NHS Guidance on Planning for Disruption to Road Fuel Supply

Strategic National Guidance for NHS Organisations
The aim of this guidance is to assist NHS organisations when preparing their business continuity plans for local or national disruption to road fuel supply in order to minimise the impact upon the safe and effective delivery of health and social care services.
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Foreword

Past events in the UK, most recently the industrial disputes in 2008 involving the temporary closure of the Grangemouth oil refinery and the strike by tanker drivers, have demonstrated that there is a clear risk of the country experiencing a period of significant disruption to its supply of road fuel. Industrial action is just one of a number of foreseeable scenarios that might prevent users from accessing fuel when and where they need it. Given the dependence of the NHS on road fuel in many aspects of service delivery, any widespread and prolonged fuel supply disruption has the potential to directly impact the ability of the NHS to provide the levels of patient care that the public normally expect of it.

This Guidance is intended to assist NHS organisations in making preparations for road fuel shortages so that the impact on patients and normal business is minimised so far as is possible and practical, while identifying steps that can be taken to reduce the quantity of fuel used. Such plans must also consider how care provision could be scaled back in a safe and prioritised manner should the fuel shortage become so acute that maintaining normal levels of service is unfeasible. Planning of this kind should represent an extension of business continuity management that most NHS organisations are obliged to perform under the Civil Contingencies Act 2004.

Additionally, the Guidance provides a background to the measures that could be put in place to protect fuel supplies for designated essential users (including some key NHS services), should the situation become serious enough to warrant the use of the emergency powers at the government’s disposal under the Energy Act 1976. The full details of these measures are contained in the Department for Energy & Climate Change (DECC) National Emergency Plan for Fuel (NEP-F)\(^1\), which sets out the cross-government plans for dealing with a national fuel crisis. This Guidance is intended to act as a supporting document to the NEP-F, providing tailored advice and support to the healthcare services in recognition of the criticality of the NHS and the scale and scope of its dependencies on fuel.

Development of the guidance has been achieved with the support from stakeholders from across the NHS (including Monitor), as well as central and local government bodies. I would like to offer my personal thanks to all of those who have contributed their time, commitment and knowledge to this development process.

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\(^1\) Formally issued by the Department for Business, Enterprise and Regulatory Reform (BERR)
Introduction

1. This document gives interim guidance to National Health Service (NHS) organisations to assist with their business continuity management (BCM) planning in response to a reduction of the normal availability of road fuel, from a minor disruption through to the activation of the National Emergency Plan – Fuel (NEP-F) 2008. This guidance follows on from the NHS Resilience and Business Continuity Management Guidance 2008 and should be used in conjunction with the NHS Emergency Planning Guidance 2005. It is subordinate to the Department for Energy and Climate Change’s (DECC) NEP-F, which is currently undergoing further review. An official summary of the NEP-F for ease of reference is at Appendix 1. It should also be noted that another document from DECC, ‘Business Continuity Planning for Fuel Shortages, Guidance for Organisations’, is currently in production.

2. A restriction of the normal supply of road fuel will pose a great challenge for the NHS and its duty of care responsibilities. In certain circumstances restrictions or limitations to normal standards of care will be inevitable despite extant BCM plans. However, robust and well thought through plans will allow organisations to prioritise and, if the situation demands it, scale back care provision in a planned and considered way. The impact of this scaling back will be felt by individual patients across the primary care, social care and acute care sectors and it is acknowledged that reduced provision in a single area may impact across the whole health system. This is where Strategic Health Authorities (SHAs) will be required to support their regions’ decision-making process and play a key leadership role in determining priorities based upon local circumstances. SHAs will also have to play a key leadership role during the recovery phase.

3. This guidance, therefore, is intended to provide a platform for all NHS organisations to undertake planning and to provide information on associated activities that may also be required. In the context of this Guidance, the term NHS organisation includes Foundation Trusts (FTs) and other National NHS bodies directly or indirectly responsible for the delivery or management of health and social care.

4. The NHS Emergency Planning Guidance 2005 gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a Major Incident Plan in place that is built upon the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. Their plans should link into the organisation’s arrangements for ensuring business continuity as required by the Civil Contingencies Act (CCA) 2004. SHAs and Primary Care Organisations (PCOs) will need to ensure that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances. Appendix 2 to this document captures the NHS’ current roles and responsibilities plan for ease of reference.

5. Whilst it is ultimately the responsibility of Chief Executives at the local level, the NHS Chief Executive has final responsibility for the NHS as a whole and therefore will need to be assured that NHS organisations are suitably prepared and resilient to the disruptive challenges that a road fuel shortage would bring. The responsibility for providing this reassurance will be through SHAs.
6. All material forming this guidance is web-based and prepared to be used primarily in that format. The web-based version of the guidance, including underpinning materials, have links to complementary material from other organisations and to examples of the practice of and approach to business continuity planning in the NHS in England. The web version of the guidance is available at www.dh.gov.uk/emergencyplanning.

7. This Guidance is built upon best practice and shared knowledge, and contributions from strategic health authority emergency planning leads and their regional NHS organisations are gratefully acknowledged.

Aim

8. The aim of this interim guidance is to assist NHS organisations when preparing their business continuity plans for a local or national disruption to road fuel supply in order to minimise the impact upon the safe and effective delivery of healthcare services.

Objectives

9. In accordance with the NEP-F, this Guidance will focus on eight key objectives:

a. Develop specific guidance to assist NHS organisations in understanding their responsibilities to be resilient to road fuel disruption.

b. Develop a strategy at local and regional level (with consideration to the NEP-F) to identify functions/personnel who are vital to the delivery of healthcare services and systems who will require priority access to any available road fuel.

c. Ensure all NHS organisations and their staffs understand the legal limitations of the priority user scheme and the obligations the NHS has to reduce its use of road fuel during periods of disruption.

d. Develop and promote a road fuel reduction scheme, which can be implemented during a crisis for the benefit of resilience, but which should also form part of NHS organisations’ longer-term sustainability plans.

e. Ensure NHS organisations identify critical suppliers and service providers who may be affected by disruption to road fuel supply and, where appropriate, provide support, in association with Local Authorities, to these organisations to achieve robust business continuity plans.

f. PCTs to work with local independent contractors (GPs, Pharmacists etc) to encourage the development of road fuel resilience plans.

g. SHAs to provide direction and leadership across the regional health economy to ensure robust plans are in place in the event of a disruption to the normal supply of road fuel.

h. Develop a process by which centrally contracted critical healthcare services are assessed, and agreed, as being suitable to be included on DECC’s NEP-F Utilities Fuel Scheme. This should include an estimate of the fuel consumption.
10. Areas not included in this guidance are:
   b. The central holding of, or management of, an NHS Priority Users list.
   c. Planning for ‘home to work’ journeys.
   d. Disruption to Heating Oil supply, which will be covered in a separate guidance document.

Background

11. The NEP-F was revised in May 2008, and is due to be updated in early 2009, to take account of recent incidents affecting fuel disruption. The NHS, as part of the UK Critical National Infrastructure (CNI), and a large national employer, has collectively identified a large number of priority users from a diverse number of specialisms who will require access to road fuel in accordance with the NEP-F. However, as a large public sector organisation, during periods of fuel disruption the NHS also has an obligation under the NEP-F to reduce its fuel usage through ‘demand calming measures’. Under the Energy Act 1976 certain journeys, such as home to work, are not included under the Emergency Powers (within the Energy Act 1976) during a period of the disruption. Therefore, plans must incorporate these constraints and be included as base line planning assumptions. Whilst the DH Emergency Preparedness Division (EPD) has an England only remit, this guidance reflects the fact that the NEP-F is a national document and the health care systems are different between the four countries of the UK.

12. The disruption to road fuel supply may come from several causes; therefore the aim of this guidance is to give clear advice to NHS organisations to maintain, where practicable, the continuous operational delivery of healthcare services. Forming part of the NHS Resilience BCM project, this road fuel disruption guidance is a key element of the Government Capabilities programme led by the Civil Contingencies Secretariat, and will ensure NHS compliance with the BCM of the CCA 2004. The CCA 2004 requires Category 1 responders to maintain plans to ensure that they can continue to exercise their functions in the event of an emergency so far as is reasonably practicable.

13. The underlying principle of this guidance is to build upon the existing NEP–F and lessons identified from the recent disruption to fuel supplies during the Grangemouth Refinery closure and the Hoyer Tanker Drivers dispute and recent training exercises.

Warning and Escalation

14. In the event of a minor fuel disruption, NHS organisations are to advise staff about responsible purchasing of fuel and fuel conservation as well as cascading central government messages to staff. In the event of major, ongoing disruption to the supply of fuel the government may introduce emergency powers and implement the NEP-F in

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2 The NEP-F only covers England, Scotland and Wales. Northern Ireland has its own fuel resilience plan.
order to both conserve fuel and ensure that priority services and infrastructure are maintained. Within this plan are contingencies to restrict the amount of fuel accessible to the public and to ensure that the emergency services are supplied with fuel to provide their services. The impact of any disruption to road fuel availability will be continually assessed by NHS organisations and it may be necessary to scale down or stop certain activities.

Case Study – Impact on fuel supplies following Hurricane Katrina

Following the devastation caused by Hurricane Katrina (USA), one of the most immediate issues faced by health organisations during the initial response phase of the disaster was disruption to fuel supplies. Fuel supplies were severely limited by widespread power outages and the limited transportation infrastructure within affected areas.

Most healthcare facilities in the affected areas remained operational through utilising generators for power. However, the fuel shortage led to the loss of power because generators were starting to run out of fuel. Health staff were tasked to go round all healthcare locations with a portable diesel tank, filling generators for hospitals and nursing homes 24/7.

Security issues presented a significant challenge, and as most healthcare facilities had generators and a limited power supply, displaced members of the public were drawn to healthcare centres for shelter, as people were attracted to the only lights that were on in the affected area.

Based on information provided to United States House of Representatives Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina, December 7, 2005 by Brian W. Amy State Health Officer, State of Mississippi.

The National Emergency Plan for Fuel (NEP-F)

15. The Department of Energy and Climate Change (DECC) is the lead Government department for coordinating the response to a significant disruption to supply or demand patterns in the downstream oil sector in the United Kingdom. DECC has developed with key stakeholders the NEP-F.

16. The NEP-F identifies how the resources of the downstream oil industry and the Government can be used and identifies the command structure and teams available to provide leadership and industry knowledge to enable the Government to select and use one or more appropriate emergency response tools to manage any significant disruption. The aims of the NEP-F and the emergency arrangements in place within DECC are consistent with the Cabinet Office “Concept of Operations”.

Maximum Purchase Scheme (MPS)

17. The MPS is a process designed to restrict retail customers to a maximum purchase limit of 15 litres (approximately three gallons\(^3\)) of fuel at any one purchase and will be

\(^3\) For getting staff to work planning assumptions, assuming an average fuel consumption rate of 25 miles per gallon across all fuel, driving and vehicle types, this gives an average 75 mile limit on a single fill up.
operated by the Government under the provisions for the implementation of Emergency Powers contained in the Energy Act 1976. This purchase limit may need to reduce further if the situation deteriorates. This is likely to have an immediate effect upon the ability of some NHS staff to travel to work in competition with their personal lives. This may have a greater effect on those workers who live long distances from work and particularly those who live in the rural community. In addition, NHS organisations should also be aware of the possible restricted hours during which filling stations may be open and selling fuel.

18. It is recommended that plans should be exercised in order to gain a better understanding of the effects on operations this may have. In mitigation, and subject to legal and local governance arrangements, consideration could be given to:

a. Offering temporary contracts to recently retired staff who can access the workplace more easily either through living in close proximity to the workplace or who may have fewer personal restrictions such as childcare requirements.

b. Use of new volunteers with similar circumstances to those above.

c. Offering temporary accommodation to workers to live on or closer to site.

Emergency Services Scheme (ESS)

19. The ESS is designed to ensure the emergency services are prioritised for access to any available fuel stocks in order for them to have sufficient fuel to deliver their essential services. Access will be via Designated Filling Stations (DFS). Local Resilience Forums (LRFs) are tasked with identifying DFSs and reviewing them on a quarterly basis and informing DECC. NHS organisations should regularly access this data via their LRFs in order to inform their own BCM plans.

Case Study – Identifying who has fuel and how to get it.

During the Grangemouth refinery strike action, the Scottish Ambulance Service had difficulty accessing fuel supplies, even when filling stations were still open to the public. In some cases, ambulances were re-directed to other filling stations where, on arrival, it became apparent there was no fuel available. This was despite the fact that some filling stations were maintaining buffer stocks for use by the emergency services. The problem had arisen because no one communicated this with the Scottish Ambulance Service. In reviewing this, it was recommended that until the NEP-F is activated, local ambulance service management maintains lines of communications with the fuel stations, especially those who the service regularly purchase fuel from, to ensure ambulances can access fuel that is held for emergency service use.

Scottish Ambulance Service Emergency and Risk Management Unit
Debrief from the Grangemouth Refinery Strike

20. The vehicles covered under the ESS are recognised by their logos, so no additional registration process is needed. These include, amongst others:

a. All logoed ambulances

b. Patient transport services
c. NHS Blood and Transplant
d. Other NHS logoed vehicles

21. Also included are the following voluntary organisations:
   a. Age Concern.
   b. British Red Cross.
   c. Salvation Army
   d. St Andrew’s Ambulance
   e. St John’s Ambulance
   f. Women’s Royal Voluntary Service.

22. In the event of any disruption to road fuel supply or distribution, the NHS will have to report its fuel requirements over a given period in order to maintain the delivery of healthcare. Therefore, NHS organisations need to be prepared to monitor and declare usage across their regions to regional resilience structures and the DH Major Incident Co-ordination Centre (MICC) via SHAs. Whilst the exact reporting route is being developed further by DECC, Cabinet Office and DH, NHS organisations should continue to provide exception reporting to SHAs via the normal NHS reporting mechanisms used locally. In order to reduce the burden of completing the information on different forms, the SitRep form, included in the NEP-F and completed by Regional Resilience Teams at Government Offices, also includes a health section which is to include ‘exception reporting’ of problems or concerns due to fuel disruption by NHS organisations. This form should then be sent by the SHAs to the DH MICC at the same time it is forwarded to Cabinet Office Civil Contingencies Secretariat (or COBR if convened).

Defined Essential Users

23. NHS organisations will retain local determination over what constitutes their other critical non-blue light functions and how they are organised and delivered during any disruption to road fuel supplies and this is to be monitored by SHAs. However, it is anticipated that as any fuel crisis escalates to the point where stocks are extremely limited, DH guidance to NHS organisations for defining essential users/functions, in priority order, should be followed and is based upon:

   a. Activities to reduce mortality, morbidity and significant progression of disease.
   b. Activities that will alleviate human suffering, including palliative care.
   c. Activities that meet any legal obligations, such as those contained in The Children Act 2004, Mental Health Act 2007 and others.
   d. All other emergency clinical and social services.
   e. All other routine clinical and social services.
   f. All other functions and services.
24. In order to access fuel via the ESS, NHS organisations need to predetermine what their priority functions are and who requires fuel to deliver them in order to assist with planning assumptions. However, it is recognised this could change as the fuel shortage situation develops. This includes NHS priority users and their designated vehicles, which may or may not be existing NHS liveried vehicles, as well as essential support or contract staff and their vehicles.

25. Some aspects of healthcare services, including those delivered by independent contractors, may have specific regulatory obligations to maintain in order to complete their function. These issues should be identified by PCTs, as part of the Business Impact Assessment (BIA) process, to ensure mitigation strategies can be developed.

### Case Studies - Maintaining Critical Supplies from Smaller Contractors

All Trusts rely on a number of suppliers to provider goods and services to the organisation. A high percentage of these will be small and medium sized enterprises (SMEs). As most SMEs are also local businesses (including in some cases local Pharmacists), it is important the NHS engages with these businesses during the planning stage to ensure Business Continuity Management (BCM) plans take account of fuel supply disruption. Whilst it will not be for the NHS to provide BCM for SMEs, it would be beneficial to ensure the full impact of any loss of fuel is understood by both parties. Under the Civil Contingencies Act, Local Authority Emergency Planning Units are responsible for providing general BCM advice to local businesses. Working in partnership with these units, NHS Trusts can help build resilience in its supply chain, whilst helping local businesses to continue to operate through the fuel shortage and beyond. Further information can be found at the Cabinet Office Civil Contingencies Secretariat (CCS) website [www.ukresilience.org.uk](http://www.ukresilience.org.uk).

**Department Health/Cabinet Office Civil Contingencies Secretariat**

**Debrief following the Hoyer Tanker Drivers Dispute**

26. Whilst acknowledging the high number of community based healthcare workers who use their own vehicles, NHS organisations are to be robust in determining priorities as the inclusion of too many users will create further strain on already limited stocks to the detriment of other essential users. NHS organisations should maintain an estimate of fuel usage of their priority users to enable effective planning and to inform their SHA and LRF.

**Temporary Logo Scheme (TLS)**

27. The SHAs (in England) are responsible for co-ordinating the issuing of temporary logos to NHS staff. Where agreed locally, the LRFs will play a significant role in co-ordinating the issue of logos to NHS staff. Where this is the case, it will be for the SHAs to agree the staff list before passing to the LRFs. Any concerns regarding the content of this list should be referred, in the first incidence, to the SHA.

28. In order to access fuel under the ESS, those personnel who have been designated

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4 Further work is on-going between DECC and Cabinet Office CCS to agree the roles and responsibilities of the LRFs during fuel disruption
priority users will draw fuel from DFSs and will be identified through their NHS logoed vehicles and ID cards. Where staff have been identified as priority users are in non-NHS logoed vehicles (and it is recognised that in some organisations this may be a considerable number), a temporary logo scheme may be authorised by DECC if the situation requires it. SHAs will manage this locally in accordance with the NEP-F guidelines and ensure control registers are kept of how many and to whom they have been issued. NHS organisations should be prepared to be challenged about their use of the temporary logo scheme and overall fuel usage and should be able to justify their positions. The temporary logo template is contained within the NEP-F. NHS organisations should ensure that all personnel requiring one are also issued with an NHS ID card.

29. It is acknowledged that some personnel and NHS organisations, particularly national ones, will cross regional NHS boundaries, but as the logo is a national one this should not be an issue. Filling stations can accept logos of any region and can contact the relevant SHA/NHS national organisation, via existing on-call arrangements, in whichever county the logo originates from if there is a query. Staff making emergency journeys will need to ensure they have sufficient fuel for potential journeys in advance rather than filling up on the way to an emergency. DECC and Cabinet Office are currently refining how all users of the TLS, including the NHS, can access operational control rooms who will give advice when problems are encountered accessing fuel by the TLS.

30. NHS organisations should determine how many temporary logos they will require and how these are to be managed internally, for example, issuing one to each function/team/practice etc. SHAs and NHS organisations should also not underestimate the administrative and command and control challenges they will be faced with when introducing this scheme. It is therefore imperative that they have tried and tested their method of activation and control of this process annually.

31. NHS organisations should also, through their LRF, determine whether there are any local challenges to how priority users would pay at point of fuel purchase during the build up to or during any crisis. Fuel cards, cash\(^5\), debit and credit cards should all be usable but NHS organisations are advised to monitor this in case this changes.

32. Continuity Plans that allow NHS organisations to scale back care in a planned way in the event of a disruption to the distribution of road fuel require developing. The impact of this scaling back will be felt by individual patients but also in some instances by social care and acute care providers. Equally, pressure from acute care and social care scaling back of services will impact on primary care. It is recommended that there is recognition of the escalation process in BCM plans as it is unlikely that services would need or be able to be moved from full service to critical only without escalation steps in-between.

\(^5\) It should be noted however that throughout the UK, over the next few years, there might be a more widespread introduction of ‘pay at pump’ by card only fuel stations. This is being introduced primarily to reduce incidences of fuel theft.
Case Study - Using Existing Resources in Different Ways

During a prolonged period of fuel disruption, elective surgery and outpatient appointments may be scaled back as part of the NHS response to concentrate on urgent and emergency patient services. If this happens, it may be appropriate for Trusts to consider using the spare capacity (in both transport and scheduling resource) from within their patient transport service (PTS) provider. This may be to consider establishing a staff home-to-work transport service for those with limited access to public transport. This service may also be beneficial to other NHS staff wider than the Trust who hold/operate the PTS contract. During the Hoyer Tanker dispute, Yorkshire Ambulance Service pre-deployed mini-buses at their control centres for just such a scenario. This could easily have been used for wider NHS staff, especially in rural areas.

Mike Shanahan,
Assistant Director Emergency Preparedness – Yorkshire Ambulance Service NHS Trust

33. Temporary logos are not generally to be used to obtain fuel for the purpose of getting staff to work when public transport should be used. However, it is recognised that certain staff, such as GPs, midwives and social workers respond to calls directly from their homes so some flexibility does exist for NHS organisations to manage this within the guidelines. It is also recognised that for shift-workers and certain key independent contractors (e.g. GPs Community Pharmacists etc) living in rural areas, public transport may not always be available to allow these staff to get to work to provide their essential service. This issue should be managed locally through PCTs completing Business Impact Assessments (BIA)\(^6\), with due consideration to equity, and the need for the NHS to reduce its demand on fuel at the time of any crisis.

34. NHS organisations should not underestimate the pressure there will be on people to access sufficient fuel to go about their own daily private lives. As such they are to have robust and regularly tested procedures in place to prevent abuse of the ESS and TLS, such as drivers filling up jerry cans in addition to their fuel tanks, unless this is for essential machinery. NHS organisations should make all staff aware that abuse of their privileged position in obtaining fuel under any of the schemes within the NEP-F, is a criminal offence. This can result in offenders being prosecuted under section 18(2) of the Energy Act 1976 and be subject to any internal disciplinary procedures by their employer. Trusts should, however, have robust internal communications plans in place to ensure staff are fully aware of the seriousness of any fraudulent actions. External communication plans should also be prepared in the event this does occur, as there is potential for negative publicity for the NHS, both locally and nationally.

Utilities Fuel Scheme (UFS)

35. This is designed to allow designated utilities personnel access to emergency stocks of fuel in order to maintain essential services. NHS organisations are advised to confirm emergency call out plans with their utility providers should they suffer coincidental failure in one or more of their utility services during any fuel crisis to determine if there may be any reduction in normal service. A reduction in road fuel stocks may have an impact upon the ability of utilities services to function at expected capacity norms due to the

\(^6\) See [www.dh.gov.uk/nhsresilience](http://www.dh.gov.uk/nhsresilience) for further information on BIAs
effects on their own workforce. As a result, the ability to maintain essential power and water supplies should also be part of all NHS organisations’ BCM plans.

Commercial Scheme

36. A commercial scheme also exists to enable national supply chains to access fuel to continue the bulk delivery of pharmaceuticals and consumables. NHS organisations, including those that provide NHS funded care, where applicable, should ensure that they engage with suppliers to receive assurance of the delivery of essential supplies. SHAs should be made aware of those critical commercial contracts that may see a reduction in normal service during a fuel dispute and in order to inform at the planning stage. Guidance on management of national contracts is under review by the DH.

Case Study - The Myth of a Central Fuel List

Following the tanker drivers dispute the Emergency Preparedness Division at the Department of Health (DH) started to receive a number of calls from local companies and national trade associations wishing to be included on a ‘central list’ of users who supply services to the NHS, and therefore need to have priority access to fuel. Whilst everyone who called provided a strong argument as to why they were vital to keeping the NHS going, DH do not hold a central list of users. Instead, companies need to engage with the part of the NHS, which contracts the service from them, and complete a business impact assessment to identify critical services, and consider any necessary mitigation measures. As with all businesses, there should be no assumption resilience is automatically achieved through having access to fuel via a temporary logo.

NHS Resilience Project
DH Emergency Preparedness Division

Bulk Distribution Scheme

37. This scheme provides a framework for the allocation and prioritisation of fuels to bulk customers. All NHS fuel bunkers will be treated as a priority for refill, as will public transport, which will be key to both essential and non-essential NHS workers’ ability to get to work. It is the government’s intent not to limit access to fuel by public transport companies. Trusts are advised to attempt to have all workers try public transport options to come to work and conduct their business so that they are better prepared in the event of any fuel crisis.

Fuel Reserves and Mutual Aid

38. Ambulance Trusts are to ensure they have guaranteed access to diesel fuel reserves to maintain emergency services in the event of a complete disruption to road fuel supplies. This should be from their own-bunkered sources\(^7\) or by agreement with the SHA, through pre-arranged and agreed mutual aid arrangements. These arrangements must

\(^7\) Storage and safety guidance can be found at [http://www.defra.gov.uk/ENVIRONMENT/water/quality/oilstore/pdf/oil_store.pdf](http://www.defra.gov.uk/ENVIRONMENT/water/quality/oilstore/pdf/oil_store.pdf), and fuel should be turned over regularly to ensure degradation of diesel fuel does not occur.
be tested regularly (as a minimum every 12 months) and should allow for an uninterrupted delivery of all emergency service functions for a minimum period of 20 days from a complete loss of access. All Ambulance Trusts will, where applicable, support the principle of mutual aid across the health economy through allowing access to their fuel by other designated NHS organisations identified by SHAs. Ambulance Trusts should work with SHAs as they produce their NHS fuel plan for the region.

Demand Calming Measures and Routine Fuel Conservation

39. One of the first and most obvious steps to minimise dependency on road fuel is to use less of it and to use diverse sources and suppliers. Sustainable and flexible organisations will nearly always be the most resilient organisations as they will then have much greater experience about achieving core organisational objectives in different ways depending upon the circumstances prevailing at that time. Operational flexibility and diversity will promote both sustainability and resilience.

40. Preparedness favours both sustainability and resilience and although the detail of the future is impossible to predict accurately, the scenarios of the future are much easier to plan for and the importance of being resilient as a core part of today’s and tomorrow’s delivery cannot be overstated. Preparation and careful realistic risk management is the best way of coping with unforeseen events. NHS organisations are therefore discouraged from developing separate and possibly competing strategies, e.g. one for a resilient travel plan, and another for a ‘green’ travel plan. NHS organisations should ensure that travel is done sustainably for reasons of cost, efficiency, environmental sustainability, resilience and emergency preparedness as well as making good business sense. Developing multiple strategies will, at best, confuse priorities, and at worst, risk developing competing strategies and guidance that risk contradicting each other.

41. NHS organisations should therefore plan to reduce their overall demand for and usage of transport fuels in order to better prepare for any future disruption, which is in line with the Department’s sustainability intentions. It should also be noted that the DH aims to support annual campaigns to encourage a lower dependency on road fuels in order to both support sustainability objectives and to measure the business impact this will have on operations. Measures during a crisis that NHS organisations might wish to consider include:

a. Car sharing.

b. Introduction of the national cycle scheme.

c. Use of official vehicles, such as Patient Transport vehicles, as a means of moving staff around, particularly from home to work.

d. Introduction of more electric/gas/bio-fuel or hybrid powered vehicles where appropriate.

e. Cancel or reschedule non-essential meetings.

f. Reduction/cancellation of none-core hospital activities such as in-hospital services (e.g. hospital shops, hairdressing etc).

g. Having a `Work from Home' plan.

h. Increased use of video/telephone conferencing facilities.

i. A reduced working week.

**Case Study - Pharmacy Repeat Dispensing**

All pharmacies are able to provide a Repeat Dispensing service, whereby patients who are stable on long-term medication are issued with up to twelve prescriptions (up to a one-year supply) by their GP. These prescriptions can then be left with the pharmacy of their choice, thereby avoiding the need for patients to make a trip to the GP for a prescription and then to the pharmacy to have the medicine dispensed. Increased uptake of this service could therefore reduce the number of car journeys, as it eliminates the need to visit the GP for repeats. This scheme is currently under-utilised. In order to maximise the potential benefits PCTs should work with Local Pharmaceutical Committee (LPCs) and Local Medical Committees (LMCs) to improve the use of the scheme identify suitable patients and enrol them on the scheme.

Information on repeat dispensing is available from Primary Care Contracting [www.pcc.nhs.uk/183](http://www.pcc.nhs.uk/183)
Pharmacy Services Negotiating Committee (PSNC) [www.psnc.org.uk/pages/essential_services.html](http://www.psnc.org.uk/pages/essential_services.html)
or the National Pharmacy Association website [www.npa.co.uk](http://www.npa.co.uk)

**Relaxation of Regulations**

42. National and local delivery target and performance assessments will be kept under review by those responsible during any fuel crisis. If necessary regulations can be adjusted to take account of local or national circumstances, but this will need to be with full transparency via the use of risk and impact assessments. If having completed this process NHS organisations believe they have identified a requirement for this option, they are to seek the appropriate authority from the SHA, Monitor or the PCT commissioners as appropriate. However, Trusts should not plan on this being an inevitable consequence of any fuel crisis, regardless of severity.

43. In order to further reduce fuel demand and maximise those who can get to work, NHS organisations should also be prepared to review their own regulations, again based upon robust risk and impact assessments, with due cognisance of any insurance or legal issues. Some examples of such policies that may need to be reviewed are:

a. Drivers’ hours (e.g. those drivers routinely covered by commercial driving regulations).

b. Flexible working hours, particularly as fuel disruption may affect other services such as schools and childcare providers and thus some NHS staff may have competing priorities for their time.

c. Bringing children to work/providing crèche facilities, for the same reasons as above.

d. Staff unable to get to work but who are within easy reach of a partner NHS
organisation could be temporarily stationed there to assist with the maintenance of capacity and capability in the NHS as a whole. This issue should be clearly articulated as a possibility to all staff as part of Trust induction training. It is acknowledged that some Trusts may already have these arrangements in place as part of their ‘Extreme Weather’ plans.

e. Staff-to-patient ratios.

f. Governance issues (clinical and managerial) between different NHS organisations.

g. General recruitment policies, and the proximity of certain key staff to their normal place of work

Voluntary Sector Partners

44. Recognition of the scale of delivery of essential services by voluntary sector partners, for example air ambulances, should form part of any risk analysis, including determination of whether they are supported in any bid to be recognised under the ESS. Aviation fuel for air ambulances (as with other operators) is covered by arrangements in the NEP-F. Air Ambulance organisations should ensure their suppliers are aware of their priority status within the NEP-F in the event of emergency powers being activated.

Security of Staff and Property

45. It is recognised that both a disruption to normal road fuel supply and any subsequent disruption to health service delivery could be an emotive subject for the general public. NHS organisations should therefore have contingency plans in place in the event of an increase in threat levels to staff and/or property as a result of any real or perceived reduction in services to health during a fuel crisis. Threats could for example take the form of malicious 999 calls or direct threats to staff to deliver perceived essential services that organisations have deemed non-essential and have suspended.

Communication Strategy

46. An effective internal and external communication strategy will be key to successful implementation of any plans as well as reassuring the public that their best interests in relation to the crisis are at the forefront of the NHS’ mind. High level external messages will be issued by the DH, and will include updates on relevant websites. NHS organisations should have their own pre-planned messages and be prepared also to use their Local Resilience Gateway to reinforce these.

Cost Capture

47. NHS organisations are to ensure that all associated unforecasted costs attributed to this guidance and any response to an actual fuel crisis are captured for audit and the lessons identified process.
Validation

48. Measures to validate the resilience of the NHS in the face of a disruption to the supply of road fuel will be put into place and will include a bespoke NHS level exercise, an exercise for NHS organisations and will also see the introduction of relevant serials for use by the HPA in DH exercises. It is however incumbent upon all NHS organisations to carry out their own local and regional rehearsals/exercises in order to assure the effectiveness of their plans.

Conclusion

49. A disruption to the normal supply of road fuel will affect, to some extent, the normal delivery of health and social care services. The scale of any disruption will clearly have a proportionate effect upon the delivery of healthcare. NHS organisations in the worst case could be faced with very difficult and challenging issues resulting in the need for very difficult decisions to be made during a widespread fuel supply crisis. Government will take the decision to implement the NEP-F, but this would only be done so when a significant disruption to fuel supplies was occurring. Government and industry’s aim would be to work hard to resolve the disruption without having to resort to the use of emergency powers. NHS organisations should therefore not expect to rely on the NEP-F for the vast majority of potential fuel supply disruptions. As such, business continuity should be the first and foremost tool for NHS organisations when preparing for disruption to fuel supplies. The development of BCM plans, as required by the CCA, and their validation and re-validation, should attract the necessary time and resources to ensure as much resilience as possible is built into operations across health and social care, including demanding evidence of BCM from business-critical suppliers. Only by doing all of this can the NHS be as ready as is reasonably practical should this situation occur, and the decision making on the day can be informed and rational and in the best interests of maintain healthcare services.
APPENDIX 1 - DECC Summary of the NEP-F

Introduction

1. In the event that there exists, or is believed to be imminent, an actual or threatened emergency in the UK affecting fuel supplies, emergency powers under the Energy Act 1976 may be brought into force. These powers allow the regulation or prohibition of the production, supply, acquisition or use of substances used as fuel. These powers underpin many of the response tools in the NEP-F. These tools can be used as appropriate to the situation. For example, it may be sufficient to implement only the Maximum Purchase Scheme, or the situation may warrant implementation of all or most of the schemes together.

2. Triggers for the implementation of the NEP-F will inevitably depend on the circumstances at the time, but will take into account the impact fuel shortages are having, or may have, against a range of indicators from industry, government and responder organisations. As with all decisions concerning the use of Emergency Plans, there are clear objectives which lie behind it and which the possible measures are designed to address, namely to:

   a. protect human life and, as far as possible, property. Alleviate suffering;
   b. support the continuity of everyday activity and the restoration of disrupted services at the earliest opportunity; and
   c. uphold the rule of law and democratic process.

3. Should it be necessary to use emergency powers the Government would prioritise fuel to the emergency services and other essential service providers such as utility companies to make the best use of reducing quantities of fuel to minimise the impact on emergency and other essential services that underpin daily life. If there is sufficient diesel to supply emergency and other essential service providers then the surplus will be prioritised to truck stops and HGV motorway filling stations to help keep supply chains operational. Any remaining fuel would then be allocated by the oil industry to retail filling stations where it would be likely that motorists would be limited to a maximum purchase of fuel per visit to the forecourt.

Response Tools

4. The main tools within the NEP-F are:

   a. **Maximum Purchase Scheme (MPS)**. This limits the general public to 15 litres of fuel per visit. This is designed to ensure that all motorists can make essential journeys and workers in priority sectors using private vehicles can purchase sufficient fuel to go about their daily business.

   b. **Commercial Scheme**. This prioritises diesel supply to commercial filling stations and truck stops to support the continuation of critical supply chains. A limit of £150 per visit could be implemented, if necessary.
c. **Designated Filling Stations DFS**. This would provide priority access to road transport fuels for defined customers requiring them for a priority use. DECC would implement the scheme designating approximately 700 filling stations throughout the UK for the provision of fuel for Emergency Service Scheme, Utilities Fuel Scheme and Temporary Logo Scheme priority use only. Fuel suppliers/distributors will be instructed by DECC to give priority deliveries of fuel to these sites.

d. **The Emergency Services Scheme (ESS)**. Fuel would be prioritised to Designated Filling Stations to allow unlimited fuel to blue light emergency vehicles.

e. **Utilities Fuel Scheme (UFS)**. Fuel would be prioritised to Designated Filling Stations for use by logoed vehicles in the delivery of essential services including utilities, transport, cash movement etc.

i. The ESS and UFS could be operated together if necessary and would allow vehicles to re-fuel at any of the Designated Filling Stations.

ii. The ESS and UFS replaces the previous Priority User Scheme (PUS) and overcomes the need for a registration process, thus removing a significant burden on Local Authorities. This allows a scheme prioritising fuel to emergency/critical services in an extremely short timeframe. Designated Filling Stations will receive a list of those logoed vehicles entitled to unlimited access to fuel from Local Resilience Forums (LRFs). A temporary logo scheme will operate for those non-logoed vehicles eligible for fuel. Regional and local responders have been asked to look at how it can be adapted to suit their needs. LRFs are being asked to review their lists of Designated Filling Station.

f. **Bulk Distribution Scheme**. This enables oil companies and distributors to prioritise fuel products in accordance with DECC instructions to supply retail filling stations, truck stops, depots and commercial storage sites in the event of an emergency.

g. **Mutual Aid Scheme**. DECC has encouraged LRFs to develop voluntary mutual aid arrangements amongst their members to support the delivery of essential services locally, particularly healthcare, where there is a reliance on non-logoed vehicles. The arrangement is aimed at making an efficient and flexible use of resources for example by re-deploying logoed vehicles and drivers to provide mobility to other responders in their delivery of essential services.

h. **Temporary Logo Scheme (TLS)**. DECC has introduced a TLS to enable access by those essential users who do not have access to logoed vehicles (e.g. GPs and many community care nurses, community pharmacies etc). However, there is an obvious risk of abuse here, and we would have to ensure that temporary logos are only given for those vehicles that are used in carrying out critical services, and which cannot gain access to fuel through any of the above schemes.
APPENDIX 2 - NHS Roles and Responsibilities

The Planning Stage

1. SHAs must be able to assume strategic control and leadership of incidents such as a fuel crisis. Each SHA needs to ensure that it has an overview of all major incidents and emergencies within its boundaries and that appropriate arrangements are made to allow for a well co-ordinated response. These arrangements must take into account the requirements of the CCA and therefore SHAs must take a proactive lead in guaranteeing the availability of support and practical mutual aid both within their area, and across SHA boundaries.

2. SHAs may wish to consider designating one of its constituent PCOs to act as the lead NHS organisation for emergency fuel planning on its behalf, for example, nominating a ‘Lead PCT’. Where there is a designated Lead PCT, it is expected that it would provide links to the LRFs making sure that the SHA is kept aware and fully briefed on decisions agreed in the planning phase. The SHA will provide the link between NHS organisations in the region with Regional Resilience Forums. Where there are no Lead PCT/PCO arrangements, the SHAs will need to retain this role at a local level.

3. A Lead PCT model is utilised by several SHAs as a preferred method of ensuring emergency preparedness. Geographically, an area a Lead PCT might cover will need to be agreed within each SHA region, and where possible, be based on inter-agency emergency planning areas or LRFs.

4. Chief Executives of SHAs are responsible for ensuring that, whatever organisational model is used, the provision of strategic command arrangements during both the planning phase and the response phase are in place across the NHS in their region and these arrangements are resilient and robust.\footnote{Following consultation with Monitor, it is agreed that due to the widespread disruption caused by a fuel shortage, it would be appropriate for the SHA’s to take the co-ordinating lead for the whole health economy.}

The Response

5. Where the designation of Lead PCTs is agreed, it must be clearly established what roles and responsibilities the Lead PCT is expected to fulfil. This could include:

   a. Leading health emergency preparedness on a strategic basis within the LRF on behalf of the wider health sector in that locality.

   b. Ensuring health is engaged in the fuel resilience planning process and where appropriate, leads the local planning for health-related workstreams.

   c. Ensure that the health sector is a full partner in the local multi-agency command and control arrangements that would operate in the event of a fuel crisis.

6. In developing arrangements for mutual aid during a fuel crisis, NHS organisations will need to be clear what aid might be required, what they themselves can offer and who their partners are. Administrative boundaries, including national boundaries within the
UK, should not be a reason for not working with organisations over those boundaries in developing mutual aid arrangements. SHAs will be responsible for ensuring robust mutual aid plans are in place across the regional NHS, and are able to provide NHS mutual aid outside of their region if necessary.

7. If the scale of any fuel crisis escalates beyond the SHA’s capacity or region, or if its duration is such that wider NHS resources are required to maintain essential services, the SHA will enact mutual aid protocols with neighbouring SHAs and, where appropriate, the devolved administrations of Scotland, Wales and Northern Ireland. For mutual aid on a large scale, the Department of Health (DH), via the Department of Health Major Incident Coordination Centre (MICC), can implement national co-ordinating arrangements. These arrangements are intended to support the SHAs, ensure wider NHS resources are made available and wider government assistance is accessed as required. It will be the role of SHAs rather than of individual PCO/PCTs to contact the DH MICC.

8. During a response to a fuel crisis, SHAs are responsible for notifying the DH Emergency Preparedness Division (EPD) and for providing an overview and initial impact assessment on routine health and social care provision. In addition, in relation to an on-going response to a major fuel shortage, SHAs must establish a mechanism to provide regular briefing reports at a time and pace set by DH EPD. DH EPD will then collate this, and other information, and submit a health briefing note to DH Ministers and to the Cabinet Office Civil Contingencies Committee (known as COBR) if established.

9. With the incorporation of the Regional Directors of Public Health (RDsPH) and the Regional Public Health Groups in the SHAs, RDsPH are the most senior public health and medical officials in the region. They are able to relate to Regional Resilience Directors at Regional Government Offices and Regional Directors from the Health Protection Agency. RDsPH should also ensure that arrangements are made for regional level communications and co-ordination if there is likely to be an impact on public health.

10. SHAs should identify key staff from all sections of the organisation that are willing and able to respond out of hours to support any SHA strategic command arrangements, providing a critical link between the regions and the DH EPD.

11. Whatever arrangements are put in place to suit the local circumstances the SHA retains overall and final responsibility for its two major roles in the health service for preparing and responding to major incidents as follows:

   a. Performance Management of NHS organisations – to ensure that local plans are consistent with NHS major incident planning guidance and other relevant legislation and guidance.

   b. Strategic Command and Control of Widespread Major Incidents – incidents that cannot be contained within the resources of a local health economy.

12. Whilst SHAs may opt for a Lead PCT model, the ultimate responsibility for ensuring an integrated emergency response from the health sector rests with the Chief Executive of the SHA.
13. In complex, large-scale incidents there is a need to co-ordinate and integrate the strategic, tactical and operational responses of each partner service. This is achieved through the formation of a Strategic Co-ordinating Group (SCG), sometimes called Gold Command, usually chaired by the Police Incident Commander. The work of the SCG is to allow organisations to share information and co-ordinate their strategic response options in the management of a major incident. In summary, the SCG is a fast moving information sharing and strategic decision-making group.

14. Where there is more than one NHS organisation affected within an area, the lead PCT/PCO may lead the strategic NHS response at the request of the SHA. Agreement must be reached during the planning phase between the designated lead health organisation and other healthcare providers as to how strategic direction will be applied during a fuel crisis. A protocol must be agreed ensuring that the lead health organisation (e.g. the Lead PCT) on SCG or Gold Command will represent the local health service and therefore have delegated responsibility to allocate resources on behalf of the other NHS organisations.

15. The SCG will meet at a nominated Strategic Co-ordination Centre (SCC). The SCC is usually a building or group of buildings previously identified in local multi-agency Major Incident Plans and is usually police-based accommodation. Prior arrangements need to ensure that there is adequate space and the necessary equipment available for the NHS to be able to fulfil its SCG role at the SCC.

16. In the majority of cases, SCG will operate at the geographical level defined by the LRF or police force boundaries. There may also be situations where there are a number of SCGs operating simultaneously. SHAs will need to provide a watching brief providing support to the lead health organisation as appropriate. In addition, in widespread incidents, there may be a need for the establishment of a Regional Civil Contingencies Committee (RCCC). The membership of the SCG or RCCC will need to be flexible to meet the needs of the incident, but the SHA will be expected to lead and co-ordinate the health input into the RCCC. However, the SHA is ultimately responsible for ensuring strategic co-ordination of the health economy during a crisis. If a lead PCT/PCO agrees to undertake these responsibilities on behalf of the SHA, the SHA must ensure that the organisation and its staff assuming this role are suitably trained, equipped and resourced.

**Roles and Responsibilities**

17. It is the responsibility of all Category 1 and Category 2 responders under the Civil Contingencies Act 2004 to ensure an appropriate response to major incidents. The arrangements should enable a co-ordinated NHS response regardless of the nature or scale of incident. Whilst it is acknowledged that not all NHS organisations are covered by the requirements of the Act, it is nonetheless considered good practice for such organisations to comply. This includes those organisations commissioned to provide services on behalf of the NHS.

18. Central to a major incident response is the integration of health service organisations. At the SCG, there are three key health functions to assist the incident commander in the management of an incident. These three functions will be:
a. **Ambulance Strategic Command.** Ambulance Strategic Command directs and commands the response of one or more ambulance trusts including voluntary and private ambulance services. A member of the ambulance executive management team at the SCG/RCCC will represent the ambulance service.

b. **NHS Strategic Command.** NHS Strategic Command directs and commands the response of all NHS resources, including ambulances. It is focused on strategic management of the NHS during the incident by ensuring HS service delivery for both the incident and normal services. A chief executive or their nominated deputy would usually lead the NHS response and represent the service at the multi-agency Strategic Co-ordination Group. Within a health community, the Chief Executive of a Lead PCT, with the prior agreement of the SHA, may deliver this function at a LRF level.

c. **Public Health Advice.** Public health advice, in the form of a STAC should be available at the SCG/RCCC to offer health-related scientific advice for all incidents that require strategic co-ordination. During the initial phase of an incident, the chair of the STAC will probably be a specialist from public health, who will act as the focal point and primary contact for the police incident commander and all responding organisations. The STAC will provide advice on health, public health, health protection and other scientific advice as part of the incident management process.

### Command Support

19. The three key health functions, Ambulance, NHS delivery and public health advice, will need to ensure the provision of appropriate command support. This must be based on an awareness of the facilities and equipment available at the SCC and include the provision of personnel, administrative support, IT resources and other equipment. A key element to the delivery of appropriate command support is the maintenance of appropriate, contemporaneous records and documentation of the incident.

20. Any organisation involved in the strategic response to a major fuel crisis must ensure that suitable records are maintained detailing any responses and management decisions made. This is best achieved through the formation of a command support team, which will include administration support staff who can provide key tasks, for example decisions for logging or minute taking.

21. If a Lead PCT model is selected then SHAs must ensure that PCT staff are sufficiently trained and resourced to complete the lead role. Furthermore, the SHAs must have mechanisms in place to support the PCT during the initial phase of the incident.

### RCCC

22. In a large-scale on-going fuel crisis where events threaten to overwhelm local ability to compensate, or which have an impact over a wide area, a RCCC may be formed to co-ordinate a region-wide response. The RCCC will include representation from those organisations that regularly attend the RRF and other organisations/agencies as required. The RCCC will be defined by the nature and scale of the threat presenting.
23. The RCCC may meet at one of three levels:

1. Level 1 – in a state of readiness, watching and evaluating how local agencies are handling the incident.

2. Level 2 – working to coordinate government resources into the response.

3. Level 3 – taking a strong strategic and executive role in coordinating all resources at both local and regional level.

24. In all circumstances, the RCCC will be focused on ensuring the direction of appropriate resources to assist in the management of the incident. It will act as a mechanism for sharing information about the impact of the incident between central government and the local area, and will consider the recovery and long-term restoration of the region following the incident. The Chair of the RCCC will be nominated at the time of the incident.

25. A diagram showing the command and control arrangements at a local, regional and national level, in the event of a major incident, can be found at www.dh.gov.uk

**DH EPD**

26. The role of the DH EPD is to:

a. support the NHS Chief Executive, DH Permanent Secretary and Chief Medical Officer (CMO) to lead the health service response during a crisis.

b. advise Ministers on the development of policy.

c. be accountable through the Chief Medical Officer (CMO) to Ministers.

d. ensure NHS and social care preparedness and contribute to the central agenda.

e. contribute to/lead the central Government response e.g. COBR or the CCC.

f. implement national and international co-ordination arrangements.

g. oversee and support the response of the NHS and partners and ensure the resilience of the NHS and partner organisations.

h. support the NHS CE to take command of the NHS during complex national emergencies/incident through the MICC.

i. contribute to the central work on communications.

j. issue authoritative material to media, professions, and the public as well as handling national media.
SHAs and RDsPH

22. The role of SHAs and RDsPH is to:

a. provide strategic leadership to the health economy during periods of disruption.

b. assess the impact on the health care system as a result of a major incident.

c. ensure that NHS organisations plan, prepare and exercise for major incidents.

d. act as a central point of contact for DH EPD providing the regular incident reports.

e. ensure resilience in the response and recovery phases of NHS organisations.

f. As part of the SHA, RDsPH specific responsibilities are:

   i. to represent the Chief Medical Officer (CMO) in the Regions.

   ii. accountable through the CMO to Ministers.

   iii. to ensure pre-planning is co-ordinated between Regional Resilience and the NHS in preparedness as part of their SHA role.

   iv. to work closely with the Regional HPA Director to provide public health advice, support and leadership especially in responding to any major public health issues.

   v. to take the lead with SHA colleagues in providing health input into the RRF and associated regional communications networks working with the Regional Director of the Health Protection Agency, the NHS and the ambulance service(s) within the region.

   vi. to contribute to policy formulation within the DH.

   vii. to ensure sign off of any public health and health protection messages to be communicated to the public.

The HPA

23. The HPA is to:

a. provide expert advice to the DH on health protection policies and programmes.

b. be accountable through the CMO to DH at a national level.

c. provide operational public health advice and support to the NHS.

d. provide resources to support the provision and delivery of health advice to the SCGs and RCCCs.
e. cooperate with others to provide health protection advice and information to the NHS, to the media and the public.

f. provide training and exercise support on behalf of DH.

g. protect the community against infectious disease and other dangers to health, prevent the spread of infectious disease, and provide assistance on public health issues to responders such as the NHS, other Category 1 Responders, the Devolved Administrations and the wider general public.

h. give advice on public health threats and may, where appropriate, make this advice public.
27. APPENDIX 3 - Planning for a Fuel Supply Disruption – A Checklist

To assist in the development and review of plans the following checklist has been developed specifically in relation to fuel shortages. The following lists identify important and specific activities that organisations can do to prepare for a fuel shortage and many of the activities will also contribute to the development of general business continuity plans. This list is not exhaustive and not all measures listed here are suitable for all organisations. Depending on your organisation, its location and its functions, a shortage of fuel will affect your organisation and the business continuity plans you have in place differently. For example, in terms of location, it may be possible to bus the majority of staff into work if they lived in an urban area and were in fairly close proximity to each other where as a more rural location may find this impractical. Therefore, it is important to tailor business continuity planning to your organisation and its needs.

1. Assessing the impacts of a fuel shortage on your business

Planning is essential for any organisation during a fuel shortage. The list below gives some guidance to basic steps that could make your organisation more resilient.

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<td>Identify your organisation’s key products and services that must be maintained.</td>
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<td>Identify the key products and services delivered by your organisation which would be affected by a fuel shortage.</td>
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<td>Which critical activities and resources (including employees) support your key products and services (e.g. raw materials, suppliers, sub-contractor services/products, security)?</td>
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<td>Consider how internal resources could be re-allocated to ensure the delivery of key products and services is maintained. Are staff able to cover other roles safely to ensure that your key products and services can be delivered? Will additional training be required?</td>
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<td>Discuss with your suppliers/sub contractors whether they have robust Business Continuity Plans in place – your organisation’s resilience is only as good as those on whom it depends. Ask your suppliers how they plan to respond to a crisis and what support they will give to your organisation. Consider whether future contracts should reflect concerns.</td>
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<td>Decide how a reduction in service could be achieved while still delivering key products and services. How non-critical work would be stopped safely, smoothly and restarted again when possible to do so.</td>
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<td>How will the support functions of your organisation be affected by a fuel shortage? E.g. building maintenance, cleaning, food provisions for staff.</td>
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<td>Identify how you would learn of a fuel shortage and what criteria would need to be met for your organisation to implement business continuity measures. What actions would need to be taken and at which points?</td>
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<td>Assess the feasibility of increasing flexible working for staff (e.g. working from home).</td>
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### 2. Travelling to and from the place of work

Getting staff to their place of work can be difficult during a fuel supply disruption, but there are various options to consider in order overcoming this obstacle.

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- Document how staff usually travel to work and whether and what alternative forms of transport would be available if required. An example template is provided at Annex B.
- Consider whether it is possible for staff to work from home and support this where feasible.
- Consider the use of satellite offices, if you have them. Staff may live closer to these offices and therefore it may be easier for staff to get to those locations to work.
- Is car-sharing possible for some staff?
- Consider hybrid cars when replacing existing cars in your organisation’s fleet.
- Encourage staff to use alternative means of transport instead of private vehicles, this may take longer but may enable staff to get to the organisation’s premises. This could take the form of offering flexibility in their working time or providing relevant facilities e.g. bike racks, showers etc.
- Is it possible to organise communal travel for some staff, for example by taxi or minibus.
- Are there local hotels or other facilities where staff could stay?

### 3. Communication

It is crucial to have clear and concise messages ready to give to your staff, stakeholders, customers and suppliers in the event of disruption to your organisation. It is important to ensure that the appropriate message is delivered to the correct people be they a staff member or a customer.

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- Have an agreed practice on how to communicate plans to staff and what might trigger the business continuity plan being implemented.
- Have clear and concise messages ready, and a means of communicating to your staff that you are implementing some business continuity measures and how this will affect them.
- Ensure that you have a named contact that people within the organisation are aware of and emergency contact details of staff.
- Have clear and concise messages ready, and a means of communicating them to your staff, to let them know that business is returning to normal and that business continuity measures are no longer in effect.
- Consider the messages you might need to give to your customers and other stakeholders and the process for doing so. In some circumstances it may be useful to discuss possible impacts in advance. This dialogue will help inform planning on both sides and will be particularly important if your products are likely to be delayed.
- Consider how your suppliers are going to be affected by a fuel shortage. Ensure there are clear lines of communications between you both and a process of keeping supplier and organisation informed of progress. Discuss with your suppliers how they intend to respond to a fuel shortage.
### 4. Other considerations

There are other considerations you may wish to take into account

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- **During a fuel shortage there may be other demands on staff (e.g. children may not be able to attend school, staff sickness). Consideration should be given to the impacts of these situations.**
- **Consider reducing the number of meetings that involve travel, and instead consider teleconferencing or re-scheduling.**
- **Can mutual aid – sharing expertise or resources, physically or at a distance – with other businesses / organisations help in delivering your critical services?**
- **Do weather or seasonal work patterns affect your plans, for example in terms of travel options, or demand for your services?**
- **Consider having a variety of vehicles in your fleet running on different fuels, for example petrol, diesel and hybrid vehicles, to provide greater flexibility and resilience.**
- **How will your customers or service recipients be affected by the fuel shortage? This could lead to reduced demand for your services, or increased demand and both will have implications for your business continuity plans.**
- **Consider keeping a supply of critical parts / commodities to ensure you can continue some, if not all, service. Your supplier may not be able to complete their deliveries.**
- **Keep details of alternative suppliers should your primary supplier fail.**