NHSScotland Standards For Organisational Resilience

Second Edition
May 2018

DOCUMENT CONTROL

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Reader Information Box	
Target Audience	NHSScotland: Chief Executives, Directors of Public Health, Chief Operating Officers, Chief Officers, Health & Social Care Partnerships NHS Resilience Leads; Scottish Government Directorates. For information: Local Authority Chief Executives and Heads of Social Work/ Chief Social Work Officers; Chairs, Regional Resilience Partnerships.
Document Purpose	To support NHS Boards to enhance their resilience and have a shared purpose in relation to health and care services preparedness in the context of duties under the Civil Contingencies Act 2004. The document promotes continuous improvement and provides a framework for self-assessment and other control processes.
Description	This document sets out minimum standards expected of NHS Boards in relation to resilience, i.e. business continuity and emergency preparedness. It is set in a 3-year timeframe (2016-2019) and will be reviewed / refreshed annually. The content reflects relevant UK legal and policy frameworks and Preparing for Emergencies – Guidance for Health Boards in Scotland published by Scottish Government (SG) in 2013, which is extant.
Superseded Documents	NHSScotland: Standards For Organisational Resilience, 1st Edition, May 2016
Action required	NHS Boards should ensure these standards are met and that evidence can be provided, when requested, as part of SG assurance processes.

Contents

Foreword

The NHS in Scotland has recently faced a number of complex disruptive challenges; some familiar and others through new disruptive threats. In this environment preparedness and organisational resilience now are more important than ever.

The last eighteen months have really tested the resilience of the NHS with a number of major incidents and disruptive events, including terrorist incidents, the increase in cyber-attacks and severe weather, impacting directly or indirectly on health and social care services in Scotland.

It is therefore important to take every opportunity to learn from experience and take steps to enhance organisational resilience. We need to ask important questions such as:

- Are our services sufficiently robust to withstand these disruptions?
- Are we sufficiently prepared to safeguard health and social care services?
- What are we doing to ensure the safety of service users and staff?
- How effectively are we protecting our assets and our reputation?

We published *Preparing for Emergencies: Guidance for NHSScotland* in 2013 to assist NHS Boards to deliver their duties under the Civil Contingencies Act 2004. Since then we have issued further guidance on topics such as Prevent, Decontamination and Responding to an Increased Threat Level to enable NHSScotland to adapt to these new demands. The focus of these is on enhancing *resilience*, that is proactive preparation, with greater emphasis on risk assessment and mitigation.

We recognise that NHS Boards have made considerable progress in developing business continuity and major incident plans, but ongoing change and developments within the health and social care context, new policy imperatives and recently identified best practice mean that plans and practices need to be constantly reviewed and revised to reflect these.

NHSScotland: Standards for Organisational Resilience Second Edition, 2018 has been updated to reflect some of the main changes and to support continuous improvement of NHS Boards' organisational resilience and preparedness.

I would ask Chief Executives to ensure that appropriate arrangements are in place to support the implementation and monitoring of these standards, given good day-to-day operational escalation and resilience will stand local services in good stead for any more disruptive events.

Alan Hunter
NHS Scotland Director of Performance and Delivery
Scottish Government

EXECUTIVE SUMMARY

NHSScotland: Standards For Organisational Resilience, Second Edition 2018 replaces the preceding version published in 2016. Produced by Scottish Government (SG) Performance and Delivery Directorate, it is aimed at supporting NHS Boards to better understand and meet their obligations under the Civil Contingencies Act 2004 (CCA).

The emphasis of this document is on enhancing *resilience* through business continuity management and emergency preparedness. These Standards are intended to promote continuous improvement of NHS Boards preparedness, and ultimately, their organisational resilience. Through better awareness and understanding of risks and threats, the document encourages NHS Boards to rise to these challenges and accordingly modify organisational capabilities.

Sections One and Two highlight what NHS Boards, particularly those designated Category 1 and 2 responders, need to do to comply with the CCA and they explain organisational resilience and its facets. They also outline the policy context for this area of work, underline the importance of giving due consideration to equalities and diversity issues and set out Scottish Government's expectation of NHS Boards in relation to achieving the identified standards.

The headings of the subsequent nine sections reflect the various dimensions of a resilient organization and the 41 standards cover a range of topics that NHS Boards need to be prepared for. Each of the standards are followed by measures / indicators to demonstrate achievement of that standard. NHS Boards are required to report on their performance against these standards annually.

The concept of organisational resilience is a developing one. Therefore, Scottish Government Health Performance and Delivery Directorate will review the content of this document so that it continues to reflect new research, good practice and lessons from the field.

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SECTION 1

INTRODUCTION

This section outlines the meaning of resilience and highlights its key components. It also explains the aim of the standards and how the document should be used.

CONTEXT

The Civil Contingencies Act (2004) and the Civil Contingencies Act 2004(Contingency Planning)(Scotland) Regulations 2005 require NHS Boards designated as Category 1 and Category 2 responders to demonstrate that they can respond to a range of incidents while maintaining business-as-usual services to patients.

These incidents may vary in scale and complexity, and range from dealing with severe weather, infectious diseases outbreaks (so-called 'slow burners) and / or major no-notice incidents (so-called 'big bangs') such as explosions or transport accidents. The NHS must plan for, and be prepared to respond and adapt to the short and long-term consequences of these various disruptive challenges.

Preparing for Emergencies – Guidance for NHS Boards in Scotland[1] (2013) set out what NHS Boards should do to comply with duties under the Civil Contingencies Act (2004) – 'the CCA' – and other key legislation, thereby enhancing their resilience. The standards and performance criteria in this document are set in the context of that guidance; they take account of experience gained since that time, recent developments and new information in the professional discipline, and new imperatives on the NHS and delivery partners in Scotland, notably Health and Social Care Partnerships (HSCP).

Designated responders

Category 1 responders are those organisations at the core of an emergency response. Within NHS Scotland, they include:

- All Territorial NHS Boards, and
- The Scottish Ambulance Service

Although Primary Care is not designated under the CCA, it is expected that Territorial NHS Boards will actively collaborate with HSCPs to encourage General Practices to plan for and respond to incidents in the same way as category 1 responders, albeit in a proportionate manner and with regard to the type of services they provide.

Category 2 responders have a lesser set of duties and they will be less involved at

[1] Preparing For Emergencies: Guidance For Health Boards in Scotland. Scottish Government, September 2013

the core of the planning, but they will be heavily involved in providing the expertise or specialist resource of their sector during incidents through cooperation in response and / or the sharing of information. Within NHS Scotland, they include:

- NHS National Service Scotland.

Although the emphasis of the standards in this document is on NHS Boards designated as Category 1 (primary responders) and Category 2 (supporting agencies) responders, it is expected that the Corporate Resilience Leads in the non-designated NHS Boards will review the content of this document, identify which standards are relevant for, or apply to their organisation and work towards achieving them on a proportionate basis.

Focus on resilience and preparedness

These forty one standards focus on *resilience,* which is *the ability of an organisation to anticipate, prepare for, respond and adapt to incremental change and sudden disruptions in order to survive and prosper.*

Resilience and *preparedness* are outcomes that are achieved over time by adopting a range of best practices to deliver business improvement by building capability across all aspects of the organisation, and making the most of opportunities to learn from experience.

Resilience requires organisations to go beyond traditional forms of risk management such as business continuity management, which are duties under the CCA. At its core it requires:

- Recognition and mitigation of risks, and implementation of means to bounce back from disruptive events; and

- Active processes to adapt to change in the short and long term.

The architecture of organisational resilience involves five key inter-related components[2], highlighted below. Together these provide a framework for creating an agile, integrated, and knowledge-based organisation that can thrive in an environment of constant change:

> **1. Leadership:** Strong and effective executive leadership that sets priorities, aligns resources and makes the necessary commitment to establishing resilience as a goal throughout the organisation. Leadership and top-tier management strives to achieve a balance between risk taking and risk containment so that innovation can continue, but does so in the context of prudent risk minimisation.

[2] The Five Principles of Organisational Resilience, Dan Durant. 2014

2. Culture: An organisation's resilience is influenced by its culture. A resilient culture is built on principles of empowerment, purpose, trust and accountability.

3. People: A workforce that is properly engaged, motivated, equipped and led will be able to overcome almost any obstacle or disruption. A key component of this is a system that supports staff to work across boundaries, regardless of time and space.

4. Systems: A robust IT infrastructure and systems that connect and inform the organisation.

5. Settings: An adequate level of workplace flexibility and agility within the organisation that mitigates the risk of catastrophic or disruptive incidents impacting various parts of the organisation.

THE STANDARDS

This document specifies minimum standards and related measures/performance indicator criteria for resilience within NHS Boards across Scotland.

A standard is a statement of an expected level of service that demonstrates delivery of practices acknowledged as safe and effective within the resilience field and it promotes understanding, comparison and improvement of that practice.

These standards and the set of minimum performance criteria for NHS Boards are based on duties set out in the CCA and other key legislation (see Section 2). They are intended to:

- Ensure compliance with legal duties
- Drive national consistency and/or local improvement;
- Promote innovative practice, continuous improvement, resource-efficiency and effectiveness
- Enable territorial and special NHS Boards across the country to have a shared objective of enhancing the resilience of the NHS in Scotland, co-ordinate activities with, and learn from each other; and to
- Provide a common framework for self-assessment during planning cycles, support internal audit and/or systematic review processes.

Scottish Government Health Resilience Unit will use the standards to monitor NHS Boards' preparedness.

The standards will be reviewed and updated as and when required to take into account new research / developments in the resilience field, lessons identified from testing and exercising, and other recognised best practice.

Layout

The standards in this document are set out on a 'best-fit' basis in sections that highlight the key dimensions of organisational resilience. Although every effort has been made to reduce duplication, inevitably some standards and/or criteria indicators will appear in more than one section, albeit with a slightly different emphasis, to highlight their importance to that particular topic.

Which NHS Boards do the Standards apply to?

The interdependence of the NHS in Scotland highlights the importance of all NHS Boards ensuring that the services they provide maintain a level of resilience that reflects their significance, role and functions.

Some threats, hazards and consequences of large-scale major incidents may, in extreme cases, require non-designated Special Boards to mobilise or 'stand up' resources in support of the Territorial NHS Boards. Therefore all Special Boards should review their resilience and capability against these standards in the event they are called upon to support the Category 1 and Category 2 responders.

Format of the standards

Each standard contains:

- A statement of what is expected;
- A Rationale/ basis outlining why the standard is considered important and /or the sources of information supporting it; and
- Indicators / measures, indicating what should be in place or achieved. They describe the structures, processes and / or outcomes that should be observable within the NHS Board to demonstrate that the standard has been met.

How the Standards should be used

The Board's Executive Lead for Resilience and their Resilience Lead should ensure these standards are achieved. With the Boards' Resilience /Civil Contingencies Committee they should monitor and report progress to the Chief Executive on a quarterly basis, and to the Board twice a year.

Scottish Government's Health Performance and Delivery Directorate will seek an Assurance of Compliance with these standards from the Boards' Chief Executive on an annual basis.

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SECTION 2

LEGAL AND POLICY FRAMEWORK

This section highlights the Public Sector Duty and the legislation underpinning these standards

EQUALITY, DIVERSITY AND THE POLICY FRAMEWORK

NHS Boards must be mindful of their duties under the Equality Act 2010[3], which requires them to consider the needs of all individuals - staff and patients - and how they may be affected when developing policy, service delivery plans and procedures[4].

In addition to complying with the Public Sector Duty (see *Preparing for Emergencies Annex: Equalities, Human Rights and Resilience Planning*), NHS Boards must uphold the UK Human Rights Act (1998) in delivering services. This requires a range of factors to be taken into account including the dignity of individuals receiving treatment, end of life considerations, prioritisation of treatments, and transparency in decision-making processes.

In the context of their duties under Equalities and Human Rights legislation, NHS Boards must undertake an appropriate level of impact assessment of key plans and protocols to ensure they do not perpetuate inequalities.

These standards take account of various legislation, some of which are set out below, and require that NHS Boards do the same:

- Health and Safety at Work Act 1974
- Children Scotland Act 1995 (and Child Protection policies)
- Data Protection Act 1998 (Sections 29; and Schedules 2 and 3)
- The Civil Contingencies Act (2004)
- Information Sharing Interagency protocols
- Public Health etc. (Scotland) Act 2008
- Public Bodies (Joint Working (Scotland) Act 2014
- Counter-Terrorism and Security Act 2015

[3] Equality Act 2010, http://www.legislation.gov.uk/ukgpa/2010/15/contents
[4] Preparing for Emergencies- Guidance for Health Boards in Scotland: Annex on Equalities, Human Rights and Resilience Planning, Scottish Government, 2013.

SECTION 3

REGULATORY

This section highlights the importance of compliance with the Civil Contingencies Act 2004 (CCA) and promoting safe working practices.

Standard 1: The NHS Board shall have effective processes for ensuring that all its resilience plans, policies and procedures are compliant with key legislation and Regulations underpinning this area of work.

Rationale/basis: The CCA – Duty to maintain plans. Audit and review underpin good governance and ensure legislative compliance. The actions of Category 1 and 2 responders following major incidents or severe disruptive events can be subjected to external scrutiny and prosecution in the event of non-compliance with legislative duties and identified shortcomings.

	Measures of the standard/ indicators
1.1	The Resilience Lead and Resilience/Civil Contingencies (CC) Committee monitor the performance of resilience / Business Continuity (BC) plans for compliance with key statutory duties and regulations. (See Section 2)
1.2	The Resilience/CC Committee maintains an overview of lessons from all major / BC incident which the Board has responded to, and ensures that policies, procedures and practice is amended accordingly.
1.3	Appropriate measures and processes are implemented to identify and respond to concerns of staff in relation to resilience plans, capability and deployment and post-deployment experience.
1.4	Resilience plans and processes are subjected to internal audit and review, and there is an action plan, with clear timescales, to address recommendations in the auditor's report.

SECTION 4

STRATEGY AND CULTURE

This section sets out standards that promote leadership of the resilience agenda, ensuring clarity of purpose and lines of accountability.

Standard 2: The NHS Board shall have clearly defined governance arrangements in place for all its resilience-related work.

Rationale/ Basis: CCA – Duty to maintain plans; Business Continuity Institute, *Good Practice Guidelines, 2018 Edition.* Top-tier management and resilience specialists can use their unique understanding of value-creation within the Board to influence and promote informed decision making.

	Measures of the standard/ indicators
2.1	An Executive-level Director is appointed as the Corporate Lead and has overall accountability for the Resilience i.e. Business Continuity (BC) management and emergency preparedness.
2.2	The Board has a Resilience/CC Committee as part of its the governance framework for resilience related work. Membership of the Committee comprises executive and senior managers from the key service sectors and departments with a role to play in enhancing the Board's resilience, such as ICT, Facilities, Human Resources, and/or supporting an effective response to major incidents and disruptive events. Chief Officers of Health and Social Care Partnerships are actively involved in the Committee.
2.3	The Corporate Lead chairs the Board's Resilience/CC Committee and oversees implementation of the organisations' resilience policies and plans.
2.4	The Corporate Lead, supported by a Resilience Lead, ensures that the Board has up-to-date (BC, Major Incident and Resilience) plans and appropriate capability.
2.5	Effective measures are in place for monitoring the performance of plans and maintaining an overview of the Boards' resilience.
2.6	The Corporate Lead, on behalf of the Resilience/CC Committee, reports to the Health Board at least annually on progress in relation to the Board's resilience plans including: • Risks and mitigation; • BC challenges; • Major incidents that have happened in the area and lessons learned; • Emergency preparedness, resourcing, and gaps in capability or capacity; and • Training and exercising undertaken. The report includes a self-assessment against these organisational resilience standards.

Standard 3: The NHS Board shall have an overarching resilience framework and/or policy that set out its objectives and expectations.

Rationale/ Basis: A clearly defined resilience policy and framework demonstrates high-level buy-in and enables staff at various levels of the organisation to understand its purpose and their role in achieving its objectives.

	Measures of the standard/ indicators
3.1	The framework / policy reflects: • How the organisation will deliver its duties under the Civil Contingencies Act 2004; and • Changes in business processes, organisational functions, recent assessments of risk, and changes in the internal and external environment.
3.2	The framework / policy has been signed-off / approved by the NHS Board.
3.3	The framework / policy has a built-in review and reporting cycle.
3.4	Information on the framework / policy is disseminated to managers throughout the organisation as well as primary care contractors where applicable.

Standard 4: The NHS Board shall promote awareness of its resilience objectives amongst the workforce, and inform staff how they can help to achieve them.

Rationale/ Basis: Organisations that promote resilience in their workforce will enhance their own resilience, that of their staff and that of the communities of which their staff are a part[5].

	Measures of the standard/ indicators
4.1	A programme to raise awareness and understanding of the Boards' resilience plans is proactively delivered to staff within a range of operational settings.
4.2	Advice and information is cascaded to staff using various means on how to prepare for and cope with various situations and risks such as severe weather, security threats etc.
4.3	There is an effective channel of engagement and communication with the workforce that enables them to contribute ideas to enhancing the organisation's resilience and preparedness.
4.4	There is a targeted programme aimed at empowering relevant operational staff to lead / respond to crisis situations effectively.

[5] Building Community Resilience. Scottish Government, January 2013.

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SECTION 5

IDENTIFYING AND MITIGATING RISK

This section sets out standards to ensure that major incident and business continuity plans appropriately address identified risks

Standard 5: The NHS Board shall have an annual programme to assess, mitigate or manage resilience risks, especially those resulting from a capacity / capability assessment.

Rationale/ Basis: CCA – Duty to assess risk; *Business Continuity. A Framework For NHS Scotland,* Scottish Government, 2009 (under review)

	Measures of the standard/ indicators
5.1	There is a process for carrying out horizon scanning at pre-agreed intervals to future-proof resilience plans, organisational preparedness and overall capability.
5.2	There is a systematic process and programme in place to review and continuously update BC / resilience plans so that they reflect the outcomes of risk assessments, capacity / capability assessments, lessons from recent major incidents or business continuity disruptions, exercises, related research, policy developments and organisational changes.

Standard 6: The NHS Board shall carry out an 'all-risks' risk assessment at least annually to identify hazards, threats and vulnerabilities which may its resilience and ability to deliver its functions.

Rationale/ Basis: CCA – Duty to assess risk. Risk assessment as part of the BC programme considers the risk of disruption due to various threats. Disruptive events in 2017/18 (cyber-attacks; severe weather) demonstrated the increasing interconnectedness of risks and how they make organisations more vulnerable to serious disruptions.

	Measures of the standard/ indicators
6.1	The Resilience/ CC Committee is aware of the potential threats that could disrupt the organisation.
6.2	There is a prioritised list of the threats to the organisations' activities, and potential options for measures to reduce the frequency or scale of impact of the prioritised threats are identified.
6.3	The outcome of risk and threat assessment have been shared with relevant managers in the Board, the local Health and Social Care Partnerships, and where appropriate with relevant resilience partners.

6.4	The Board's Resilience/CC Committee maintains a Risk Register, and key resilience / BC risks and capability gaps are escalated to and identified on the relevant Departmental, Strategic or Corporate Risk Register.
6.5	The Boards' identified (resilience-related) risks are reflected in the L/RRP's annual Risk and Preparedness Assessment.
6.6	Business Continuity and major incident plans are amended to mitigate identified risks.

Standard 7: The NHS Board shall have an overarching Business Continuity (BC) policy and a robust BC Management process.

Rationale/ Basis: CCA – Duty to maintain Business Continuity plans. BC is the key discipline that is at the core of building and improving organisational resilience. It is a tried and tested methodology that should be adopted as part of an approach to managing risks and threats. BCM identifies organisational priorities and solutions to disruptive threats.

	Measures of the standard/ indicators
7.1	There is a BC policy for the organisation that sets out the purpose, context, scope and governance of the BC programme, formally approved by the Boards' Corporate Management Team. It: • Defines 'business continuity' within the organisation • Includes a statement of governance and leadership commitment • Roles and responsibilities for the BC programme, incident response capability • Identifies methods and frequency for review of all stages of the BC lifecycle • Methods for sign-off and communication of the policy and all programme activities.
7.2	An effective BCM process is in place for the organisation, overseen by the Chief Executive, Chair of the Board's Resilience/CC Committee or an Executive-level Director.
7.3	The Board's Resilience/CC Committee • Ensures that BC plans for the prioritised services, functions and assets are signed off by the respective Head of Service; • Maintains a record of BC plan reviews and updates; • Ensures that an incident debrief is carried out and reported on within 4 weeks of its closure and that a process is implemented to respond to the lessons identified.

Standard 8: The NHS Board shall have up-to-date, effective Business Continuity (BC) / contingency plans for all prioritised services and functions.

Rationale/ Basis: CCA – Duty to assess risk; *Business Continuity. A Framework For NHS Scotland,* Scottish Government, 2009 (under revision).

	Measures of the standard/ indicators
8.1	A Business Impact Analysis, using an appropriate approach, has been undertaken for all identified key services / assets, functions or activities. It covers key elements including people, policies, plans, procedures, structures and resources.
8.1	BC Plans set out: • Priority and urgent functions/ activities; • The risks and threats to critical and essential services, functions and assets, and how they will be mitigated and protected respectively; • Activation procedures, escalation processes, roles and responsibilities of staff; • Incident response solutions and resources required to deal with the disruption at various stages; • Recovery steps and target timescales to return the service to normal operation; • How the plan will be maintained; • Arrangements for communicating BC arrangements to staff and enabling them to understand their roles and responsibilities.
8.2	There is a senior level Lead within each key service or functional area who is responsible for overseeing and maintaining the respective BC plan.
8.3	All BC plans for prioritised services/functions are: • Regularly tested and exercised at least annually; and • Signed-off by the Boards' Executive Lead for Resilience.
8.4	Steps have been taken to work with the local Health and Social Care Partnership(s) to encourage General Practices / Primary Care Services to have BC plans in place, and to monitor the proportion of Practices with BC Plans.
8.5	BC plans are in place to respond to the consequences of national risks such as Communicable Diseases Outbreak (including Pandemic Flu); Severe weather; Fuel Shortages and Industrial Action.
8.6	BC plans are prepared in line with key legislation (including Equalities and Human Rights), current guidance and recognised good practice, and staff are clear about: • Their roles and responsibilities; • Triggering and activation protocols at various levels; and • Incident reporting and recording procedures.
8.7	A capability/resource assessment is undertaken at least annually and capability is reviewed after every BC/major incident debrief to take account of lessons identified.

SECTION 6

PREPAREDNESS

This section sets out standards to ensure NHS Boards are appropriately prepared for and have an adequate level of resilience to deal with a range of incident scenarios.

Standard 9: The NHS Board shall have Major Incident and/or Resilience plans that reflect its emergency preparedness and which have been developed with the engagement of relevant internal /external stakeholders.

Rationale/ Basis: CCA – Duty to maintain plans; Preparing For Emergencies Guidance.

	Measures of the standard/ indicators
9.1	The key stakeholders, especially the local Health and Social Care Partnership(s) (HSCP), with a role to play in delivering the Major Incident plan(s) have signed off the plan.
9.2	Major Incident plans have been signed-off by the Boards' Corporate Management Team and/or the NHS Board. They identify: • Overall capability for various types and scale of incidents; • Pre-hospital /at scene response capability; • Resource-escalation triggers and arrangements; • Dynamic Lockdown procedures to ensure patient and staff safety.
9.3	Protocols / Standard Operating Procedures (SOPs) are in place for the management of: • Multiple child casualties; • Protected Persons, VIPs and/or high profile patients; and • Vulnerable people.
9.4	Major Incident plans and accompanying SOP's have been risk assessed, and there is a process for undertaking rapid risk assessments of incidents prior to deploying staff and resources, including a process (relevant to Cat 1 and 2 responders) for conducting joint dynamic hazards assessments at a live deployment.
9.5	The HSCP, and through them, General Practitioners / Primary Care services have been made aware of their role in the Major Incident plan(s) and expectations of them.
9.6	There is a Memorandum of Understanding between the Board and the local HSCP(s) that clarifies mutual expectations, roles and responsibilities during various types and scale of major incidents.
9.7	Pre-determined processes and administrative arrangements are in place for post-incident debriefing: • A 'Hot' debrief should take place within 48 hours of an incident response being stood down and appropriate action taken to address points requiring

	immediate attention; and • A full ('Cold') debrief should take place within 6 weeks of the incident occurring, with a written report with key learning and actions to inform future plans produced two weeks later i.e. within 8 weeks of incident. For incidents involving prolonged periods of recovery, debriefs are held at appropriate stages[6].
9.8	The Boards' Major Incident plan has been shared with Local/Regional Resilience Partnership (L/RRP).
9.9	Operational (especially clinical) staff have been made aware of: • The role and remit of a Casualty Bureau; and • The protocols for sharing information on casualties and fatalities that have been approved by the Caldecott Guardian.

Standard 10: The NHS Board shall address the specific needs of children and young people in all relevant Major Incident and Business Continuity plans, and ensure that its responses / interventions are sensitive to their needs.

Rationale/ Basis: Children Scotland Act 1995 (and Child Protection policies); CCA (Vulnerable People); Preparing For Emergencies Guidance. Children are more vulnerable in crisis situations than adults, especially if separated from parents or carers. They are also less able to describe or assert their needs to others.

	Measures of the standard/ indicators
10.1	Major Incident (and relevant BC) plans demonstrate that: • Paediatric services and Children's Social Work Services (Chief Social Work Officer) have been involved in the planning process; and • Responses are appropriate to the needs and rights of children.
10.2	Clear protocols are in place to indicate when children would be diverted to adult Emergency Departments (ED) and how this would be coordinated in the event of a mass casualties incident occurring in an area that has separate adult and paediatric ED's.
10.3	Appropriate training on the needs of children and use of equipment is provided for staff who may be called upon as part of a pre-hospital response capability.
10.4	Major Incident / BC plans demonstrate consideration of how children's rights (e.g. keeping children and their parents together), and child protection standards will be maintained.
10.5	All volunteers constituting part of the Board's major incident response have been subjected to a (Basic) Disclosure Scotland or PVG check.

[6] National Debriefing and Lessons Identified Protocol, Version 3, November 2016. Scottish Government

Standard 11: The NHS Board shall have pre-determined Command, Control and Coordination (C3) arrangements in place at Board (strategic level) and Hospital– levels (Operational level) to respond effectively and efficiently to various types and scale of major / mass casualties incidents.

Rationale/ Basis: CCA; Preparing For Emergencies Guidance**.** Major incidents require effective coordination, clear leadership and accountable decision-making so that resources are deployed effectively and efficiently. C3 is a structured approach to incident management.

	Measures of the standard/ indicators
11.1	There is a single point of contact and/or Duty Director protocols within the Board that: • Is capable of receiving major incident ('declared' or 'standby') notifications from Scottish Ambulance Service at all times; • Can effectively communicate notifications to the appropriate points within the Board, hospital or senior management; • Is tested on a mutually agreed frequency with Scottish Ambulance Service.
11.2	There are clear protocols and procedures for triggering and establishing C3 arrangements at Board and/or Hospital level for various types and scale of incidents, i.e. incident-specific governance arrangements.
11.3	There is a clear remit / role specification (with defined competences) for the on-call staff / Duty Director, backed up by a training and development programme, to ensure that the relevant personnel have the requisite knowledge and skills to undertake the task.
11.4	The Chief Executive and Executive level Directors (i.e. nominated substitute(s) from the Corporate Management Team) have been made aware of the role and function of a Strategic Health Group (SHG), and there are: • Action cards to enable them to fulfil the role of Chair / participant when required; • Appropriate arrangements in place to support them in convening / leading a SHG; • Plans in place to periodically test/review the above.
11.5	Robust procedures are in place to clearly identify: • Where and how a major or business continuity incident will be managed; • Decision-making processes; • Minuting, recording and documenting requirements and systems; • Availability of trained Loggists and how to access them; • A timely process for completing, authorising and submitting SitReps internally and externally (to Scottish Government Health Resilience Unit) during the incident.
11.6	There is a robust and timely process for gathering (hospital capacity) information and reporting to the NHSScotland Health Information Cell (See NHSScotland Mass Casualties Incident Action Plan 2015) and SG Health Directorates during a mass casualties incident. *(This is under review)*

11.7	There are clear protocols for accessing 24-hour specialist advice and support for specific types of incidents such as firearms, CBRN, HazMat, and establishing internal strategic and tactical command arrangements for managing these incidents.
11.8	There is a sufficient number of Public Health Consultants trained to chair Scientific & Technical Advisory Committees within the Board, or there are agreements with neighbouring NHS Boards to provide such trained personnel if necessary.
11.9	There are arrangements for gaining access to radiation protection advice on a 24/7 basis in line with local and national mutual aid arrangements.

Standard 12: The NHS Board shall have a training and exercising plan in place to test its state of preparedness and to inform its response capability.

Rationale/ Basis: CCA; Preparing For Emergencies Guidance. Training and exercising programmes are important in ensuring that incident response plans are up-to-date and will be effective when implemented. They should provide the organisation with assurance of capability for various types of incidents.

	Measures of the standard/ indicators
12.1	A progressive, targeted training and exercising programme is implemented following a training needs analysis.
12.2	The Board's Major Incident Plan is • Exercised in full at least every 3 years, or with a review undertaken at 18 months to take account of significant organisational changes; • Tested through a table top exercise every year; • Cascaded internally and externally to partners periodically (especially following any revisions) with a reminder of their roles they are expected to play in its delivery; • Communicated internally to staff via the intranet, and a summary is placed on the Board's website.
12.3	There is an on-going exercising programme that involves relevant partners and stakeholders, especially the local Health and Social Care Partnership(s) and through them GP/primary care.
12.4	There is a process / system for recording and reporting the outcome of exercises and ensuring that lessons are used to inform / revise existing plans and protocols, and to address capability gaps.
12.5	There are up to date records to inform the organisations' awareness of its capability including: • Training / exercising undertaken and staff participation; and • Skills-availability within Board.

Cooperation

Standard 13: The NHS Board (designated as Category 1 and 2 Responders) shall actively participate in Local and Regional Resilience Partnerships(RRP). The Chief Executive, Executive-level Director for Resilience or a relevant Executive Director shall represent the NHS Board on the RRP and ensure the organisation actively engages, cooperates with and works in partnership with other responders.

Rationale/ Basis: CCA – Duty to cooperate. Working together with other responders in supportive partnerships ensures that work is coordinated, free from duplication of effort or unaddressed gaps.

	Measures of the standard/ indicators
13.1	The Chief Executive or a delegated Executive Director regularly attend RRP meetings; The Resilience Manager / senior manager regularly attend the LRP.
13.2	Arrangements are in place: • To brief the Board representatives attending the L/RRP on issues affecting the Board and/or the Boards' position in relation to regional strategic issues under consideration; and • To report back / disseminate information on key L/RRP decisions following meetings.
13.3	Major Incident plans and capability assessments are shared with and understood by other NHS Boards in the RRP area. Where necessary, mutual aid arrangements are in place to fill identified capability gaps.
13.4	Arrangements are in place for responding to (mass casualties / multiple site) incidents in neighbouring (within the RRP area) and other NHS Boards (other RRP) areas.
13.5	HSCP's (and through them GP/Primary Care), National Services Scotland and NHS 24 have been made aware of the support required of them during a major incident.
13.6	There is demonstrable active multi-level engagement and partnership working with other Category 1 and Category 2 responders and Scottish Government.

Standard 14: The NHS Board shall have agreed mutual aid arrangements with a range of providers (i.e. other Category 1 and 2 responders and non-designated statutory and voluntary agencies) which form part of its plan to enhance its capability and responsiveness to various types of Major / Business Continuity incidents.

Rationale/ Basis: Mutual aid agreements ensure that the organisation will have access to appropriate supplementary and /or specialist resources in the event of major / BC incident.

	Measures of the standard/ indicators
14.1	There is a clear understanding of what sort of mutual aid might be required by the Board for different types of incident(s) from L/RP partners, including Third Sector agencies, what can be offered to other partners and the accompanying governance arrangements in these circumstances.
14.2	A Memorandum of Understanding (MoU) or protocol is in place with key statutory/public sector and Third Sector agencies, indicating what mutual aid will be required in different circumstances, how it will be requested, co-ordinated and monitored when implemented.
14.3	The Board has made the local Health and Social Care Partnership(s) and neighbouring NHS Boards aware of its MoU's (or other types of agreements) with key statutory/public sector and Third Sector agencies in the RRP area, for assistance during major / business continuity incidents, and agreed how to cooperate with them in times of potential competing demand.
14.4	Where there are mutual aid agreements to treat, transfer and / or provide follow-up care for patients outside the NHS Board area during a major incident, clinical accountability arrangements are in place to cover such eventualities.

SPECIFIC SCENARIOS

Pandemic Influenza

Standard 15: The NHS Board shall have up-to-date and robust arrangements for responding to Pandemic Influenza, which reflect strategic and operational guidance issued by Scottish Government.

Rationale/ Basis: Pandemic Flu is identified as the top national risk in the UK (National Risk Assessment, 2016) with a potentially disruptive or devastating impact on organisational functioning and the economy.

	Measures of the standard/ indicators
15.1	Pandemic plans follow national guidance and address planning assumptions as contained in: • UK Influenza Pandemic Preparedness Strategy (2011)[7]; and • Health & Social Care Influenza Pandemic Preparedness and Response (2012)[8]
15.2	The response arrangements and plans are underpinned by a review and revision cycle.
15.3	Key issues identified in Exercise Silver Swan (2015) have been addressed by the Board's Resilience/CC Committee and planning and response arrangements have been revised to reflect learning from the national exercise.
15.4	Relevant lessons from the UK Exercise Cygnus Report (2017) and Exercise Odette[9] have been taken into account.
15.5	Business Continuity plans have been cross-matched with all aspects of the Pan Flu plan.
15.6	The plan (including the identification of learning, challenges ahead for the organisation and mitigation) has been endorsed by the Resilience/CC Committee and submitted to the NHS Board / governance structures for approval, or a process towards this end has been implemented.

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213717/dh_131040.pdf
[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf

[9] Scottish Government Quarterly Lessons Report Number 11. April 2018

Standard 16: The NHS Board shall develop and review its Pandemic Influenza Plan jointly with local Health and Social Care Partnerships (HSCPs) and the Regional Resilience Partnership (RRP), and seek their endorsement. A joint / multi-agency plan shall be developed, if one does not already exist.

Rationale/ Basis: CCA – Duty to co-operate. Partnership working makes the best use of available collective resources in the event of a crisis occurring. Recent changes in the health and social care sector and will have implications for local and multi-agency pandemic plans.

	Measures of the standard/ indicators
16.1	Relevant local partners (such as the RRP, HSCPs, the local authority) have been engaged in the development of local plans and response arrangements. Plans have been shared and ideally agreed with partner agencies.
16.2	Planning arrangements and plans take account of, and reflect: • Recent changes within the NHS Board, and the role and remit of HSCPs; and • Current local resilience planning and response structures
16.3	Roles, responsibilities and decision-making processes within the Board and between agencies are clearly outlined in the plan.

Standard 17: The NHS Board shall exercise its Pandemic Flu plan in full every 3 years.

Rationale/ Basis: CCA- Training and exercising to ensure effectiveness.

	Measures of the standard/ indicators
17.1	The NHS Board has held an internal exercise and/or participated in a multi-agency exercise with the Resilience Partnerships since updating their local plan to reflect changes and learning described in the Standards 15 & 16 above.
17.2	HSCPs, and through them General Practitioners / primary care services, have been actively encouraged to engage in local learning and exercising programmes.
17.3	There is an up-to-date record of pandemic flu exercises undertaken, including information on participating agencies / teams, lessons identified and how the plan has been revised to reflect them.

Winter Plan

Standard 18: The NHS Board and the local Health and Social Care Partnership(s) shall have a robust Winter Plan and implement a range of actions to enhance resilience during the winter period.

Rationale/ basis: Scottish Government 'Preparing for Winter' Guidance encourages local health and social care system to prepare for potential business continuity challenges during the winter months such as severe weather, increased demand on services due to seasonal illnesses and trips and falls, and workforce issues.

	Measures of the standard/ indicators
18.1	Resilience and Unscheduled Care Leads collaborate with key stakeholders including HSCPs to assess the key disruptive risks to the organisation / services during the winter period and put in place appropriate mitigation measures.
18.2	A Winter Plan is developed in line with national guidance and integrated with the local health and social care systems' wider demand and capacity planning frameworks. It highlights: • Additional capacity planned for winter especially in acute, intermediate and community care facilities; and • Workforce capacity / provision over the winter period, which encompasses all health and social care services, particularly over weekends and bank holidays.
18.3	Fully tested Business Continuity and Escalation plans are in place across all services, including primary care, Out-Of-Hours and community services. Plans have taken into account expected surge periods and are signed off jointly by senior-level officials in line with the local governance arrangements.
18.4	Business Continuity and Escalation plans highlight arrangements for ensuring continued access to essential supplies and services during severe winter weather. Agreements with appropriate voluntary organisations, such as 4x4 vehicle clubs / owners, are in place.
18.5	Optimised discharge processes are in place to eliminate delays in patient pathways, especially at weekends and bank holidays.
18.6	Communication plans are in place to keep the public, patients and staff informed of winter pressures, their impact on services, and the actions being taken.
18.7	The Health Protection Scotland Norovirus Outbreak Guidance is effectively implemented to protect staff and patients and to help maintain capacity across local health and social care systems.
18.8	Chief Medical Officer Guidelines on seasonal flu vaccination have been implemented for staff working in areas where patients might be at greater risk.

Critical Infrastructure

Standard 19: The NHS Board shall maintain a single up to date list of its critical infrastructure (CI) assets that is stored safely and securely.

Rationale/ Basis: Secure and Resilient, Scottish Government, 2011; Keeping Scotland Running (to be issued Spring, 2018). The Health Sector is a one of 13 critical infrastructure (CI) sectors that are required to take appropriate action to protect their critical assets and systems against threats and hazards described within the National Risk Register 2017[10].

	Measures of the standard/ indicators
19.1	The critical elements of the organisation's infrastructure ('the critical infrastructure assets') have been identified and their security and resilience assessed. The outcome of the assessment has been reported to Scottish Government Health Resilience Unit.
19.2	The CI interdependencies have been mapped and: • The 'map' is regularly updated (version-controlled); • There is active engagement with other relevant (the inter-dependent) organisations to share information and promote mutual understanding of risks and /or vulnerabilities, and how to mitigate them.
19.3	There is an 'asset owner' for each of the identified CI assets and their roles and responsibilities in relation to these assets are clearly defined.
19.4	The Board's Resilience/CC Committee is aware of the CI Asset List and ensures that it is stored safely and kept up to date.

Standard 20: The NHS Board shall assess the vulnerability of its critical infrastructure assets in the context of the Local/Regional Resilience Partnership (L/RRPs) Community Risk Register, and mitigate the risks.

Rationale/ Basis: CCA requires Cat 1 and 2 responders to work together (through the RRP) produce Community Risk Registers. Work to identify critical infrastructure assets and systems assists in providing context for this work and mitigation measures required.

	Measures of the standard/ indicators
20.1	There is a schedule to periodically review the vulnerabilities of the identified CI assets across all risks and threats.

[10] Cabinet Office, National Risk Register of Civil Emergencies, 2017 Edition.

20.2	Asset owners update the Board's Resilience/CC Committee on the CI assets' upstream and downstream dependencies (and supply chains), and vice versa.

Standard 21: The NHS Board shall have enhanced resilience plans and security arrangements to protect its critical infrastructure (CI) assets and systems.

Rationale/ Basis: Security Services Standards For NHSScotland, NSS Health Facilities Scotland, 2014; Secure and Resilient, Scottish Government, 2011.

	Measures of the standard/ indicators
21.1	Enhanced resilience plans are in place to protect the identified CI assets and there is: • A pre-agreed review schedule; • Engagement with Police Scotland Counter Terrorism Security Advisers where appropriate.
21.2	The Board acts on information relating to the sectors' risk and threat profile and takes immediate action to improve the asset resilience plans accordingly.
21.3	Effective response-and-recovery plans are in place in the event a risk or threat cannot be prevented.
21.4	Assurance of the resilience of CI assets is provided to Scottish Government when requested.

HAZMAT/CBRN

Standard 22: The NHS Board shall have a specific Hazardous Materials / Chemical, Biological, Radiological, Nuclear Explosives (HAZMAT/ CBRN(e)) plan or a dedicated section within its Major Incident plan that sets out its preparedness for and response to such incidents.

Rationale/ Basis: CCA; National Risk Register For Civil Emergencies, 2017 Edition, Cabinet Office; Local Community Risk Register and RRP Risk and Preparedness Assessments.

	Measures of the standard/ indicators
22.1	The Boards' capability is based upon a local risk and/or hazard assessment and reflects the capability of the whole organisation, not just those of the Emergency Department(s).
22.2	The Board has Consultants in Public Health Medicine who are appropriately trained to convene and chair a Scientific and Technical Advisory Committee (STAC) in the event of a HAZMAT/ CBRN incident.
22.3	Appropriate HAZMAT/ CBRN risk assessments are integrated into wider resilience risk assessments and relevant major incident exercising programmes.
22.4	There are plans/ standard operating procedures (SOP) for both improvised and clinical decontamination, which are consistent with the most recent national guidance[11] [12]. The plans and SOP's are tested on an annual basis.
22.5	The Boards' Decontamination Plan identifies: • Command and control interfaces • Interoperability with other relevant agencies • The process for activating staff and equipment • Decontamination sites and access to facilities • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • The process for communicating with the public and partner agencies • Access to national reserves (e.g. pharmaceutical countermeasures and/or PRPS) • How a cordon will be set up and maintained and access to the site controlled • Emergency / contingency arrangements for staff contamination • How hazardous waste will be managed • Arrangements for post stand-down debrief and processes for returning to business as usual and recovery.

[11] Initial Operating Response to a CBRN Incident. Scottish Government, July 2015.
[12] Guidance for Health Facilities on Surface Decontamination of Self-Presenting Persons Potentially Exposed to Hazardous Chemical, Biological or Radiological Substances (Scottish Government, March 2016).

22.6	A plan is in place to establish, with local planning partners, a Radiation Monitoring Unit (RMU) in line with the Scottish Government RMU Template Plan Guidance 2017.

Standard 23: The NHS Board shall undertake appropriate HAZMAT / CBRN decontamination risk assessments and take appropriate action to address the results.

Rationale/ Basis: CCA - Duty to assess risk.

	Measures of the standard/ indicators
23.1	Impact assessments of HAZMAT/CBRN decontamination of key NHS facilities have been undertaken.
23.2	Arrangements for the management of hazardous waste are in place.
23.3	There is a sufficient number of decontamination-trained staff available so that the Board has 24/7 capability.

Standard 24: The NHS Board shall have an accurate inventory of equipment required for decontaminating patients and retain appropriate equipment for the safe decontamination of patients and protection of staff. It shall also maintain an accurate inventory of any local stockpile of Scottish Government CBRN countermeasures, such as chemical pods.

Rationale/ Basis: CCA – Emergency preparedness. *Guidance for Health Facilities on Surface Decontamination of Self-Presenting Persons Potentially Exposed to Hazardous Chemical, Biological or Radiological Substances* (Scottish Government, March 2016).

	Measures of the standard/ indicators
24.1	There is an up-to-date inventory of decontamination equipment, and a named role is responsible for routinely checking stock and equipment.
24.2	The Board has the number of Powered Respirator Protective Suits (PRPS) (sealed and in date) specified by Scottish Government available for immediate deployment if necessary.
24.3	A plan and finance are in place to support revalidation PRPS suits in line with the Manufacturer's advice, so that suits are available through to the end of their shelf life.
24.4	Routine checks are carried out on the decontamination equipment and there is a named role responsible for ensuring these checks take place.
24.5	There is a timely and accurate response to the Scottish Governments' annual CBRN

	countermeasures stock assurance process.

Standard 25: The NHS Board shall implement a programme of HAZMAT / CBRN Decontamination training to enable it to deliver the assessed level of capability.

Rationale/ Basis: Cabinet Office National Risk Register For Civil Emergencies, 2017 Edition.

	Measures of the standard/ indicators
25.1	There is a Decontamination Training Lead and a sufficient number of 'trained' Decontamination Trainers to fully support the staff training programme.
25.2	Internal training is based upon current good practice and uses validated training material such as the Initial Operational Response DVD[13].
25.3	There is a documented training (including refresher training) programme and a record of staff trained.
25.4	Established system for refresher training and staff that are CBRN Decontamination trained receive refresher training within a reasonable time frame (annually).
25.5	A range of staff roles are Decontamination trained.

[13] http://naru.org.uk/videos/ior-nhs/

CONTEST *(See appendix)*

PREVENT

Standard 26: The NHS Board shall have a plan that clearly sets out how it will work with delivery partners, specifically Health and Social Care Partnerships, to meet the objectives of Prevent and fulfill its statutory duties.

Rationale/ Basis: The Counter Terrorism and Security Act 2015 places a statutory duty on all NHS Boards to have, in the exercise of their functions, "due regard to the need to prevent people from being drawn into terrorism". The priorities and expectations of NHS Boards are highlighted in Playing Our Part, Scottish Government Guidance published in 2015. Similar guidance is available for local authorities.

Measures of the standard/ indicators	
26.1	There is a designated a Prevent Lead who is appropriately authorised and resourced to ensure the organisation's effective performance in relation to Prevent, including having arrangements in place to • Monitor incidents and referrals, collate information and report to SG Health Resilience Unit on a quarterly basis; • Learn from practice experience; • Capture staff perceptions and experience of Prevent.
26.2	There is a clear and agreed protocol between the Board and local Health and Social Care Partnership(s) that clarifies roles and responsibilities of each entity and mutual expectations.
26.3	There is evidence of partnership working and engagement with relevant agencies, especially the local Health and Social Care Partnership(s) (HSCPs), at strategic and operational levels.
26.4	The Prevent Implementation Plan identifies actions and activities aimed at delivering the *Prevent* objectives in line with Playing Our Part (2015), including • The priorities; • Assigned lead roles and responsibilities; • Communicating the objectives / priorities to staff.
26.5	There is a programme to deliver appropriate awareness-raising training for staff (within the NHS Board and the local HSCPs) including eLearning and Workshop to Raise the Awareness of Prevent (WRAP) sessions, and monitor, record and report on the uptake on a quarterly basis.
26.6	There is a sufficient pool of accredited WRAP facilitators / trainers within the NHS Board to meet training needs of staff within the NHS Board and the HSCPs.

***PROTECT** (Also see Critical Infrastructure standard)*

Standard 27: The NHS Board shall take appropriate and proportionate action to promote security and counter-terrorism awareness within its workforce.

Rationale/ Basis: One of NHSScotland's Quality Ambitions – *Safe,* (Quality Strategy) is to ensure healthcare environments are safe and secure at all times for the delivery of patient services. Furthermore, security services[14] continue to highlight the need for employers to be alert to threats which potentially arise from inadequate supervision and management of people, facilities, (technological) equipment.

	Measures of the standard/ indicators
27.1	An assessment of workplace security and safety is undertaken as the first step in identifying high-risk locations from people and operational standpoints.
27.2	There is a proactive programme of measures to help staff understand the threat from terrorism and to enable them to recognise and report suspicious activity. Such programmes are monitored by the Board's Resilience/CC Committee and have due regard to equality and diversity issues.
27.3	Awareness-raising packages / programmes such as Stay Safe, Run, Hide, Tell, Argus and/ or Griffin are implemented with advice from Police Scotland local Counter Terrorism Security Advisers.
27.4	There is a protocol / procedure outlining the role of staff in securing hospital premises in the event of the national security threat-level being raised to 'Critical'.
27.5	Proactive measures are implemented to ensure staff have and wear employer-issued photographic identity cards at all times whilst at work or on business.

[14] CPNI Insider Data Collection Study; Report of Main Findings, April 2013

***PREPARE** (Interim Standards)*

Standard 28: The NHS Board (Category 1 Responders) shall maintain an overview of terrorist threats at national and local levels and collaborate with other statutory agencies and Scottish Government to plan for the consequences of terrorist incidents.

Rationale/ Basis: Cabinet Office National Risk Register For Civil Emergencies, 2017 Edition.

	Measures of the standard/ indicators
28.1	The NHS Board has a Director-level 'Contest Lead' who participates in the local multiagency Contest Group, reports to the Board's Resilience/CC Committee on key issues and monitors the appropriateness of the organisations overall response capability and preparedness for threats identified.
28.2	Appropriate and effective arrangements are in place to enable the Chief Executive and/or the Contest Lead to disseminate restricted / sensitive security information from Police briefings to relevant senior managers in the Board and local the Health and Social Care Partnership(s) in a timely manner and on a need-to-know basis.
28.3	Arrangements are in place to ensure that security within healthcare facilities / premises reflect the prevailing national (UK) threat level for the benefit of staff and patients. These arrangements are: • In line with the Scottish Government Health Resilience Unit Draft Guidance 'Preparedness For An Increased Threat Level', April 2017; and • Reviewed and/or tested at least on a 6-monthly basis.

Standard 29: The NHS Board (Category 1 Responders) shall maintain operational capability to respond to the consequences of terrorist incidents resulting in mass casualties.

Rationale/ Basis: The increased frequency of various types of terrorist incidents in the UK and Europe during 2017/18 resulted in a range of mass-casualty scenarios. They highlighted the capacity and capability challenges for health and social care services and the need to maintain a constant level of organisational preparedness and resilience. Cabinet Office National Risk Register For Civil Emergencies, 2017 Edition; NHSScotland Mass Casualties Incident Plan for NHS Scotland, Scottish Government, 2015.

	Measures of the standard/ indicators
29.1	The Major Incident plan identifies how receiving hospital/ acute services' operational capability will be scaled up and/or modified to respond to the demands of a mass casualties incident.
29.2	There is a robust and timely process to identify lessons following terrorist related incidents in the UK, and to review / revise the Boards' capability, SOP's, training and

	interoperability arrangements: • Lessons identified in debrief reports following recent terrorist incidents in the UK have been taken into account / acted upon.[15] [16]
29.3	There is an up-to-date register of the Boards' assets that can be deployed to a terrorist-related mass casualties incident.
29.4	Clinical staff have been made aware of national guidance regarding Crown Office requirements in relation to retention and safe storage of material for evidential purposes (regarding body parts and other possessions of live people) in the event of Mass Casualty/Fatality Incidents[17].
29.5	There is an up-to-date policy and procedure for deploying suitably trained staff to Marauding Terrorist Firearms Assault (MTFA) incidents requiring specialist capability.
29.6	There is a procedure for (hot and cold) debriefing (See 9.7) of staff following each terrorist related incident deployment, and reporting the outcomes to the Executive Director for Resilience and/or the Resilience Committee.

Standard 30: The NHS Board (i.e. Category 1 responders) shall maintain an appropriate number of staff trained to respond to a terrorist related incident at scene (with a corresponding safe system of work) when necessary.

Rationale/ Basis: Cabinet Office National Risk Register For Civil Emergencies, 2017 Edition.

	Measures of the standard/ indicators
30.1	All staff deployed to a terrorist-related incident as part of the organisations capability must have undergone appropriate selection and training to ensure their competence, and be provided with post–incident debriefing and support.
30.2	There has been a recent audit of special skills required (e.g. surgical skills to deal with numerous patients with high velocity weapons / bomb-blast injuries) to respond to consequences of terrorist incidents, and there are arrangements for gaining access to them if necessary.
30.2	Comprehensive training records are maintained for each member of staff included in the organisations terrorist–incident specialist capability, including: • A record of training completed with date of completion/ due to be completed.

[15] Enhancing the Resilience of the NHS: Preparing For Beyond Day 1- Report of National Seminar, 9 June 2016.
[16] Reports of Seminars following London and Manchester Terrorist Incidents (OFFICIAL SENSITIVE), circulated to NHS Boards on 6 July 2017.
[17] http://www.sehd.scot.nhs.uk/cmo/CMO(2010)28.pdf

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SECTION 7

DIGITAL HEALTH

This section sets out standards to ensure the Health Board's Information and Communication Technology systems are sufficiently robust and secure.

Standard 31: The NHS Board shall have adequate information security management arrangements that conform to NHSS Information Security Policy Framework (2015), GDPR, Cyber Essentials and the NIS Directive and it shall have an appropriate level of resilience within its Information and Communication Technologies (ICT) service portfolio.

Rationale/ Basis: NHSS Information Security Policy Framework (2015); Data Protection Act (1998); Data Protection Bill (2017), and GDPR (2018) – the technical and other measures to obtain the right level of information security for safeguarding Personal Data; and, the NIS Directive (2018) – Security of the Network and Information Systems which applies to the health sector as an 'operator of an essential service'.

	Measures of the standard/ indicators
31.1	There is evidence of Leads for eHealth, Information Governance/Security and Resilience/Civil Contingencies collaborating to • Identify information assets and services of value; • Develop and maintain a high-level Information Asset Register with clearly identified owners; and • Reporting this information to the appropriate governance structure.
31.2	There are up-to-date policy/procedures for management of information assets (paper or electronic info assets) life cycle across Board.
31.3	There is a record of reported compliance breaches, disruptive incidents and lessons identified following a review of the breaches/incidents. The lessons and actions taken or to be taken to address them (with timescales) is reviewed by the Resilience / CC Committee and /or the appropriate eHealth governance structure.
31.4	The ICT Asset Register is reviewed and updated on a quarterly basis by the Board's Resilience/CC Committee.
31.5	The criticality of a subset of the ICT assets /services has been identified and an appropriate level of resilience developed to protect them. This includes having: • An up-to-date list of critical systems; • Undertaken a risk assessment for each system; • Documented security controls for each system.
31.6	There is a clear understanding of the level of resilience within the Board's overall ICT service portfolio i.e. evidence of overall ICT portfolio risk position and an aggregated

	ICT portfolio risk assessment, and there is a corporate plan to mitigate identified risks.
31.7	All Service Departments have ICT BC plans to prevent serious disruption to clinical ICT applications, including reactive and proactive measures to recover after a serious incident occurs. For ICT management purposes, the BC plans identify which ICT service the Department has a high-dependency on including: • Clinical Applications (e.g. PAS, PACS); • Non-clinical Applications (e.g. Finance system, HR /Payroll system); • National IT Services (e.g. Internet, Network, NHSMail). There is an up-to-date list of Departments within the Board with and without corresponding BC plans (including date of last review).
31.8	Working with ICT Management, Service Departments clearly understand the level of resilience that is currently available within the Board's ICT service provision including 1. If the service fails, o What measures are available to mitigate loss; o How long it should take for it to be restored and at what point it should be restored (recovery time and recovery point objectives); and o How the service loss incident should be managed. 2. When the service returns, o Identifying lost or corrupted data o Identifying whether information needs to be re-keyed. There is an up-to-date record of disruptive incidents affecting each Department, lessons identified and remedial action taken.
31.9	There is a framework to ensure that future investments in IT resilience are focused on areas of high-priority from a BC perspective, and evidence that planning and investment in ICT resilience are aligned with identified high priority areas.
31.10	Managers are made aware of the national reporting arrangements and thresholds for reporting ICT outages to Scottish Government eHealth and Health Resilience Units, and timely reporting takes place. There is a record relevant incidents reported to Scottish Government eHealth Unit.

Standard 32: The NHS Board shall develop and implement awareness-raising programmes that alert staff to the information security risks and encourage them to adopt safer practices in relation to information handling and the equipment used on-site and off-site.

Rationale/basis: Data Protection Act (1998); Data Protection Bill (2017). Cyber security (especially external human attackers exploiting interactive networks/Internet connectivity) is identified as a national threat.

	Measures of the standard/ indicators
32.1	Information security staff awareness-raising initiatives are implemented at least annually, and there is an Information Governance and Security awareness/training plan to ensure this happens. The plan covers different training levels according to staff roles and its performance / delivery of plan is monitored and reported to the Resilience/CC Committee.
32.2	A gap analysis has been carried out on the sub-set of security controls that mitigate the risks in relation to ICT and the outcome reported to Scottish Government eHealth.

Standard 33: The NHS Board shall ensure that its telecommunications systems and arrangements to be implemented in emergency situations are fit-for-purpose and ready to be used by trained staff.

Rationale/ Basis: CCA – Emergency preparedness; Preparing For Emergencies Guidance. NIS Directive (2017). Effective and resilient telecommunications systems are essential in enabling C3 groups to communicate with key personnel internally and externally during a major incident.

	Measures of the standard/ indicators
33.1	Appropriate telecommunications systems (e.g. Airwave, MTPAS) are available and accessible to staff who may need them with accompanying protocols for their use.
33.2	Competence of all staff who may be called on to fulfil a C3 function (Standards 11 and 13) in an emergency situation is regularly monitored.
33.3	The functionality of the equipment is regularly tested / reviewed.

SECTION 8

HUMAN CAPITAL

This section sets out standards aimed at ensuring the competence and wellbeing of staff.

Standard 34: The NHS Board shall have a robust management and support framework that enables its Resilience Lead(s) to work effectively and continuously develop skills in line with the competences required.

Rationale/ Basis: NHS Reform (Scotland) Act 2004. NHS Scotland Staff Governance Standard: A framework For NHSScotland organisations and Employees. Staff who are well informed, appropriately trained and sharing best practices, can influence and deliver services to the best of their ability in the changing health care setting.

	Measures of the standard/ indicators
34.1	Resilience Leads / staff are suitably qualified and experienced to deliver the resilience functions.
34.2	Resilience Leads / staff are provided with opportunities to undertake competency based training, and to participate in appropriate learning and continuous professional development programmes.
34.3	Resilience staff keep themselves up to date with developments in the Resilience field.
34.4	Regular support and supervision are provided for resilience staff.
34.5	Resilience staff have an annual work programme that is consistent with the priorities of the Boards' Resilience Plan and the needs of the organisation. Their annual work programme is endorsed by the Chair of the Board's Resilience/CC Committee.
34.6	Resilience staff are aware of Board policies that are relevant to the organisation's resilience and of organisational / changes and developments so that they can ensure BC plans are kept up-to-date.
34.7	Resilience staff are actively encouraged and supported to work across departmental and organisational boundaries, and are actively engaged in promoting resilience-related work in specialist areas such as Facilities, IT, and Procurement.
34.8	Resilience staff are provided with a continuously improving and safe working environment that promotes their health and wellbeing.

Standard 35 : The NHS Board shall have in place robust arrangements to secure the health, safety and wellbeing of all staff called upon to respond to major incidents.

Rationale/ Basis: CCA-Care For People; Health and Safety at Work Act 1974.

	Measures of the standard/ indicators
35.1	The roles and responsibilities staff are expected to undertake / as part of a major incident response / SOP's have been risk assessed.
35.2	Appropriate governance arrangements (covering for example role definition, training, accountability) are in place for staff involved in responding to major incidents.
35.3	Arrangements are in place to debrief staff following deployment to a major incident.

Standard 36: The NHS Boards shall have arrangements in place to provide timeous and confidential support to staff after they have been deployed to a major incident.

Rationale/ Basis: Preparing Scotland, Care for People Affected by Emergencies, Scottish Government, 2009; Preparing For Emergencies Guidance, 2013; Preparing Scotland, Planning for the Psychosocial and Mental Health Needs of People Affected by Emergencies, 2013.

	Measures of the standard/ indicators
36.1	The Human Resources (HR) Department and Occupational Health (OH) provider have been made aware of the characteristics of post-traumatic stress and have protocols in place for referrals to specialist services where necessary.
36.2	HR, OH and other key staff are trained in Psychological First Aid.
36.3	All service managers likely to be involved in a major incident response are made aware of Psychological First Aid as an intervention, and how to access training.

Standard 37: The NHS Board shall inform its employees of its overall resilience objectives and Business Continuity plans, and raise awareness of their roles and responsibilities in delivering them.

Rationale/ Basis: CCA – Warning and Informing duties. Staff engagement potentially raises ownership of and commitment to Business Continuity planning.

	Measures of the standard/ indicators
37.1	The Human Resources Department is actively engaged in the Board's Resilience /

	Civil Contingencies Committee, supports the delivery of resilience objectives and the roll-out of relevant information to the workforce.
37.2	Information is disseminated to staff on what to do in the event of travel restrictions due severe weather and/or other business continuity disruptive events.
37.3	Staff are made aware of the need for security vigilance and how to report concerns in a confidential manner.
37.4	There are effective means of communicating with staff working on site or remotely during significant major incidents or national security alerts.
37.5	A summary of the Board's Resilience Plan and departmental business continuity plans are accessible to staff.

SECTION 9

CLIMATE CHANGE

This section sets out a standard to enable NHS Boards to begin to address the effects of climate change. The standard links with the standard on Critical Infrastructure in Section 6

Standard 38: The NHS Board shall develop a robust approach towards implementing a range of actions to assure the continuity of quality healthcare services before, during and after extreme weather events.

Rationale/ basis: The impacts of climate change are expected to grow more severe in the coming decades. In recent years, severe weather has severely disrupted NHS and other key services across the UK. The Public Bodies Climate Change Duties (section 44 of the Climate Change (Scotland) Act 2009) encourage public sector agencies to work together to address the risks.

	Measures of the standard/ indicators
38.1	The impacts of past severe weather events on the organisation / services have been identified and 'Lessons' from NHS Board and partner-agency debriefs on weather-related events are used to revise relevant organisational policy, processes and training.
38.2	The role of healthcare services during and after identified extreme weather events is understood, and this knowledge is used to inform resilience plans.
38.3	A Climate Risks and Vulnerability Assessment has been undertaken to assess current climate risks and those that are predicted to increase due to climate change; this information is used to inform healthcare services and infrastructure planning. Actions to reduce risks have been incorporated into risk management and reporting procedures and / or a climate change adaptation plan.
38.4	There is a catalogue of land use, building design and regulatory context for health care facilities. Site improvements and building structures are assessed for their ability to withstand extreme weather events now and in the future.
38.5	Consideration is given to the larger local and community land use vulnerabilities that may impact on healthcare facilities in the face of extreme weather such as aging or inadequately sized infrastructure or the removal of natural buffers.
38.6	Infrastructure resilience measures are implemented to reduce disruption, incapacitation or loss of use of critical health care facilities. Arrangements are in place for the safe closure of less critical facilities prior to an extreme weather event with the ability to resume services within 48 to 96 hours after it terminates.
38.7	Plans are in place to ensure that essential clinical services remain operational during and immediately following extreme weather events, including handling of patient care surges related to the weather event.
38.8	Consideration is given to the non-traditional disaster response role of community

	healthcare settings, such as sources for clean water, food, and shelter for an affected population, and plans are in place to provide a healthcare response to people in the community following extreme weather events, especially those who are vulnerable, as part of the local multiagency recovery plan.

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SECTION 10

SUPPLY CHAIN

This section sets out a standard to ensure the resilience of NHS Boards supply chains.

Standard 39: The NHS Board shall have a schedule for reviewing the resilience of its main suppliers and implement appropriate risk mitigation measures for their loss.

Rationale/ basis: Extreme weather events and industrial action are amongst the two most significant causes of supply chain disruption and potentially threaten business continuity. Loss of a supplier can have a massive business continuity impact on the organisation. It is important that NHS Boards understand that they may be held responsible for business continuity disruptions that they have been exposed to, but have been caused by their suppliers; thus highlighting that while certain activities may be outsourced, the risk is not.

	Measures of the standard/ indicators
39.1	There is effective and proactive engagement between the Boards' Resilience and Procurement Leads with the former being involved in the early stages of a procurement / commissioning process (to advise on the appropriateness of supplier business continuity plans / risk mitigation activities) and contract review processes.
39.2	There is a clear understanding of the organisations' supply chain resilience and an assessment of risk exposure has been carried out, documented and reported to the Board's Resilience / CC Committee. Appropriate risks are recorded on the Board's Risk Register.
39.3	There are up to date Business Continuity (BC) plans to mitigate the effects of a range of supplier disruptions such as fuel, utilities etc.
39.4	There is a proactive channel of communication and liaison between the Board and its key suppliers so that both parties are kept aware of each other's current challenges and risks, and can make the necessary advanced preparations.

SECTION 11

PUBLIC RELATIONS AND COMMUNICATION

This section sets out standards for ensuring the resilience of internal and external communication arrangements.

Standard 40: The NHS Board shall have robust and effective arrangements in place to warn and inform the public and patients during major/business continuity incidents.

Rationale/ Basis: CCA – Duty to communicate. Preparing For Emergencies Guidance 2013.

	Measures of the standard/ indicators
40.1	There is a communication plan that is periodically tested and which takes into account lessons identified by reviews of previous major incident and exercises. The plan: • Identifies internal and external communication arrangements that will be implemented during major/Business Continuity (BC) incidents; • Has been developed in conjunction with the Regional Resilience Partnership; • Has been assessed against the Board's Equalities and Human Rights duties.
40.2	A Communications Lead actively participates in the local RRP multi-agency public communications group.
40.3	Staff are made aware of their roles and responsibilities and the procedures in relation to media handling during major/BC incidents, and have received appropriate competency-based training.
40.4	Optimum and effective use is made of social media platforms. (Staff are made aware of their responsibilities under the Board's Data Protection policies in relation to the use of messaging apps during major/BC incidents).
40.5	Arrangements are in place to ensure the Board can communicate internally and externally during ICT equipment failures.
40.6	Arrangements are in place to clearly identify how and when NHS 24 helplines and (social) media outlets will be used during major/BC incidents. Pre-prepared information resources (standard messages) for various types of incident scenarios are available and a protocol has been agreed with NHS 24 as to how they will be pushed out to the public / patients.
40.7	Suitably equipped space is designated for use as a Media Centre during major incidents, with the objective of protecting patient's and staff's right to privacy.

Standard 41: **The NHS Board shall have effective arrangements for communicating and sharing information with appropriate statutory/Regional Resilience partners.**

Rationale/ Basis: CCA – Information Sharing between responders. Information is an integral part of civil protection and interagency cooperation.

	Measures of the standard/ indicators
41.1	The role of the Caldecott Guardian is clearly identified in the information sharing protocol in relation to advising staff on sharing sensitive or confidential information.
41.2	Information sharing protocols have due regard to the Boards duties under the Data Protection Act 1998, GDPR and the Freedom of Information Act 2002.

Appendix

Information about Contest

CONTEST is the UK's counter-terrorism strategy. It deals with all forms of terrorism and is based on four main strands: Pursue, Prevent, Protect and Prepare which together aim to reduce the national threats and vulnerabilities. The NHS plays a key role in the latter three 'P' strands.

The CONTEST framework sets out strategic objectives and priority activities in response to changing threats. The rapid change in the extent and types of terrorist threat means that work has to continually adapt.

The Counter-Terrorism and Security Act 2015 enhances the role of various statutory organisations, including the NHS, to counter extremism and terrorism:

Prevent: places a duty on the NHS and local authorities to prevent people being drawn into terrorism;

Protect: promotes increasing the resilience of critical infrastructure; and

Prepare: promotes building generic capabilities to respond to and recover from a wide range of terrorist and other civil emergencies; improving preparedness and capabilities for the highest impact risks in the National Risk Assessment.

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