Services Organisation

Incident Control Team (Silver) Meeting

Chair:

Date	Action No	Action Agreed	Person Responsible	Status
	1			
	2			
	3			
	4			
	5			
	6			
	7			

Appendix G – Joint SILVER PR/Communication Plan

Joint HSCB/PHA/BSO Emergency Preparedness Communications Plan

1. Purpose

In the event of a major emergency, maintaining clear and effective communication will be key. The purpose of this joint HSCB/PHA/BSO communications plan is to set out how we will communicate amongst ourselves and across organisations within and external to the HSC to respond to a major emergency.

Definition of Lead Communications Officer

During office hours, the Lead Communications Officer will be the Head of Communications or nominated Communications Manager. Out of Hours, the Lead Communication Officer will be the On Call Communications Officer.

2. Alert and Activation of Joint Communications Strategy

In Office Hours

To trigger the joint Emergency Plan (EP) initial notification will be made by PHA and /or HSCB senior management to both PHA and HSCB Lead Communications Officers.

Out of Hours

To trigger the joint Emergency Plan (EP) initial notification will be made by PHA and/or HSCB senior management to both PHA and HSCB On Call Communication Officers.

If Level 3 or above is activated out of hours, the Out of Hours Communication Officer will inform their Head of Communications.

3. Communications Response

Following notification, an appropriate level of response will be initiated by the lead organisation. This will be decided at the time of the emergency through initial discussion by senior officers within PHA and HSCB.

If the incident is predominantly a public health emergency the PHA will take the lead in managing the response. If the incident is predominantly a service continuity incident the HSCB will lead the response.

However, both organisations will respond and assist and BSO will also be involved if the incident is Level 3 or 4 emergency.

In the event of the establishment of an Emergency Operations Centre (EOC) and/or Incident Control Team (ICT), the Lead Communications Officer(s) will join the incident team at the EOC.

In other incidents that do not require the establishment of an EOC there may still be a requirement for media input. This may be through 'virtual' meetings, i.e. teleconferencing, etc.
Dependent on the level of response the Lead Communications Officer(s) may contact members of the communications team(s) to provide appropriate communications support. This may involve setting up and staffing a media room.

4. Level of Joint Response – Communications Support

Level 1 – An Acute Incident with no public health or service continuity implications.

Response: Business as usual.

Level 2 – An Acute Incident with potential public health or service continuity implications.

Response: If a decision is taken to establish an Incident Control Team (ICT), the Lead PHA/HSCB organisation will invite their Lead Communications Officer/On Call Communications Officer(s) to join the team to provide appropriate communications support. This may involve preparing a draft holding statement in the event of potential media enquiries or communicating appropriate public messaging as determined by the Incident Control Team to the media, stakeholders and the wider public through a range of appropriate communications channels.

The Lead Communications Officer will ensure colleagues in the DoH, Trusts and partner organisations are fully briefed and updated on the communications approach. The Lead Communications Officer will also feed in any key information from partner organisations to the Incident Control Team (ICT).

If a decision is taken not to establish an Incident Control Team (ICT), the Lead PHA/HSCB organisation will advise their Lead Communications Officer/On Call Communications Officer(s) of the incident in the event of potential media interest.

Level 3 and Level 4 – An Acute Incident with definite public health/service continuity implications

Response: Both PHA and HSCB Lead Communication Officer/On Call Communications Officer will join the Incident Control Team (Silver) or Emergency Outbreak Control EOC/Information Hub to provide appropriate communications support The Lead Communications Officer/On Call Communications Officer(s) will decide if further communications staff are needed to provide additional support to the incident.

The Lead Communications Officer/On Call Communications Officer(s) will advise on the communications approach and share media statements with the DHSSPS Information Office (or On Call Government Officer) and any other relevant Trust/PHA/HSCB or other organisation if a joint/multi-agency response is agreed.

Communication activity may include appropriate public messaging as determined by the Incident Control Team and preparing media statements, updating website/social media sites, identifying spokespersons, organising media briefings (although not exhaustive). A media room may be set up.

Communications with Trusts

The PHA/HSCB will provide an overview of the incident; however, Trusts are likely to be approached by the media for comment at an operational level. The Lead Communications Officer/On Call Communications Officer(s) in conjunction with the DoH/(On Call Government Officer), as appropriate, will establish a communications teleconference for DoH, HSCB, PHA and Trusts to ensure a consistent and joined up approach.

Communications with other partner organisations

The Lead Communications Officer/On Call Communications Officer will share joint media statements with the communication leads of any relevant partner organisation involved in managing the incident as appropriate.

5. Media room (if set up)

The media room will be equipped with

- telephone, computer, photocopier and internet access
- access to facilities for refreshments

The media room will be staffed by the Lead Communications Officer/On Call Communications Officer(s) for the HSCB/PHA and members of the Communications team(s). Media enquiries should be directed to the media room and managed by the Lead Communications Officer(s) or nominated deputy.

6. Access to premises and facilities.

If necessary, access to premises and facilities will be arranged through the HSCB. It has been agreed that Corporate Services will facilitate access to the required HSC building and details on how this can be achieved is contained within the EOC Operational Plan.

7. Contacting other members of the Communications team

On determining the level of response required the Lead Communications Officer/ On Call Communications Officer will contact members of the Communications team both in and out-of hours.

(a) Action cards

Lead Communications Officer

Communications Officer

8. Staff requirements

The Lead Communications Officer/On Call Communications Officer will have to consider issues on a graduated response to dealing with a prolonged incident. This should include adequate rest breaks; shift changes and also achieving a graduated response in the event that an incident escalates.

9. Long term Communications support

The communications support will be kept under regular review by the respect Heads of Communications within the PHA and HSCB.to ensure that a sustainable level of support is provided throughout a major emergency event.

10. Decision Log and Action Log

Pre-agreed decision and action logs have been developed to ensure recognised good emergency planning practice record keeping.

Use template in Appendix M of PHA/HSCB/BSO Joint Response Emergency Plan

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

Joint HSCB/PHA/BSO Emergency Preparedness Communications Plan

Lead Communications Officer/On Call Communications Officer

Definition of Lead Communications Officer

During office hours, the Lead Communications Officer will be the Head of Communications or nominated Communications Manager. Out of Hours, the Lead Communication Officer will be the On Call Communications Officer.

Levels 2, 3 and 4

If the Lead Communication Officer is not the Head of Communications, he/she will be required to notify their respective Head of Communications or the issue/incident.

The Lead Communications Officer/On Call Communications Officer will notify appropriate parties e.g. members of the PHA Communications team/HSCB Communications team and other relevant communications teams that an incident has occurred and to provide updates.

The Lead Communications Officer/On Call Communications Officer will provide communications advice and support to the Incident Control Team (ICT) or Emergency Outbreak Team (EOC). This will include the communication of appropriate public advice information and business continuity arrangements (if appropriate) together with appropriate media management of the incident in a timely manner.

ACTIONS

1. Attend Incident Control Team (ICT) or Emergency Outbreak Team (EOC), receive briefing and obtain a detailed understanding of the problem and its impact. If ICT or EOC has yet to be established it may be necessary to receive initial briefing by telephone.

2. Maintain communications with senior PHA staff/HSCB staff.

3. Maintain communication with communications leads from other organisations involved in the incident (DOH (NI), Trusts, Councils, PSNI etc).

4. Keep OWN timed log of actions taken / decisions made.

5. Establish a single media contact telephone number for the PHA/HSCB.

6. Convene and manage PHA/HSCB Communications team and establish shift patterns if necessary.

7. Establish holding statement and agree timetable for media briefings, releases and interviews.

8. Agree key messages and audiences with incident control team and senior management.

9. Agree nominated spokesperson(s) with incident control team and senior management and provide appropriate support in relation to any media interviews.

10. Set up and manage, as appropriate, any press briefings/conferences.

11. Manage and ensure all media and public relations activity is documented.

13. Maintain and keep records for purposes of debrief and potential Inquiry

14. Monitor media coverage during the incident and post incident.

15. Brief replacement staff in the event of any handover.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

RECOVERY

The Lead Communications Officer will review the communications support and incorporate lessons learnt from the incident into the Joint PHA/HSCB/BSO Emergency Preparedness Communications Plan.

COMMUNICATIONS OFFICER

Levels 2, 3 and 4

The Communications Officer (HSCB/PHA) will prepare and disseminate information to staff, the media and public. The Communications Officer will act as first point of contact for media enquiries and provide support to ensure that all audiences get access to up to date information. If necessary, the Communications Officer will organise facilities for media briefings.

ACTIONS: On receiving notification of a major incident:

1. Proceed to the designated media room.

2. The Lead Communications Officer will provide a briefing on communication roles and responsibilities.

3. Log all media requests and develop responses in conjunction with the Lead Communications Officer and appropriate communications staff.

4. Keep the Lead Communications Officer informed of progress and media interest and assist in progressing these bids as appropriate.

5. Monitor media coverage of the incident.

6. Maintain and keep records for purposes of debrief and potential inquiry.

7. Brief replacement staff in the event of any handover.

ALL DECISIONS AND ACTIONS THAT ARE AGREED SHOULD BE RECORDED AND FILED ACCORDINGLY FOR POTENTIAL FUTURE LEGAL OR PUBLIC INQUIRY REASONS

HSC Public Health Agency | HSC Health and Social Care Board | HSC Business Services Organisation

Appendix H – HSC Silver SITREP Template

Daily Situation Report – OVERARCHING (HSC - SITREP)

Date of Report: .....

Time of Report: .....

RAG Rating:

- Red = Significant Impact & actions being taken
- Amber = Potential impact & further

Period information refers to: .....

Author of Report: ..... **Contact Details:** .....

(Named Officer)

Next SITREP due: .....

New Information not previously reported will appear in yellow

1. Summary Key Points/Overview of HSC Position

2. Service Continuity by Trust & Integrated Care (incl. Key Actions Taken):

Trusts

- NIAS =
- WHSCT =
- BHSCT =
- NHSCT =
- SEHSCT =
- SHSCT =

Integrated Care

3. Public Health Issues & Actions Taken:

Health Protection Incidents

Enhanced Surveillance:

- Notification of Infectious Diseases (NOIDS):
- Syndromic Surveillance;
- International Surveillance;
- ROI Surveillance:
- Air Pollution Alerts;
- Weather Update:

4. Media

5. North South Cross Border or Other Issues

Appendix I – Teleconference Guidelines

Guidelines for the organisation of and participation in regional teleconferences

Consideration should be given to whether there should be a teleconference or a face-to-face meeting. If the purpose of the meeting is to report activities, a teleconference may be appropriate but if detailed discussions are likely or it is the first meeting of a group it may be more appropriate to meet in person.

Within the Public Health Agency, the phones and codes can be booked through the Assistant Director / Director's PAs. Emergency codes are available for out-of-hours use

The agenda, papers and dial in number / participation code should be circulated in advance (preferably a week but at least 24 hours).

Approximately 10mins before the start of the teleconference, the phone will be set up by the PA. The chair should be available 5 minutes before the start time.

There should be a prompt start and following a roll call the teleconference should be 'locked down' (*7 to lock and unlock).

All those joining the teleconference should identify themselves by name, location, organisation and function (i.e. infection control; catering etc) when joining. The chair reserves the right to 'lock out' any unidentified participants.

Throughout the course of the teleconference, participants should give their name and organisation when they start to speak.

If joining on a mobile phone or otherwise calling in from noisy surroundings (eg station, train, airport, busy road) participants should use their phone mute facility when not speaking (refer to mobile phone provider instructions).

No-one should leave the during the telephone conference unless in a real emergency (this will be facilitated by making all telephone conferences targeted and as short as possible).

Emphasis should be placed on keeping teleconferences short, focused and objective. All participants should have the opportunity to speak in turn and not be interrupted.

Patient confidentiality should be strictly adhered to - there should be no sharing of patient names, initials or any other identifiers on teleconferences, especially as there may be other organisations on the conference call who may not be bound by HSC legal requirements with

regard to patient data. Such information can shared through approved routes, off line, if required.

The general rule is to be specific and stick to the point, but this to be borne in mind:
Keep information as concise as possible –

A accuracy – ensure information is accurate
B brevity – keep points and discussion brief
C clarity – communicate as clearly as possible

Appendix J – PHA Outbreak Plan – Abstract to plan only

The new Northern Ireland Infectious Disease Outbreak Plan 2013 developed by the Public Health Agency in liaison with Trust and DOH (NI) colleagues.

The Plan is based on the most up-to-date guidance available on leading and managing an incident or outbreak, and was developed as part of the implementation of the RQIA Review of Outbreaks of Pseudomonas aeruginosa in Neonatal Units in Northern Ireland, 2012.

The Outbreak Plan and Joint Response Plan interface with each other and can work alongside one another.

The link to the plan can be found here.

http://www.publichealth.hscni.net/publications/northern-ireland-infectious-disease-incident-outbreak-plan-2013

Appendix K - Protocol for Escalation of a Multi-Agency Response

PROTOCOL FOR ESCALATION OF THE MULTI-AGENCY RESPONSE

Introduction

1. The purpose of this Protocol is to set out interface arrangements to facilitate the smooth and effective escalation of the multi-agency response to an anticipated or actual emergency from the local to the strategic level.

2. This Protocol relates only to emergencies as defined in the NI Civil Contingencies Framework 2011 as:

   - An event or situation which threatens serious damage to human welfare, the environment or the security of Northern Ireland or the UK as a whole.

3. "Serious damage" in this context is where a number of organisations are required to act to prevent, reduce, control or mitigate the emergency's effects, or otherwise take action, and

   are unable to do this without changing the deployment of their resources or acquiring additional resources. This protocol does not therefore address minor, day to day type incidents that organisations deal with within their normal operational procedures and resources.

4. Emergencies cover a broad spectrum of events with varying impacts and consequences. An emergency can range from a purely local incident to one having an impact across NI and beyond. These events require different co-ordination arrangements which are capable of being applied flexibly as an emergency develops or changes in character. While the majority of emergencies are local level and dealt with entirely by emergency responders acting on a sub-regional basis, some due to the nature and scale of their impacts require strategic co-ordination by central government.

5. In Northern Ireland emergencies are classified as:

   - Local Level – emergencies where the outcomes are such that the response can be delivered entirely by organisations operating sub-regionally, or

   - Strategic level (Government) – emergencies where the extent or severity of their impact is such that strategic level intervention and co-ordination by central government is required. Emergencies at this level are split into Level 1 – Significant, Level 2 – Serious, and Level 3 – Catastrophic, depending on how the strategic co-ordination is delivered.

6. This document sets out:

   - the mechanisms for sub-regional, regional and strategic inter-agency communication and co-ordination;

   - the triggers for sub-regional, regional and strategic co-ordination;

- The assessment arrangements and triggers to determine the need for escalation.

7. The document does not set out the detail for the operation of the various co-ordination mechanisms as this is covered in the plans and protocols for those arrangements. It will be important however that all such plans and protocols are reviewed to ensure that they remain consistent with the terms of this protocol.

Step 1: Local Level Emergency – Multi-Agency Teleconference Calls / Meetings

Activation and Triggers

Sub-Regional Communication and Co-ordination

8. Where an emergency responder or an essential service provider anticipates or detects an issue with multi-agency impacts, the PSNI can convene and chair a sub-regional multi-agency conference call / meeting to co-ordinate the response where there is a threat to life. In all other circumstances the relevant District Council can convene (via the relevant

   Emergency Planning Co-ordination Officer) and chair a sub-regional multi-agency conference call / meeting to co-ordinate the response. Another emergency responder organisation eg PHA can, by agreement, chair these meetings where it would be more appropriate for them to do so – this would be determined by the circumstances at the time.

9. The likely triggers for sub-regional co-ordination and information sharing would include:

   - People / environment affected confined to sub-regional area;
   - Disruption to services / public confined to sub-regional area;
   - Incident capable of being dealt with by organisations acting on a sub-regional basis;
   - Short-term impact on delivery of sub-regional supply chains and services;
   - Small number of District Council areas impacted;
   - Some impact on economy in sub-regional area;
   - An unusual event which may have multi-agency implications.

Regional Communication and Co-ordination

10. Where there is a need for a regional conference call/ meeting dealing with local level type issues, then depending on the activation arrangements (see paragraph 8 above) local government or PSNI will act as default chairs of the teleconference or meeting. Alternatively, it may be more appropriate for another organisation eg PHA to chair – this would be determined based on the circumstances at the time. Sub-regional teleconference calls / meetings may, depending on identified need, continue to be held

once the regional teleconferences / meetings have been established.

11. The likely triggers for regional co-ordination and information sharing would include:

- People / environment affected across a wide geographical area;
- Disruption to local area services over a wide geographical area;
- Impact covering wide geographical area / large number of District Council areas;
- Incident can be dealt with by organisations acting at sub-regional level;
- Short- term impact on delivery of supply chains and services;
- Impact on economy in local areas.

Purpose

12. The purpose of the multi-agency teleconference call / meeting is to:

- facilitate information sharing and co-ordination;
- offer support between organisations; and
- consider the need for escalation.

Step 2: Escalation Assessment

Activation and Triggers

13. Where a potential need for escalation has been identified by two or more relevant responding organisations because:

- the impact is likely to be severe and /or prolonged and affect a widespread geographical area; and / or
- there is potential for progression / expansion from a Local Level emergency to a Strategic Level (Government) emergency

then CCPB, or if more appropriate the Lead Government Department[6], will convene an assessment group of key responders to the incident to make a joint multi-agency risk assessment of the potential or actual impact for the wider community. CCPB will act as default for this function.

[6] See The Guide to Emergency Planning Arrangements in Northern Ireland –2011

Purpose

14. The purpose of the multi-agency Assessment Group is to:

- collate and assess information from relevant sectors;
- carry out joint risk assessment of the situation;
- determine whether the event requires escalation to Strategic Level (Government) co-ordination; and
- determine timescales for action.

15. In assessing whether the incident or anticipated incident needs to be escalated to Strategic Level (Government) the triggers which the assessment group can consider would include:

- Very large numbers of people affected;
- Serious and prolonged damage to the environment;
- Serious and prolonged damage to key infrastructure;
- Prolonged impact on delivery of key supply chains and services;
- Serious impact on economy;
- Extensive clean up and recovery costs;
- High degree of public anxiety;
- Need for strategic co-ordination of the media response;
- Implications beyond Northern Ireland.

STEP 3: Strategic Level (Government) Emergency - Determination and Activation of the Appropriate Level of Response

16. The outcome of the Assessment Group will be used to determine whether strategic co-ordination through central crisis arrangements either by the Lead Government Department (Level 1 – Significant emergencies) or by the NI Central Crisis Management Arrangements (Level 2- Serious / Level 3 – Catastrophic emergencies) should be invoked. These arrangements are detailed in the CCG(NI) Protocol for the NI Central Crisis Management Arrangements. Where for Level 1 emergencies there is no identifiable Lead Government Department, or where responsibility is not clear, TEO will agree the lead role with relevant departments.

17. Separate, and in addition to the above assessment process, the CCG(NI) Protocol for the NICCMA provides for the establishment of the NICCMA in response to a request from a Lead Government Department to do so.

18. Where it has been agreed that there is no requirement for strategic co-ordination by Government the existing sub-regional and/or regional co-ordination arrangements will continue to apply in order to deliver the local level response to the emergency. The same

    applies where strategic co-ordination **is** required by Government, in which case the Chair or agreed representative of the group delivering the local level co-ordination function will attend Lead Government Department (Level 1) or CCG(NI) (Levels 2/3) strategic co-ordination meetings to inform the strategic decision-making process and to provide a liaison point between the local level and strategic level groups.

19. In the event of a Level 2 or Level 3 emergency CCG(NI) will co-ordinate the strategic level response/recovery. Depending on the nature of the emergency there may be one or more Lead Government Departments whose role at CCG(NI) meetings will be to provide information and expertise to inform the management of the response. Representatives of

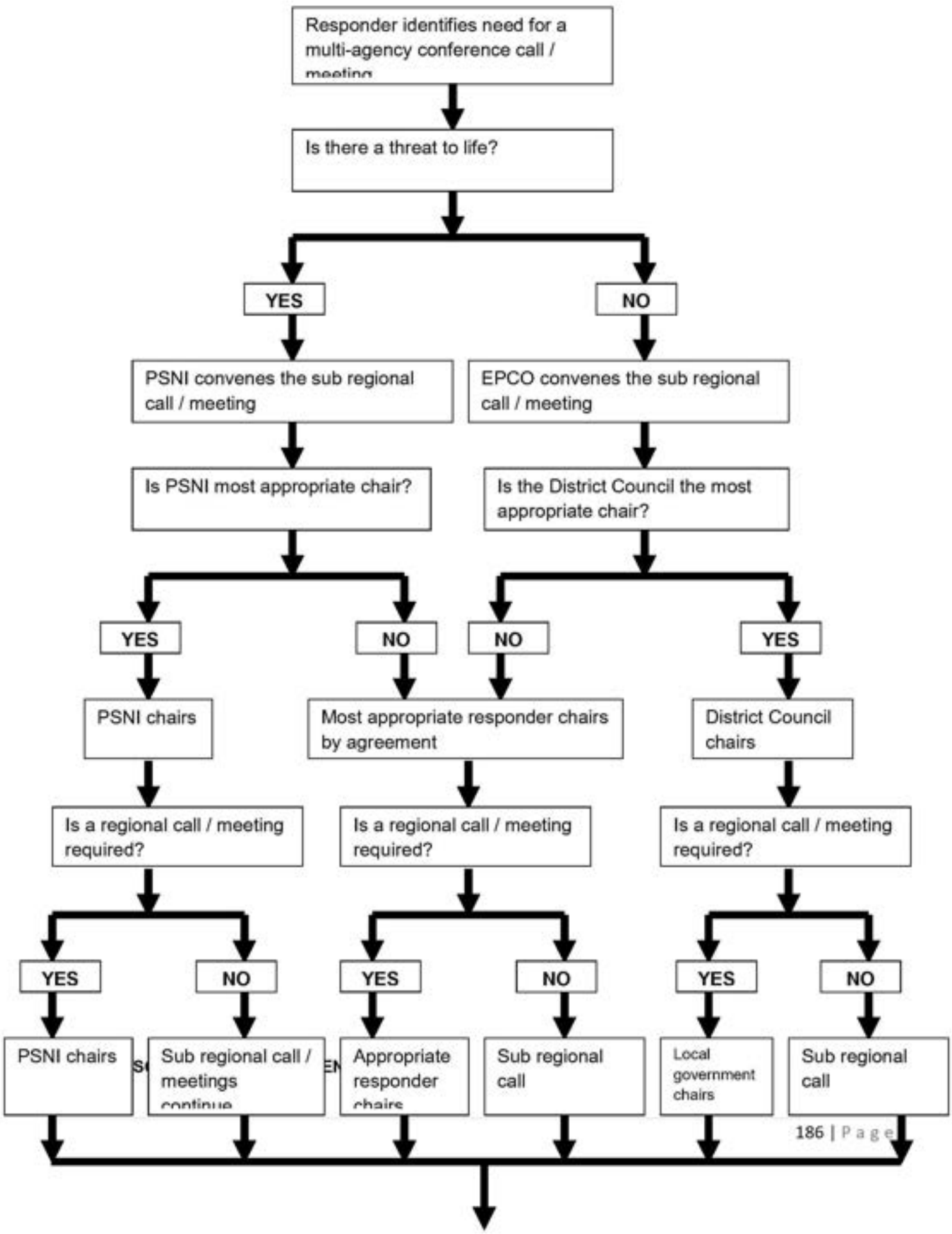
    the Lead Government Department should also be available to inform the local level co-ordination group as necessary.

20. A flow chart summarising the arrangements described in this Protocol is at Annex 1.

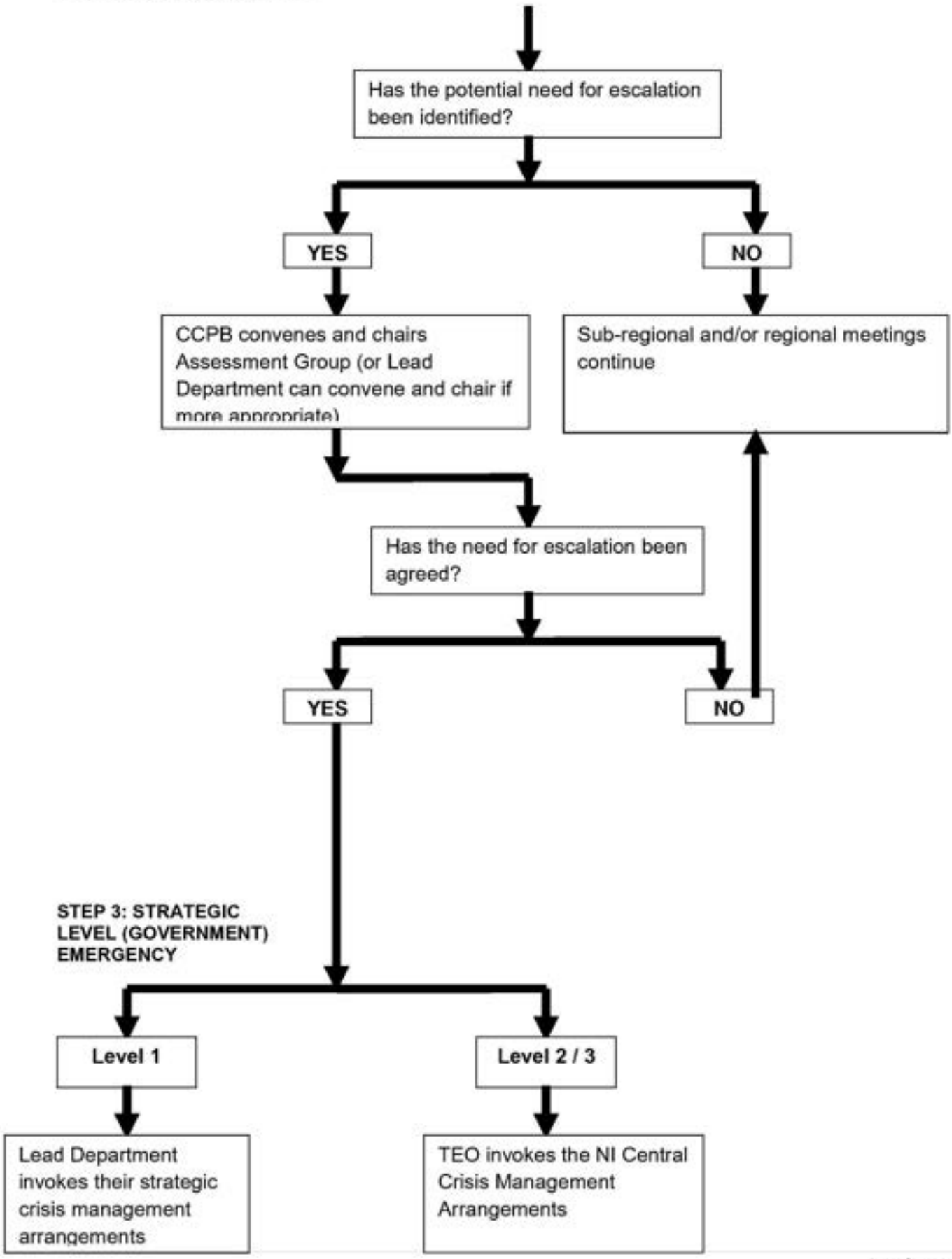
Civil Contingencies Policy Branch
September 2016

HSC Public Health Agency | HSC Health and Social Care Board | HSC Business Services Organisation

ANNEX 1
ESCALATION PROTOCOL FLOW DIAGRAM
STEP 1: LOCAL LEVEL EMERGENCY



ESCALATION ASSESSMENT



Appendix L - Protocol for Multi-Agency Co-Ordination

PROTOCOL FOR MULTI-AGENCY CO-ORDINATION OF LOCAL LEVEL RESPONSE AND RECOVERY

Introduction

1. The term emergency within this Protocol is defined as:

   - An event or situation which threatens serious damage to human welfare, the environment or the security of Northern Ireland or the UK as a whole. (NI Civil Contingencies Framework - refreshed 2011)

2. In Northern Ireland emergencies are classified as follows:

   - Local Level – emergencies where the outcomes are such that the response can be delivered entirely by organisations operating locally/sub-regionally, or

   - Strategic Level – emergencies where the extent or severity of their impact is such that strategic level intervention and co-ordination by central government is required.

3. The purpose of this Protocol is to set out arrangements to facilitate the multi-agency response to, and recovery from, local level emergencies.

4. The terms of this Protocol are complementary to those of the separate but associated 'Protocol for the Escalation of the Response from the Local to the Strategic Level', and follow the principles of DOE Circular LG 07/06 which provided guidance to District Councils in Northern Ireland in relation to emergencies. That guidance was specifically developed to assist Councils in the discharge of discretionary functions adopted under Article 29 of the Local Government (Northern Ireland) Order 2005.

5. The document sets out arrangements for:

- multi-agency assessment of an anticipated or developing situation;
- co-ordination of the multi-agency response and recovery; and
- inter-agency communication and compilation of an accurate and up to date information picture for the developing situation.

6. It is anticipated that these arrangements will usually be delivered on a sub-regional basis, based on the boundaries of the Sub-regional Civil Emergency Preparedness Groups (EPGs), but can be delivered regionally for local level type issues.

7. The document does not set out the detail of internal arrangements within individual organisations, but rather focuses on the multi-agency effort.

Multi-Agency Assessment

8. It is important that when an issue is anticipated or developing which has the potential for multi-agency impacts it is monitored and assessed on a multi-agency basis to determine the need to activate arrangements to co-ordinate the multi-agency response / recovery.

Alert

9. Where a lead agency anticipates an issue within its sector with the potential for multi-agency impacts, it will alert all relevant response partners who may be required to provide support or assistance should an emergency develop. In most instances these partners will comprise those organisations that are represented within the EPG for that area.

10. In response to an alert from the lead agency, or from another emergency responder or essential service provider anticipating an issue, depending on circumstances at the time either PSNI or the relevant District Council CEO/Emergency Planning Co-ordinator

(EPCO) can convene multi-agency conference calls / meetings to monitor and assess the developing situation. The relevant District Council will be the one within whose area the emergency has occurred. Alternatively where the emergency impacts on more than one District Council within the sub-region; or where it is unclear which District Council should co-ordinate; this function will be delivered by an agreed Council Chief Executive or the EPCO. A key outcome from these conference calls/meetings will be the determination of the need to establish full multi-agency co-ordination of the emergency response /recovery.

Multi-agency Co-ordination

Activation

11. Where a Lead Agency, District Council, EPCO, other emergency responder or an essential service provider becomes aware of an emergency with multi-agency impacts a sub-regional multi-agency emergency response group may be convened.

12. Where the emergency services (first responders) do not clearly have a primary role in responding to the incident the response group would normally be convened by the relevant EPCO and be chaired by the District Council Chief Executive. (The District Council Chief Executive may delegate the role of chair to the EPCO). However, where the first responders have a primary role in the response, PSNI can convene and chair the multi-agency response group.

13. Where another emergency responder organisation, e.g. PHA would more appropriately chair the multi-agency response group, this would be determined by agreement.

Responsibilities

14. Response to Local Incidents. The PSNI will co-ordinate the multi-agency response group where the incident poses a threat to life. In all other circumstances the co-ordination role will be assumed by the relevant District Council unless it is more appropriate for another member of the multi-agency group to do so. The EPCO for the area will support the District Councils in the coordination.

15. Where PSNI is co-ordinating the multi-agency response group the District Council may identify a need during the response phase, to co-ordinate the contributions of responding organisations not directly concerned with the main strands of the response. Where this occurs, the District Council, via the EPCO, will determine the most advantageous means of providing the necessary co-ordination of these organisations, while also reporting the activities, developments and support available at that level into the consideration and agreed actions of the main multi-agency response group.

16. Response to tactical level sub-regional Incidents. Where incidents affect a wider area than single or conjoined council areas and risks to life are limited to discrete locations within the affected area, it may be appropriate for PSNI to coordinate the response in those areas where the risk to life occurs, whilst agreeing that the coordination of the multi-agency response to the wider, lower-risk, incident may fall to local government or other agreed appropriate agency.

17. A multi-agency response group may seek advice from departments, agencies and organisations with specialist knowledge and skills to inform response plans and prioritise actions. Sub-groups of the multi-agency response group may be formed for this purpose.

18. Recovery. In principle the recovery phase of an incident will be chaired and coordinated by a District Council. In the initial phases of an emergency, the multi-agency response group will co-ordinate any necessary recovery issues in parallel with the response. Where the PSNI is co-ordinating the initial response and recovery issues, the handover of co-ordination responsibility to the District Council for the recovery phase can occur by agreement at the most appropriate juncture. Where multi-agency co-ordination is already being provided by the District Council then they will retain this responsibility for the recovery phase to completion.

19. The convening of a multi-agency response / recovery group in no way overrides or affects the policy and operational responsibilities of the constituent organisations.

Membership

20. The range of agencies required to participate in the multi-agency response group will vary according to the nature, scale and scope of the incident. In determining the appropriate membership of the group, the EPCO will immediately facilitate liaison between representatives of the lead agency, PSNI and the District Council who will collectively decide on the initial membership. In the majority of circumstances membership will consist of those individuals represented within the EPG. Other agencies may also be required to participate and these will be contacted as soon as possible on activation of the protocol

Communication

21. To facilitate the timely activation of the multi-agency response, PSNI and the EPCOs will maintain robust and up to date contact arrangements for all relevant organisations that may be required to participate in the multi-agency group. These contact directories will contain contact details for all members of the EPG and of other organisations that may be required to attend the sub-regional multi-agency response group. Additional details of national and regional, departmental and agency contacts and of key contacts in adjoining EPGs will be held by the EPCO and be available at a regional level

22. In order to ensure full, clear and accurate communication of the initial nature of the incident, the lead agency should in the first instance complete and distribute the Incident Report template attached at Annex A.

23. Following this, upon activation of a multi-agency response group the co-ordinating organisation will ensure completion of a composite Situation Report with input from all participating organisations (Annex E). This template should be used regardless of the medium through which communications are taking place between Group members.

24. The Agenda suggested in Annex B outlines the main considerations that should be discussed during the co-ordination of the multi-agency response and recovery phase. An aide memoire/ checklist of possible actions during implementation of the protocol and for sub regional coordination is attached in Annex C. This document aims to

provide a recording mechanism for the allocation and progression of tasks on a multi-agency basis.

25. The multi-agency group will agree the best means and frequency of communication, the appropriate distribution lists for the aide memoire (Annex C), incident log (Annex D), situation reports (Annex E) and any other working documents. In addition and as necessary, they will also agree the communication of essential information and/or support requirements to any strategic co-ordination mechanism forum that may have been activated, e.g. the NI Central Crisis Management Arrangements (NICCMA).

Handover and Stand-down Arrangements

26. The responsibility for chairing the multi-agency group may be passed by agreement to another organisation at any stage within an emergency where it becomes apparent it is more appropriate for that organisation to deliver the function. This is most likely to be the case in the transition from response to recovery where PSNI has been chairing the multi-agency group in the response phase and is handing over to the relevant District Council for the recovery phase.

27. The multi-agency group co-ordinating the response / recovery will stand-down following agreement amongst members that the group is no longer required to manage the multi-agency effort.

INITIAL INCIDENT REPORT **Annex A**

INITIATING AGENCY…..... DATE/TIME .....

OFFICER RESPONSIBLE…..... CONTACT DETAILS…..

a) The nature of the incident.	
b) The location of the incident	
c) Date and time of occurrence	
d) Available estimate of the severity. *e.g. Casualty numbers, environmental contamination issues, extent of areas affected, areas at risk*	
e) Response Phase Lead	
f) The location from which the response will be co-ordinated *e.g. Police Silver Command or Sub-regional Multi-Agency Group* Contact details for lead agency	
g) Other Organisations and Agencies involved Key contact details	
h) Identified objectives and priorities	
i) Immediate support	

required. *E.g. provision of accommodation, personnel, equipment or other support.*	
k) Information available regarding access to designated buildings, safe routes etc.	
l) Estimate of duration of response phase	
m) Key information for public.	

It is suggested that this form should be completed in the first instance by the lead agency and, if subsequently the incident passes to a sub-regional multi-agency group, by the coordinator of that group.

TEMPLATE AGENDA

Annex B

MEETING OF THE MULTI-AGENCY CO-ORDINATION GROUP

1. Purpose of Meeting
2. Assessment of Situation : Update from Relevant Organisations
3. Determine/Anticipate Impacts
4. Vulnerabilities. *Infrastructure, Vulnerable Premises/Persons,*
5. Command and Control. *Responsibility for Coordination, Coordination Centre, Assessment of requirements*
6. Setting Objectives. *Mission and Task objectives. (Long, medium and short term)*
7. Responses. *Capacity of lead departments and agencies, requirements for mutual aid, sources of mutual aid, anticipation of other needs. Sources of support*
8. Media / Information to the Public/ Elected members/. *Multi-agency lead for communication*
9. Next Steps : Actions and Timescales for Delivery
10. AOB
11. Time of Next Meeting

Check list/Situation Report for Multi-Agency Use

Aide Memoire/ Checklist of Possible Actions during Implementation of the Protocol for Multi Agency Coordination of Local Level Response & Recovery and Sub Regional Coordination

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
2	ASSESSMENT OF SITUATION	Input from Lead department/Agency/Met Office (as rqd) Obtain outline description of event, estimation of extent, duration, severity, known characteristics and unknown characteristics						
3	IMPACT ASSESSMENT	Lead departments/Agency, Met Office Identify geographic area(s) affected, population exposed, extent of knowledge of risks and overview of responses necessary. Consider need for specialist advice/support to determine general and local impacts: (STAC, Vulnerable people, GDS, SpatialNI)						

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
4	VULNERABILITIES	Identify/assess Critical Infrastructure in affected area, e.g. NIE, BT, Gas, NIW						
4	VULNERABILITIES	Identification of locations of vulnerable people -Schools, nurseries, playgroups -Hospitals, Residential Homes, Hostels, Care Homes, sheltered accommodation. -Isolated properties -Other						

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
4	VULNERABILITIES	Identify vulnerable persons via Critical Care Lists -NIW -HSCT -NIE Invoke community support links Consider media messages for self-declaration of vulnerability						
4	VULNERABILITIES	Identify any Planned Events/Gatherings bringing people into affected areas Consider school opening and closure requirements School transport						

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
5	COMMAND &CONTROL	Agree coordination responsibilities. Local, Subregional, Tactical (PSNI/Local Government), Strategic (escalate to CCG(NI)) Identify other coordination/command centres Consider/establish communication, liaison and representation between centres. Complete initial incident report (Annex A) and programme on-going situation reports (Annex B). Plan distribution of sitreps. (Lead departments, PSNI, partner agencies, TEO, DfC LGPD, other command/coordination centers) Identify key partners and agree representation required at coordination center						
5	COORDINATION FACILITIES	Consider requirement/location for coordination centre Pre-planned list of centres, Space, Access, Safety, Facilities, (ITC and IT support, catering arrangements), Administrative capacity, Preparedness, Resilience (power and comms, standby arrangements for failure) Competing uses, Consider/plan shift cover for all personnel						

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
5	COORDINATION FACILITIES	Assess need for Administrative Support -Logs -Minutes -Conference Calls -SITREPS						
6	TASK OBJECTIVE	Consider: - preservation of life, prevention of injury or harm to people, protection of environment, minimisation of economic impacts, restoration of normal conditions,						

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex |D)
6	SHORT TERM OBJECTIVES	12 hour objectives Establish sources of advice, information Prioritise responses, seek specialist advice if required Identify resource requirements and availability, mobilise support Assess and respond to requests for support. Need for ESCs, flood mitigation and response, Establish communications – public and cross organisation Identify likely forthcoming requests.						
6	MEDIUM TERM OBJECTIVES	Review response priorities and modify. Improve support services if required. (mapping, specialist advice). Review likely duration and plan for resource needs if extended. Plan hand-over of coordination						

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
6	LONG TERM OBKJECTIVES	To begin recovery planning as soon as appropriate Consider welfare needs of: affected persons, responders, others Link to CG, Lead Departments, Agencies in respect of housing, economic impacts, funding needs						
7	PERSONNEL	Availability of personnel for response or mutual aid, from: - Each participating agency - Other agencies/organisations - Planned Mutual Aid Deployment - Community Assistance Ensure provision of advice/briefing – e.g. instruction, supervision, training, PPE.						

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
7	EQUIPMENT	Assessment of need for Equipment - Types of equipment required - Availability of equipment from participating agencies - Availability of equipment from other organisations - Lead time until deployed - Expected duration of deployment						
8	PUBLIC INFORMATION	Assessment of need for information to the public via: -Briefed Elected Members -Briefed Community representatives - SMS messaging to known recipients -Social media -Internet -EIS/NI Direct -Other media streams						

HSC Public Health Agency HSC Health and Social Care Board HSC Business Services Organisation

Cross Ref with Agenda (Annex B)		Issue /Descriptor	Priority (H,M,L)	ACTIONS	Status R, A, G	Assigned To:	Completed Date/Time	Comments/ cross referee with log (Annex D)
9	OTHER							
9	OTHER							

Status key:

Red = Problem that requires action immediately. Amber = On track but requires attention to complete. Green = On track and no problems are envisaged at this point

Incident Log **Annex D**

Date/Time	Caller Details	Entry Type	Details
Date dd/mm/yy Time 24 hr clock hh:mm	Name, Organisation, Designation, Contact details. (Phone, e-mail etc.)	A = Action D = Decision MI = Message In MO = Message Out	**Brief details of Actions, Decisions or Messages**

SITUATION REPORT FOR DURATION OF MULTI AGENCY COORDINATION
Annex E

DATE/TIME .....

CONTACT DETAILS.....a) Situation Overview	
b) Current Situation	
c) Key Events for this Reporting Period	
e) Other relevant Information e.g. manpower/staffing issues/support required media/communications	
f) Actions planned to take place over next reporting period	
g) Forward Look: issues that may arise over longer period	
h) Other Information not covered elsewhere	
i) Attached information	
j) Time of Next Update	
k) Relevant contact details	

CCG (NI)
Vulnerable People Protocol

Addressing the needs of vulnerable people in an emergency

Version 6 September 2016

CONTENTS

FIVE STEP CHECKLIST

ACTIONS TO IDENTIFY AND MEET THE NEEDS OF VULNERABLE PEOPLE

In order to provide an effective response to address the needs of vulnerable people and to maximise resources at the disposal of the multi-agency response in an emergency, all relevant responding organisations and agencies should follow the five steps outlined below to help identify and prioritise vulnerable people.

Step 1 Include 'vulnerable people' as a standing item on agenda for discussion at multi-agency group meetings.

This will ensure that there is early identification of specific vulnerable groups and individuals and help inform how they should be prioritised in the response, as well as monitoring how the evolving incident may impact on other groups and cause them to become vulnerable.

To ensure the identification of vulnerable people is effective, consideration needs to be given at the outset of the multi-agency group meeting that all appropriate organisations and agencies are represented and actively participate in the discussion.

Step 2 Agree an incident-specific definition of "vulnerable" and keep this definition under review as the incident unfolds.

Some organisations or agencies already have lists of vulnerable people which they use for the prioritisation of services, such as social services, GPs, utility companies, etc.

It must be remembered that some people may not perceive themselves as being "vulnerable" and therefore will not be captured on any list or register or known to services/agencies. However it needs also to be recognised that people may become vulnerable as a situation or emergency unfolds, or continues for a protracted period.

Consequently responding agencies need to be responsive to emerging situations and recognise that their existing lists of vulnerable people (where these exist) may

not be useful in the particular circumstance that they face and that they need to keep this under review.

Therefore, responding agencies should acknowledge that the definition of "vulnerable" which is agreed by the multi-agency group will be subject to the information that is available to it at any given time, as the situation develops.

Responding organisations should advise any strategic or tactical coordination tier[7] (in line with the CCG(NI) Escalation Protocol) that a definition of vulnerable has been agreed and that they will be kept informed of any further action being taken in this regard (including how this definition should be applied in the particular circumstances).

Step 3 Participate in a joint dynamic risk assessment.

This will involve all multi-agency partners involved in the response assessing the information available and reaching a consensus as to which groups of people have specific needs during the emergency, and how these needs can be collectively prioritised and addressed.

The joint dynamic risk assessment will rely on the range of information tabled by individual organisations, bringing their own unique knowledge and expertise to the situation to inform decisions and achieve effective outcomes.

Responding agencies also need to ensure that they advise any strategic or tactical coordination tier of the outcomes of the Joint Dynamic Risk Assessment they undertake in order to inform potential strategic/tactical level decisions that might be taken, including decisions about the deployment of resources.

Where responding organisations have identified and agreed the vulnerable groups likely to be impacted by an emergency, they should then seek to identify vulnerable individuals included in their existing critical care lists or customers, patients or clients who are likely to fall within these groups. These individuals should then be prioritised for service provision and to ensure there is close communication with them or their families and friends, as appropriate. These customers, clients and patients falling within the definition of 'vulnerable' should be triaged (and re-triaged) as the emergency progresses to ensure that the needs of individuals are prioritised and responded to appropriately within the resources available

Where possible, responding organisations should share and explain the decision-making process on how and why these priorities were agreed, or why this specific service provision will be required to address the circumstances being faced. Whilst

[7] CCG(NI) Protocol for Escalation of the Multi-agency Response (Sept. 2016)

consideration may need to be given to sharing information on individuals with other responding organisations, it will be necessary to be mindful of potential issues in relation to data protection and information sharing as outlined in Section 4 of this protocol which relates to the requirements of the Data Protection Act 1998.

Step 4 **Record the outcome of the joint dynamic risk assessment at each stage along with decisions taken, the rationale for these decisions and actions proposed with regard to meeting the needs of those identified as vulnerable in this situation.**

There is a requirement that all decisions, the rationale for these decisions and the actions proposed are accurately recorded – and that these should all be kept under review as the incident or event unfolds. Extensive contemporaneous records should be logged (ideally by a trained loggist), stored securely and should be easily retrieved in the event of them being required, particularly for judicial proceedings after an emergency[8].

The chair of the multi-agency group is responsible for recording the detail of the joint dynamic risk assessment, taking account of the likelihood of the situation deteriorating and the impact this will have on the different vulnerable individuals and groups, so that response plans can be adapted accordingly.

Step 5 **Communicate with the public, including about how people are to be prioritised, with particular reference to those identified as being vulnerable. It is important to convey consistent messaging in relation to prevention and community emergency preparedness, and to encourage individuals to be more proactive about helping themselves and their neighbours, especially those who are vulnerable.**

Organisations and agencies need to be careful to manage the public's perceptions and expectations with regard to how they will be prioritised and ensuring they understand that this prioritisation may not necessarily mean a return to full normal service – it could mean that they will receive a partial return of service or an alternative form of the service as an interim measure.

[8] See also paras 9.15 - 9.17 of A Guide to Emergency Planning Arrangements in NI (Sept. 2011)

This should be carried out in line with the lead organisation's communications strategy and should be a collaborative and consistent message with responding partner organisations, and in line with the CCG(NI) Collaborative Communication protocol[9]. Full utilisation of NI Direct and local media should also be considered.

There should be an agreed Single Point of Contact (SPOC) for handling communications during an emergency, and this SPOC should lead communications with the public, to both ensure consistency of media messaging and to inspire public confidence.

[9] CCG(NI) Protocol for the Collaborative Communication Process (Sept. 2016)

1 BACKGROUND

1.1 In 2011, as part of the review by the Civil Contingencies Group (Northern Ireland) (CCG(NI)) into the response to winter 2010, a DHSSPS-led Task Group was asked to consider how best to respond to the needs of vulnerable people in an emergency.

1.2 One of the first considerations of the Task Group was the feasibility of creating a single multi-agency list of vulnerable people for Northern Ireland that could be used to identify all vulnerable people affected by the emergency in question. This was quickly discounted for the following the reasons:

- lists held by responding organisations varied considerably in terms of the purposes for which these lists were created and the definitions of vulnerable people used;
- some people may not perceive themselves as being vulnerable and would not be captured on any list or register but may become vulnerable as a situation or emergency unfolds or continues for a protracted period. Therefore responding agencies need to be responsive to emerging situations and the fact that their list of vulnerable people (where these existed) may not be useful in the particular circumstances faced;
- data protection issues were an obstacle with regard to creating a single list or register or sharing information between organisations, given that: the information was collected for differing purposes; differing definitions of vulnerable were used, hence the lists contained different people; lists were likely to be incomplete; and lists were confidential and contained sensitive personal data.

1.3 In light of the outcome of the scoping exercise, the focus of the Task Group in developing the Vulnerable People Protocol was on how to:

- define vulnerable people;
- assess the impact on these groups in an emerging situation;
- maximise information available; and
- harness resource and support services available.

1.4 It was recognised that each event could have different characteristics and therefore the same people would not always be classified as vulnerable and needing extra assistance.

1.5 Therefore this paper is developed in three parts to help support multi-agency groups responding to an emergency situation. It recognises and builds on the Cabinet Office concept[10] of developing a 'list of lists' to maximise the resources and information readily available in the locality to responding agencies. It does this by:

- providing a **checklist of 5 steps** to follow when an emergency has been declared or a significant event is unfolding to ensure that the needs of vulnerable people are being considered from the outset;
- providing clarification on how information can be shared whilst still adhering to the principles of the **Data Protection Act** (see Section 4);
- promoting awareness of **geo-spatial mapping** which can be of benefit to responding agencies in a number of areas (see Section 5); for example:
  - Locating facilities where vulnerable people are present e.g. hospitals, schools, day care centres, etc.;
  - identifying exclusion zones around an incident, so that decisions on implications for evacuation can be made;
  - identifying appropriate locations for the establishment of Emergency Support Centres; or
  - Supporting decision-making on, for example, phased outages of water, electricity or gas, etc.

[10] Identifying People Who are Vulnerable in a Crisis: Guidance for Emergency Planners and Responders (Cabinet Office, Feb. 2008)

2 DEVELOPMENT OF THE PROTOCOL

Purpose of this protocol

2.1 The purpose of this protocol is to provide responding organisations in Northern Ireland with a checklist of steps or an aide memoire for use in helping to identify people who are, or might become, vulnerable as a result of an emergency.

Definition of an emergency

2.2 For the purposes of this protocol an emergency is defined in the Northern Ireland Central Crisis Management Arrangements protocol[11] as

"an event or situation which threatens serious damage to human welfare, the environment or the security of Northern Ireland"

Development of this protocol

2.3 This paper was initially developed by a Task Group led by the Department of Health, Social Services and Public Safety (DHSSPS) on behalf of the Civil Contingencies Group (NI) (CCG(NI)) as a result of the lessons learned following the response during the extreme weather experienced in Northern Ireland in winter 2010. It was further tested and refined following debriefs from two local exercises during 2012.

2.4 It has now been refined in light of lessons learned and recommendations made in debrief reports from the Spring Blizzard 2013, Exercise Eluvies 2013 and the Tidal Surges experienced in Northern Ireland in early 2014.

2.5 When an event, incident or emergency has occurred which requires the convening of a multi-agency group at local, sub-regional or regional level[12], consideration needs to be given to identifying and meeting the needs of people who are defined as vulnerable for that emergency.

[11] CCG(NI) Protocol for the Northern Ireland Central Crisis Management Arrangements (Sept. 2016)
[12] CCG(NI) Protocol for Escalation of the Multi-agency Response (Sept. 2016)

Definition of vulnerable

2.6 CCG(NI) has agreed the following as a broad, generic definition of vulnerable, which should be kept under review and refined as an emergency unfolds:

(i) a person/group living in the community who is known to Health and Social Care organisations, is in receipt of health and social care services or packages of care.	(ii) those customers of utility companies, agencies or other Government Departments for the purposes of ensuring they are prioritised for receipt of specified services, or for communication in relation to these services, during an emergency.	(iii) those members of the public who are <u>not</u> usually known to any responding organisation/agency or utility company, who declare themselves vulnerable as a result of a prolonged period without essential services, or due to a specific emergency, <u>and who have been risk assessed as vulnerable at the time of the incident</u>.
(i)-(ii) individuals within these categories of the definition must also be risk assessed as being vulnerable for the incident in question.		
(i)-(iii) as part of a joint dynamic risk assessment process, it should also be recognised that people may move between the 3 categories of the definition of vulnerability outlined above as the incident develops/unfolds.		

Identifying vulnerable people

2.7 The most effective way of identifying vulnerable people is to work with those organisations which are best placed to have up-to-date records of individuals and will be aware of their specific needs. Identifying, planning and providing for the needs of vulnerable people will involve a significant number of partner organisations and gathering together a large amount of complex and perhaps, rapidly changing, information. The creation of this "list of lists" at a local level will assist greatly with planning.

2.8 A "list of lists" will not be a central list of individuals who are vulnerable, but rather is a list of partner organisations and their contact details that can be used to gather relevant information in the event of an emergency. This approach might include development of:

- **List of organisations** (likely to be key planning partners) which hold and maintain information on vulnerable people. For example a Data Sharing Agreement (see Section 4) can be established in advance between partner organisations so there is clarity around the parameters in which they will be working in the event of an emergency. This approach might help avoid some data sharing difficulties during an actual emergency.

- **List of types of vulnerability** – identifying the potential range of vulnerable people with specific needs within a local area in advance of an emergency (but not sharing the details of this) will assist with planning and response. This will need to be built upon in the event of an emergency unfolding and more vulnerable people being identified. See Tables 1 and 2 in Annex 1 for a template which summarises potentially vulnerable people/groups and the organisations most likely to be able to identify them and which can be adapted at local level.

- **List of establishments housing vulnerable people in your area** – identifying the key establishments that accommodate vulnerable people that are likely to require additional assistance - for example nursing and residential homes.

2.9 It is important to ensure that lists of key contact details for all appropriate organisations are kept up-to-date, allowing the response to vulnerable people to be activated as soon as required.

2.10 Responding organisations should fully utilise available networks to develop position reports on vulnerable people and enable the deployment of resources to assist with addressing their needs.

2.11 To ensure a co-ordinated approach, the full range of all available organisations should be used to gather information, identify individuals, discuss concerns and identify actions to address needs. These groups include: the statutory sector; the voluntary sector; community groups; elected representatives; utility companies; peripatetic employees (eg. milkmen, refuse collectors, postmen, hairdressers, etc.); friends and neighbours; family members; faith groups; and other private industry.

3 INFORMATION SHARING AND DATA PROTECTION

3.1 When considering sharing data or information about people, regardless of whether it is during an emergency, one of the key considerations will be compliance with the requirements of the Data Protection Act 1998, the Human Rights Act 1998 and the common law duty of confidentiality.

Eight principles of the Data Protection Act

3.2 The Data Protection Act contains eight data protection principles that must be adhered to when processing personal data – these are legally enforceable standards of good information handling:

(1) Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless at least one of the conditions in Schedule 2 is met; and in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met.

(2) Personal data shall be obtained only for one or more specified and lawful purpose, and shall not be further processed in any manner incompatible with that purpose.

(3) Personal data shall be adequate, relevant and not excessive in relation to the purpose for which it is processed.

(4) Personal data shall be accurate and, where necessary, kept up to date.

(5) Personal data processed for any purpose shall not be kept for longer than is necessary for that purpose.

(6) Personal data shall be processed in accordance with the rights of data subjects under the Data Protection Act.

(7) Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

(8) Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

3.3 It is the duty (under the Data Protection Act 1998) for each organisation involved in the response to an emergency to comply with the 8 data protection principles in relation to all personal data for which they have responsibility. These principles have equal weight and there must be compliance with all of them. The ICO provides guidance on data sharing in a Code of Practice[13] and

[13] https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf

on the application of the 8 principles[14]. Further information can be found on the ICO website.

3.4 It is difficult to find a 'one size fits all' approach to information sharing. As the circumstances are likely to be different in each instance, so the unique circumstances of an emergency should be taken into account, with only those agencies who need the information receiving it, and only the personal data which is required being shared. Proportionality and necessity should be key considerations, alongside the conditions set by the other principles.

3.5 Responding organisations should, where possible, endeavour to share information for the purposes of assisting an emergency response, whilst being mindful of, and adhering to, the principles of the Data Protection Act 1998.

Personal data versus sensitive personal data

3.6 The Data Protection Act differentiates between personal data and sensitive personal data as follows:

- ***Personal data*** is information relating to a living individual (e.g. name, address, date of birth) from which that individual can be identified, or which can be used to identify that individual, in conjunction with other information held by a data controller.

- ***Sensitive personal data*** consists of information about an individual's race/ethnic origin, political opinion, religious belief, Trade Union membership, health, sexual life or criminal activity.

3.7 With regard to sharing personal data, or sensitive personal data, responding organisations should be aware that consent is only one of the conditions which allows for data to be shared.

Schedule 2 conditions

3.8 If ***personal data*** is to be shared, responding organisations must meet at least one of six conditions set out in **Schedule 2** of the Data Protection Act. These 6 conditions include:

- consent has been given by the individual; or
- sharing is necessary to protect the person's vital interests (ie this can include situations where there is a risk of significant harm to life); or

[14] http://ico.org.uk/for_organisations/data_protection/the_guide

- sharing is necessary to comply with a court order; or
- sharing is necessary to fulfil a legal duty; or
- sharing is necessary to perform a statutory function; or
- sharing is necessary to perform a public function in the public interest; or
- sharing is necessary for the legitimate interests of the data controller, or of the third party to whom the data is disclosed, unless the rights or interests of the individual preclude sharing.

Schedule 3 conditions

3.9 If ***sensitive personal data*** is to be shared then one or more **Schedule 3** conditions must also be met, in addition to Schedule 2 conditions. These include:

- that the individual has given "explicit consent to share their information; or
- sharing information is necessary to establish, exercise or defend legal rights; or
- sharing information is necessary for the purpose of, or in connection with, any legal proceedings; or
- sharing information is necessary to protect someone's vital interests and the person to whom the information relates cannot consent, is unreasonably withholding consent, or consent cannot reasonably be obtained; or
- sharing information is necessary to perform a statutory function; or
- is in the substantial public interest and necessary to prevent or detect a crime and consent would prejudice that purpose; or
- processing is necessary for medical purposes and is undertaken by a health professional; or
- processing is necessary for the exercise of any functions conferred on a constable by any rule of law.

Vulnerability maps

3.10 It is possible to create a resource pool of information which can also be shared in an emergency situation. For example, a 'vulnerability map' which would plot the geographical location of those people who may need specialised or prioritised assistance in an emergency. Land and Property Service has been progressing this area of work on behalf of CCG(NI) and has developed a template for a Data Sharing Agreement and a Privacy Impact Assessment for use by responding organisations to help them address these

issues in relation to data sharing. Section 5 has further information on geo-spatial mapping.

3.11 The starting point for creating this vulnerability map would be lists of vulnerable people already held by organisations and agencies for their own business purposes, and augmenting this as an emergency unfolds and more vulnerable people are identified. As part of the multi-agency group's joint dynamic risk assessment, when deciding whether or not to share information in an emergency, the risks in not sharing it must also be considered. It should be noted that during an emergency, it is more likely than not that it will be in the interests of an individual for their personal data to be shared[15]

Exemptions to the Data Protection Act

3.12 Where appropriate, exemptions to the Data Protection Act should be considered and documented, if it is decided to apply these. Where a decision has been made to share personal data in an emergency responding organisations should maintain a record of the decision and the rationale.

3.13 At all times responding organisations and agencies must look to the eight Data Protection principles to advise on individual cases, taking into account the unique circumstances, fairness and conditions for processing as defined within Schedule 2 and 3 to the DPA.

Privacy Notices

3.14 It is the responsibility of responding organisations to consider how best to meet the interests of the data subjects and ensure that all partners (with whom they share information) are aware of the requirement to keep information secure and the level of security appropriate to the nature of the data to be protected. Each responding organisation (or data controller), is required to inform users about its use of privacy notices and to ensure that these privacy notices are updated to reflect the circumstances where data might be shared, with or without consent. Further information and guidance can be found in ICO guidance on its' website[16].

Retention and destruction periods

[15] Data Protection and Sharing – Guidance for Emergency Planners and Responders (Feb. 2007) available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60970/dataprotection.pdf
[16] http://ico.org.uk/for_organisations/data_protection/the_guide

3.15 Responding organisations should also provide details of retention and destruction periods for the information shared, and should articulate what steps should be taken by all partners in terms of identifying how long this shared information should be retained and how it will be destroyed. This detail should be set out in detail in Data Sharing Agreements.

3.16 Regardless of the cause of the emergency, the effects can be the same and require an emergency management response which may require the sharing of sensitive personal data about vulnerable people to better meet their needs by a range of responding agencies working together.

Key points to note regarding information sharing

3.17 In Northern Ireland, some key points to note with regard to information sharing are as follows:

- The DPA does not prevent organisations sharing personal data, where it is appropriate to do so. Rather, it provides a framework for sharing data, with appropriate safeguards around the handling of this data to ensure that an individual's privacy is respected.

- Factoring in the risks involved in not sharing data is an important consideration. Responding organisations and agencies need to balance the potential harm to an individual (and, where appropriate, the public interest) in not sharing information, against the public interest in sharing the information as part of the response to an emergency (including the humanitarian response).

- Consent of the data subject is not a necessary precondition for lawful data sharing. It is only one of a number of conditions which allows for data sharing in relation to personal or sensitive personal data. Furthermore, this consent does not need to be explicit – it can also be implicit. See information in relation to Schedules 2 and 3 to the DPA set out in paragraphs 3.8 and 3.9 for further detail.

- In some cases, information shared may relate to the physical or mental health of an individual who is considered to be vulnerable – this would be considered to be sensitive personal data for the purposes of the DPA. Therefore one condition from Schedule 2 and a further condition from Schedule 3 will need to be met. Conditions that may apply in these situations are where the processing is necessary "in order to exercise any statutory function" (Schedule 3, condition 7) or "to protect the vital interests of an individual" where consent cannot be given (Schedule 3, condition 3). The 'vital interests' condition provides that

personal data (and sensitive personal data) can be shared "*in order to protect the vital interests of the data subject or another person where consent cannot be given by or on behalf of the data subject, or the data controller cannot reasonably be expected to obtain the consent of the data subject*". The condition of vital interests would apply to "life and death" situations, but is also likely to be particularly relevant in emergencies where there is substantial risk to an individual's life. For further information on this see guidance produced by the UK government (in consultation with the ICO) in relation to data sharing in the context of emergencies[17].

Information sharing and vulnerable people

3.18 There is likely to be reluctance among organisations and agencies to identify vulnerable groups or individuals, or to share specific details in advance of an incident or emergency due to worries about breaching data protection legislation.

3.19 Before organisations share information they must ensure that they have the legal power or ability to do so. All agencies that are considering sharing information should check their legal status in this regard. Further guidance can be found in the ICO's Data Sharing Code of Practice[18].

Planning stages

3.20 At the planning stages however these organisations or agencies could do the following:

- **Share information about who holds what** sort of details, for what purposes, along with relevant contact details. This should include details for out-of-hours contact that would only be shared with other responding organisations and agencies. That way, in an emergency, organisations can save time and be one step ahead.
- **Share less detailed information** – such as giving an indication of the type of vulnerabilities and indicative numbers that may exist in certain geographic areas. The detail of who those people are; their vulnerabilities; and what their needs might be, may only need to be shared when an incident is imminent or an emergency happens.

[17] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60970/dataprotection.pdf
[18] https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf

- **Agree the method and format** in which information could be shared in the event of an incident or emergency. This could take the form of a Data Sharing Agreement , which clearly sets out:
    - what personal data each organisation holds, what can be shared, for what purposes, how and with whom in the event of an emergency;
    - what triggers would be set for providing more detailed information; and
    - what the organisations' (data protection) responsibilities are regarding that information, including its' destruction, after the emergency is over.
- Where a **Data Sharing Agreement** is in place it should be reviewed regularly, particularly where information is to be shared on a large scale or regular basis. This agreement should be clear and transparent about the roles of the parties involved, and make it clear what is happening to personal data at each stage of the process. Personal data, particularly sensitive data, should be held securely, with a clear retention policy in place for when the data is no longer needed.

3.21 Furthermore, when deciding whether to share information in an emergency, the risks in not sharing must also be considered. This needs to be balanced against any unwarranted detriment to an individual whose personal data is shared, and wherever possible, individuals should be aware that the sharing might take place in certain circumstances, or have given consent for that to happen.

- **Produce a vulnerability map** using anonymised data, using geo-spatial mapping capability with the assistance of Land and Property Services (LPS). This mapping can be done in advance and shared with responding organisations in the event of an emergency. This data can be over-layered with information already held by other responding organisations to produce a more complete picture of unfolding events and impacts on particular areas (see further information on geo-spatial mapping at Section 4).

  There is no difficulty with sharing anonymised data with other organisations as it is not sensitive personal data as defined in the Data Protection Act. However, depending on what and how information is held in a 'vulnerability map', if this leads to an individual being identifiable, then it is considered to be personal data and should be treated as such. This does not necessarily mean it cannot be shared,

just that if vulnerability maps do contain personal data then the DPA must be considered when deciding whether, and with whom, to share.

- **Seek consent from those listed as vulnerable** on existing lists to share their personal or confidential information in an emergency situation, in order to best meet their needs. Organisations should take the advice of their organisational Data Protection Officer (DPO), Personal Data Guardian (PDG), Information Asset Owners (IAOs) (or equivalent, where these specific roles do not exist), and/or the Information Commissioner's Office (ICO), to satisfy themselves that they are following best practice in this regard.

- **Keep lists and contact details up to date.** Responding organisations and agencies should ensure that their lists of vulnerable people, where they exist, are as up-to-date as possible and reviewed on a regular basis – this is a key requirement of the Data Protection Act.

4 GEO-SPATIAL MAPPING

4.1 The Northern Ireland Executive made a commitment to developing a Geographic Information (GI) strategy for Northern Ireland. Geographic information includes any information that can be referenced to a specific location (such as a grid reference or postal address) and can be represented on a map. The core premise of this strategy is to encourage the effective use of GI throughout government in Northern Ireland by placing information about location at everyone's fingertips in order to:

- deliver better services to the public;
- improve data utilisation and sharing;
- manage resources more effectively and efficiently; and
- inform evidence-based policy decisions through access to more information.

4.2 Most emergencies have a strong geographical dimension, since their location and spread will determine their impacts and how they should be managed. Consequently, many local and regional responders have found that Geographical Information Systems (GIS) provide a valuable tool in planning for, responding to, and recovering from incidents that may require evacuation and shelter. GIS can:

- assist emergency managers to identify and take account of demographic aspects of an emergency (such as its location, extent, consequences, and who will be affected); and
- allow geographical information from multiple sources and agencies to be integrated to provide an informed response.

Spatial NI

4.3 In Northern Ireland Land and Property Services (LPS) within the Department of Finance operates the Spatial NI GIS portal – further information is available at: www.spatialni.gov.uk

4.4 Spatial NI provides much of the GIS functionality required to support civil contingency planning, response, recovery and restoration and a dedicated emergency response viewer and support service has been created to assist CCG(NI) activities. The system already contains a number of data sets relevant to emergency management.

4.5 Spatial NI sits within the IT Assist secure environment and has a range of access controls that can be enabled to protect the information held within the system and restrict who has access to that information.

4.6 Spatial NI will provide those organisations that are required to share information on vulnerable people with a secure means to do so and, more importantly, a range of mapping and visualisation tools to help make more effective use of the information during an emergency.

4.7 All responding organisations and agencies should consider making use of Spatial NI by collaborating with LPS to populate maps with relevant information in advance of an emergency and agree permissions to allow other responders to view/share their information as necessary.

ANNEX 1:

Templates for sample tables

Table 1: Identifying potentially vulnerable people and communicating with them through other organisations

Table 2: Example of generic information that might be used for planning/sharing purposes

Table 1: Identifying potentially vulnerable people and communicating with them through other organisations

Potentially Vulnerable Individual/Group	Examples and Notes	Target through the following organisations/agencies	Contact details
Children	Where children are concerned, whilst at school, the school authorities have duty of care responsibilities. Certain schools may require more attention than others.	• Education Authority • Department of Education • HSC Trusts • Crèches/playgroups/nurseries	*Responding organisations should insert local contact details for appropriate organisations in this column* Schools are mapped at www.spatialni.gov.uk
Older People	Certain sections of the elderly community including those of ill health requiring regular medication and/or medical support equipment	• Residential Care Homes • Nursing Homes • Age NI • HSC Trust Social Services • Supported housing/sheltered accommodation	NIHE has contact details for over 300 community groups - RQIA's website has details of the locations of registered nursing and residential homes http://www.rqia.org.uk/ inspections. Nursing and residential homes and hospitals are mapped on Spatial NI at www.spatialni.gov.uk Fold Telecare
Mobility impaired	For example: wheelchair users; leg injuries (e.g. on crutches); bedridden/ non movers; slow movers.	• Residential Care Homes • Charities • HSC Trust service providers • Community mental health care teams	RQIA's website has details of the locations of registered nursing and residential homes http://www.rqia.org.uk/inspections. Nursing and residential homes and some HSC facilities (including
Mental/cognitive function impaired	For example: developmental disabilities; clinical psychiatric needs; learning disabilities.		

Potentially Vulnerable Individual/Group	Examples and Notes	Target through the following organisations/agencies	Contact details
			hospitals and mental health facilities) are mapped on Spatial NI at www.spatialni.gov.uk
Sensory impaired	For example: blind or reduced sight; deaf; speech and other communication impaired.	• Charities eg RNIB, RNID • Local groups	
Individuals supported by HSC Trusts		• HSC Trust Social Services • HSC Trust Community Care Teams • GP practices	
Temporarily or permanently ill	Potentially a large group encompassing not only those that need regular medical attention (e.g. dialysis, oxygen or a continuous supply of drugs), but those with chronic illnesses that may be exacerbated or destabilised either as a result of the evacuation or because prescription drugs were left behind.	• GP practices • Other health providers (public, private or charitable hospitals etc.) • Community nurses	
Individuals cared for by Relatives/friends	• Home ventilated patients • Home dialysis patients • Older people • Learning disabled adolescents/adults • Children with special needs	• GP practices • Carers groups eg Carers NI, Belfast Carers Centre, The Princess Royal Trust for Carers	
Homeless		• Shelters • Soup kitchens • Salvation Army	
Pregnant women		• GP practices • HSC Trust ante-natal clinics	

Potentially Vulnerable Individual/Group	Examples and Notes	Target through the following organisations/agencies	Contact details
Minority language speakers		• Community Groups • Job centres • Interpretation services	NIHE has contact details for over 300 community groups
Tourists		• Transport and travel companies • Hoteliers • Bed and Breakfast establishments • NI Tourist Board • Port Authority	
Travelling community		• HSC Trust Social Services • Education Authority • Community groups • Local Traveller support groups eg An Munia Tobar	NIHE has contact details for over 300 community groups

Table 2: Example of generic information that might be used for planning/sharing purposes

Potentially vulnerable group(s)/ individuals	Location	Address	Contact details	Estimated numbers of vulnerable involved	Anticipated support needed	Notes
Elderly people	Detail area/ location involved List whether independent sector or private residence	List the full address of the facility and postcode (for GIS purposes)	Include: name of contact(s); their role; organisation; contact no.(s); etc	Detail actual or best estimate of numbers involved	Detail what sort of support needed or anticipated. Equipment dependent?	Include any other relevant information
Adults	List whether private residence, sheltered accommodation or other	List the full address of the facility and postcode	Include: name of contact(s); their role; organisation; contact no.(s); etc	Detail actual or best estimate of numbers involved	Any physical or mental disability? ie. needs water for dialysis or needs electricity for life saving/medical equipment	Include any other relevant information
Children	List whether • schools • special schools • crèches/nurseries	List the full address of the facility/location and postcode	Include: name of contact(s); their role; organisation; contact no.(s); etc	Detail actual or best estimate of numbers involved	Medication dependent?	Schools mapped on Spatial NI at www.spatialni.gov.uk
Travelling community	List camp sites in council areas	List the full address and postcode	Include: name of contact(s); their role; organisation; contact no.(s); etc	Detail actual or best estimate of numbers involved	Detail what sort of support needed or anticipated	

Potentially vulnerable group(s)/ individuals	Location	Address	Contact details	Estimated numbers of vulnerable involved	Anticipated support needed	Notes
People in HSC facilities eg hospitals, statutory homes, day care centres, etc.	Detail area/ location of facility	List the full address of the facility and postcode	Include: name of contact(s); their role; organisation; contact no.(s); etc	Detail actual or best estimate of numbers involved	Detail what sort of support needed or anticipated	Health facilities and independent sector homes/centres freely available on Spatial NI at www.spatialni.gov.uk
Insert date table last updated/by whom						

Appendix N - Enhancements to Civil Contingencies Arrangements

This appendix should be read in conjunction with appendix E

Office of the
First Minister and
Deputy First Minister

Civil Contingencies Policy Branch

Irrelevant & Sensitive

Tel: I&S Fax: I&S

CIVIL CONTINGENCIES CONTACTS

26 May 2011

Dear Colleague

ENHANCEMENTS TO NI CIVIL CONTINGENCIES ARRANGEMENTS

I am pleased to advise you of the recommendations from another of the workstreams, led by DFP, which sought to identify how telephony resource across the public service could be better aligned and co-ordinated to support the provision of effective call handling capability in an emergency.

Recommendations to Enhance Call Handling Capability

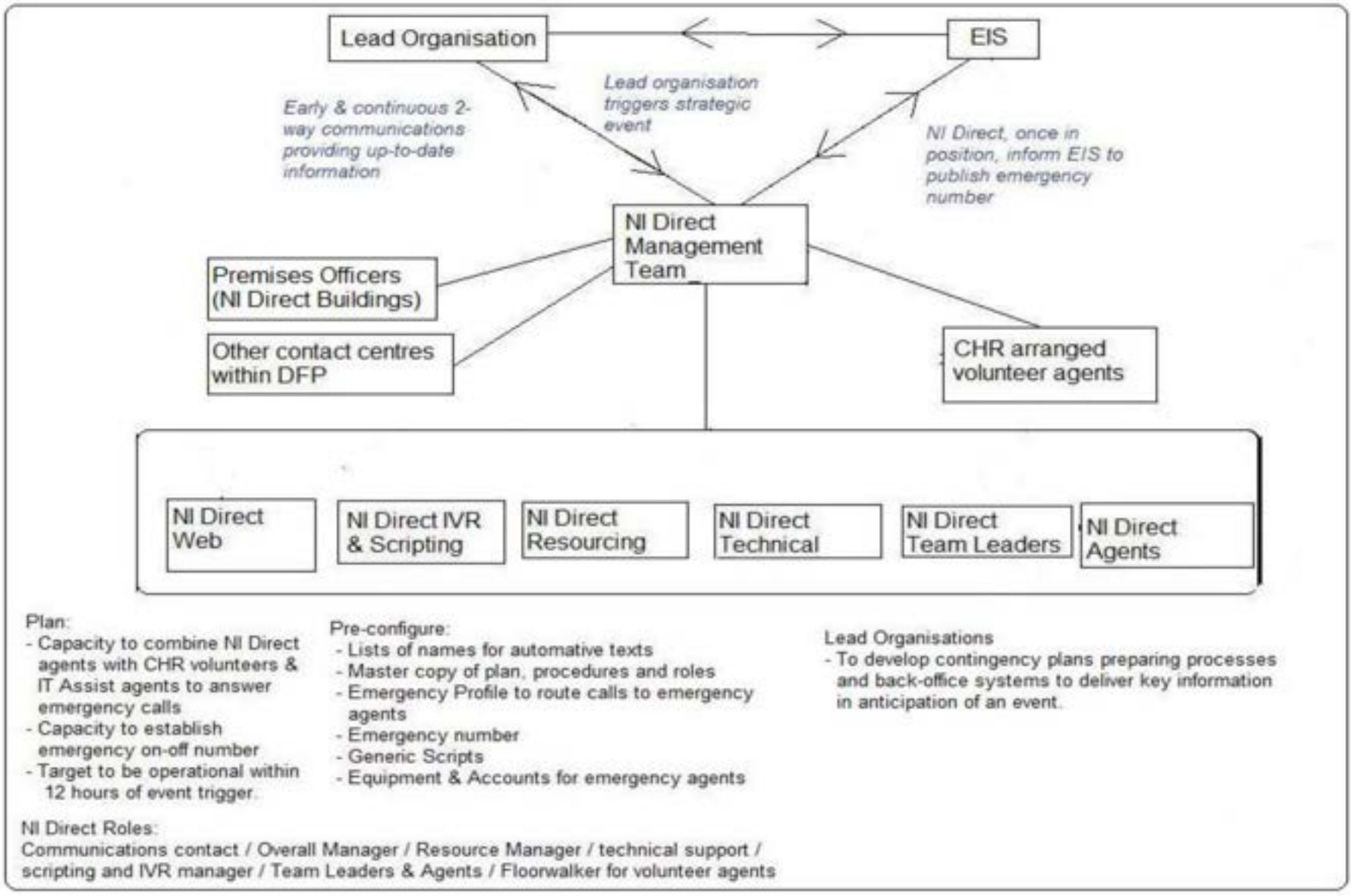
It was found that there was considerable scope for organisations in the first instance to develop their own internal call handling capacity to help them respond to emergencies. **Therefore, organisations should now give consideration to identifying and putting in place the call handling capability and capacity they require to meet their needs in the event of an emergency impacting on their organisation or sector.** OFMDFM will be incorporating this advice into current and future civil contingencies guidance

It was acknowledged however that while internal arrangements can be bolstered it may not always be possible to develop sufficient capacity in-house and that there is potential in an emergency for other organisations to lend trained telephone agents to assist others.

Work currently being taken forward within the NICS to give effect to a suitable mutual aid arrangement is summarised below. It is recommended that other organisations outside the NICS consider what similar arrangements they might put in place.

- NICS Corporate HR has agreed to consider what contingency arrangements should be developed to formalise the system of calling for volunteers for call handling from within the NICS at short notice to provide mutual aid. These arrangements will be in place ahead of the coming winter season.
- NI Direct is revising their emergency arrangements to accommodate the provision of additional volunteer workforce, complemented by existing DFP contact centre staff and NI Direct's own call agents. The objective of the new arrangements is that once an emergency is declared (regardless of whether it occurs outside of normal business hours), NI Direct will have established emergency telephone and web capabilities within 12 hours. This is dependent on having established a two-way communication link with the lead organisation for the emergency to facilitate the provision of timely, up to date information. A process diagram for the augmentation process is attached at Annex 1.

NICS organisations should now consider to what extent they may need to seek mutual aid to augment their internal call handling capacity, and liaise with NI Direct on implementation.



Plan:
- Capacity to combine NI Direct agents with CHR volunteers & IT Assist agents to answer emergency calls
- Capacity to establish emergency on-off number
- Target to be operational within 12 hours of event trigger.

Pre-configure:
- Lists of names for automative texts
- Master copy of plan, procedures and roles
- Emergency Profile to route calls to emergency agents
- Emergency number
- Generic Scripts
- Equipment & Accounts for emergency agents

Lead Organisations
- To develop contingency plans preparing processes and back-office systems to deliver key information in anticipation of an event.

NI Direct Roles:
Communications contact / Overall Manager / Resource Manager / technical support / scripting and IVR manager / Team Leaders & Agents / Floorwalker for volunteer agents

Appendix O - Protocol for Collaborative Communications Process (September 2016)

Protocol for the Collaborative Communications Process

1. The term emergency within this Protocol is defined as: An event or situation which threatens serious damage to human welfare, the environment or the security of Northern Ireland or the UK as a whole. (NI Civil Contingencies Framework - refreshed 2011)

2. In Northern Ireland emergencies are classified as follows:

   - Local Level – emergencies where the outcomes are such that the response can be delivered entirely by organisations operating locally/sub-regionally, or

   - Strategic Level – emergencies where the extent or severity of their impact is such that strategic level intervention and co-ordination by central government is required. Emergencies at the strategic level are split into different levels; Level 1 Significant, Level 2 Serious and Level 3 Catastrophic. Multi-agency co-ordination for Level 1 emergencies is delivered by the appropriate Lead Government Department and by the NI Central Crisis Management arrangements for Levels 2 and 3.

Local Level

3. In the case of a local level emergency the lead agency will co-ordinate the arrangements for communicating with the public, except in circumstances where there is a threat to life when the PSNI will deliver this function. Where there is no threat to life, and no clear lead agency can be identified, the district council that is co-ordinating the emergency response will also co-ordinate the public communications arrangements. The organisation co-ordinating the public communications arrangements at this level should alert the Head of the Executive Information Service (EIS) to the emergency.

4. In all circumstances the identification of the lead agency (or in the absence of a clear lead agency the organisation co-ordinating the public communications arrangements) in an emergency is the key trigger for the collaborative communication process. The lead agency Head of Communications will define the initial communications issues and set out the initial communications strategy.

5. Following the identification of the lead agency the Head of the EIS will contact the lead agency Head of Communications to establish whether any assistance is required. As set out at paragraph 3, where the emergency is at the local level the organisation co-ordinating the public communications arrangements will contact the Head of EIS. EIS is now operating a rolling list of staff at all grades who will be available on a "drop everything" basis to assist in an emergency, particularly during holiday periods.

6. It is important to stress that EIS will be offering assistance and will not be seeking to direct the lead agency's communications effort – that is the responsibility of the lead agency's Head of Communications. It may well be that, particularly in the early hours of the emergency, that the lead agency does not require formal assistance in terms of resources or expertise.

7. Beyond the lead agency there will be other responders and in the early stages of the emergency EIS will be in contact with relevant Heads of Communications to become the communications link with the lead agency. The intention is to take as much of the liaison burden off the lead agency's communications team as possible and to allow them to get on with the core job of delivering their communications strategy.

8. The key role for EIS at this point will be to co-ordinate the key messages across all responders and develop a core script that all responders can draw on and to consider and facilitate as necessary the provision of joint media messaging spanning key responders to the emergency. This will necessitate EIS being supplied with all news releases and all lines to take from all responders, including FAQs. This information will then be published on the NI Direct website and will be significantly augmented through the use of social media. In the event of power outages communication with the public will be via radio bulletins, nidirect through smart phones and direct contact with emergency centres where applicable.

9. Throughout this period the Head of EIS will continue to liaise with the lead agency Head of Communications to keep the level of assistance required under review. This will be particularly important if or when the lead agency changes as the emergency moves into the recovery phase.

10. EIS will participate in multi-agency co-ordination meetings to provide briefing for Ministers and senior officials on the developing situation and lines to take. A circulation list, which also includes key officials, has been created within EIS and is shared with all duty press officers.

Strategic Level

11. In the case of strategic level emergencies where a Lead Government Department is co-ordinating the response EIS staff out-posted in that department will co-ordinate the media response and provide input to the briefing to Ministers and senior officials.

12. In the case of a strategic level emergency where the NI Central Crisis Management Arrangements (NICCMA) have been activated, EIS will co-ordinate the media response and will lead on development of the media strategy to support the strategic priorities identified by NICCMA. This will be done in close liaison with the Head of Communications from the Lead Department / Agency, as well as their counterparts in other responding organisations. The Head of EIS will keep all responders up to date on communications issues at NICCMA meetings and will be available to brief

Ministers and key officials in conjunction with TEO officials co-ordinating the response.

Emergency Planning

Collaborative Communication Process