Agenda Item 20

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Denise Smith, Chief Operating Officer	Decision		High	Med	Low
	Discussion			✓	
	Information	✓			
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
David Coe, Emergency Planning Manager	Strategic				
	Operational	✓			
	Governance	✓	**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)	Safe, Well-led				

Meeting Date: 27 August 2019

Report Title: Emergency Preparedness, Resilience, Response and Business Continuity Assurance 2019

PURPOSE:

This paper details the Trust self-assessment against the Core Standards for Category 1 Responders for Emergency Preparedness, Resilience and Response. This is required in order to provide assurance to NHS England that robust arrangements are established and maintained and that the Trust is capable of planning for, responding to and recovering from significant events.

SUMMARY:

The Trust is classed as a 'category 1 responder' under the Civil Contingencies Act 2004, and as such is subject to specific requirements with regard to Emergency Preparedness, Resilience, Response (EPRR) and Business Continuity

NHS England completes an assurance process each year to assess the preparedness of the NHS (both commissioners and providers) against common NHS EPRR Core Standards.

This paper sets out our self-assessment rating against the core standards and the action plan to address those areas where partial or non-compliance has been identified. The Trust self-assessment indicates a rating of 'substantially assured'

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
✓	✓			✓	

RECOMMENDATION/S:

Trust Board is asked to note the report.

1. Introduction

This paper details the Trust self-assessment against the Core Standards for Category 1 Responders for Emergency Preparedness, Resilience and Response. This is required in order to provide assurance to NHS England that robust arrangements are established and maintained and that the Trust is capable of planning for, responding to and recovering from significant events.

Category 1 Responders are required to:

- Assess local risk and use this to inform emergency planning.
- Put in place emergency plans.
- Create Business Continuity Plans to ensure continuance with critical functions
- Make information available to the public about civil protection matters and maintain arrangements to warn inform and advise the public in the event of an emergency.
- Share information with other responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.
- Provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only).

NHS England publishes the core standards each year. For 2019/20 there is a focus on both Business Continuity planning and Chemical, Biological, Radiation and Nuclear capability by organisations. In addition, the deep dive element concentrates on extreme weather and adaptation planning

The Trust is required to self-assess and RAG rate against all of the 69 core standards and 20 'deep dive' subsets. This self-assessment, together with evidence submission, will be peer assessed during September 2019 prior to submission to NHE England.

2. Self-assessment

The core standards and internal self-assessed RAG rating are appended for information. The overall self-assessment is 'substantially assured'.

None of the core standards are RAG rated as red (red denoting where no arrangements are in place or scheduled). However, 2 subsets are rated as amber (denoting partial assurance or where further action is required). These refer to: -

- **The availability of 24 PRPS suits**. The Trust currently has 12 suits; Respirex are the sole provider to the NHS and there is currently a shortage in supply. Therefore, national distribution is currently ensuring all Trusts have a minimum of 12 suits.
- **The Trust has a process for internal audit of Business Continuity, and outcomes are included in the report to the Board.** The last internal audit was carried out in 2011 and is include in the programme for 2019/20.

1. Recommendations

The Board is note the report.

Copy of Self-assessment against Core Standards:

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self-assessment
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Chief Operating Officer	Fully compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust Major Incident Response plan has a clear references to roles, training and exercising are included within the plan. It also mentions risk assessment, responsibilities of the trust under the CCA. All EPRR and Business Continuity policies within the Trust have version control, review schedule. It clearly identifies the dates these are required, and who is responsible for the policy. The EPO ensures that all EPRR policies are up to date	Fully compliant

3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	The EPO presents the standards self-assessment to the Trust Board. . A paper covering the training, exercising and any incidents is produced annually for Hospital Management Board.	Fully compliant
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an annual work programme	Fully compliant
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	The Trust has an EPRR Committee consisting of staff from across the organisation at all levels. The committee reports into the Trust Executive Committee. the EPO also sit on the Medical Gas Committee, Infection Control, and Fire policy committees. There is a job description for each team member clearly stating the roles and responsibilities	Fully compliant
6	Governance	Continuous	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the	Y	• Process explicitly described within the EPRR policy statement	The process is described	Fully compliant

		improvement process	development of future EPRR arrangements.			within the Major Incident Response plan. A hot and cold debrief are held following any incidents or exercises. From which a report and action plan are written and sent to the Hospital Management Board	
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	The risk assessments for the organisation are recorded on the corporate risk register and are reviewed in line with Trust Policy or following an incident. The trust has input into the LRF risk register for any health-related risks via the LHRP.	Fully compliant
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR risks are reported in line with the Trusts Risk Management Policy. EPRR is included within that policy	Fully compliant
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Partners and Stakeholders are considered and consulted with in planning.	Fully compliant

1 1	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current escalation plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
1 2	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
1 3	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant	Fully compliant

						personnel and published on the Trust intranet. This is tested within current guidelines	
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly	Current plans in line with current National Guidance.	Fully compliant

			Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.		• signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependent on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current	Fully compliant

						guidelines	
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant	Fully compliant

						personnel and published on the Trust intranet. This is tested within current guidelines	
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Current plans in line with current National Guidance. There is clear version control, who owns the policies and it is shared with all relevant personnel and published on the Trust intranet. This is tested within current guidelines	Fully compliant
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	THE Trust has Silver and Gold on call. Tactical response is available 24/7	Fully compliant

			notifications to an executive level.			on site. There is a call out cascade for use in an incident. The Trust uses page one to cascade all incident messages.	
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	All on call staff are trained to the National Occupational Standards. Records of individual training are held by the EPRR team and recorded on ESR. This training is provided at strategic level by NHSE, Tactical level by the LHRP. Directors are expected to use the Joint Decision-Making model, and report using the SBAR principles. Loggists are trained and a register is maintained. This is emphasised in training, and all decision makers have a personal log book in case an incident occurs when they are off site and no loggist	Fully compliant

						is with them.	
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	All relevant staff are trained to carry out their role. All training programmes have recently been revised and updated. Training records are kept by the EPRR team, and also recorded on ESR	Fully compliant
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Following each exercise or incident, a report is written and action plan if required and report through the EPRR committee	Fully compliant
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	The EPRR Team maintains training records. Each individual member of staff is responsible for maintaining their individual records. This is also recorded on ESR	Fully compliant
3	**Response**	**Incident**	The organisation has a preidentified Incident Co-ordination	Y	• Documented processes for establishing an ICC	The ICC is in the	Fully

0		**Co-ordination Centre (ICC)**	Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose and supported with documentation for its activation and operation.		• Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Conference Room. The equipment is tested periodically by the EPO. Fall back location is the Operations Centre. If unable to use the Trust, then the fall back will be at the Fermoy unit.	compliant
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Planning arrangements are easily accessible - both electronically and hard copies. There is a dedicated EPRR page on the intranet with links to the most up to date policies. All on call staff have on call memory stick with all polices available. Hard copies are available in the on-call folder in the ICC.	Fully compliant
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	The Trust has an overarching business Continuity policy, each department then has their own plan. Hard copies are kept within the departments,	Fully compliant

						with electronic plans stored on the intranet	
33	Response	Loggist	The organisation has 24-hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records	A register of trained loggists is maintained and held in the EPRR office and on page one alert system. This is available 24/7	Fully compliant
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Sitreps are completed by the EPRR Lead / Tactical commander and signed off by the AEO or director on call. This is the same procedure as the daily sitreps requested by NHSE/I	Fully compliant
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	Guidance is available on the EPRR intranet site	Fully compliant
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies	Guidance is available on the EPRR intranet site	Fully compliant
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications	The LHRP has a system communications plan, developed and owned by the CCG's. The Trust has a	Fully compliant

					• Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	social media policy and Major Incident communication plan. The Trust has social media accounts by which it communicates on a daily basis and this would be used in an incident. The Trust has a number of pre-prepared statements. Comms influenced by the learning from incidents that have occurred elsewhere e.g. Manchester, and table top exercises. The Trust has a communication s team. They have a process for tracking information and logging requests as part of their normal daily working. This process will remain the same during any incident. Comms dept. responsible for communicating with external stakeholders including the media. Messages to	

						staff are communicated via email and the trust intranet	
3 8	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	The LHRP has a system communication s plan, developed and owned by the CCG's. The Trust has a social media policy. The Trust has social media accounts by which it communicates on a daily basis and this would be used in an incident. The Trust has a number of pre-prepared statements. Comms influenced by the learning from incidents that have occurred elsewhere e.g. Manchester, and table top exercises. They have a process for tracking information and logging requests as part of their normal daily working. This process will remain the same during any incident. Comms dept.	Fully compliant

						responsible for communicating with external stakeholders including the media. Messages to staff are communicated via email and the trust intranet	
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	The LHRP has a system communications plan, developed and owned by the CCG's. The Trust has a social media policy. The Trust has social media accounts by which it communicates on a daily basis and this would be used in an incident. The Trust has a number of pre-prepared statements. Comms influenced by the learning from incidents that have occurred elsewhere e.g. Manchester, and table top exercises. They have a process for tracking information and logging requests as part	Fully compliant

						of their normal daily working. This process will remain the same during any incident. Comms dept. responsible for communicating with external stakeholders including the media. Messages to staff are communicated via email and the trust intranet. Gold staff are trained in media awareness.	
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings	The AEO or appropriate deputy have attended 75% of meetings / teleconferences	Fully compliant
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	Represented on liaison groups either by own EPRR Lead of nominated representative from the LHRP Working group. Represented at Executive LRF level by the chairs of the LHRP Executive	Fully compliant
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Mutual aid agreements in place both locally and via the LHRP/NHSE/i.	Fully compliant

			process for requesting Military Aid to Civil Authorities (MACA) via NHS England.			The trust would follow the MACA requesting procedure should it be thought to be required.	
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	The trust has an overarching Information Governance Strategy, an IG policy, IG information Investigation policy. Sharing of information is part of the GDPR and follows the National Guidance. The trust follows the National guidance around FOI requests	Fully compliant
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	BC Policy	Fully compliant
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to	Documented within the Trust BC Plan. All departments have a standard template	Fully compliant

					ensure they are aware of their roles • Stakeholders		
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Documented within BC Policy and each departmental plan has a BIA. Version controlled and updated annually	Fully compliant
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	IT department comply with data protection and security tool kit. A programme of works to update is in place.	Fully compliant
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Documented within the Trust BC Plan. All departments have a standard template which includes BIA	Fully compliant
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand-alone Business continuity policy • Board papers	Stand-alone BC Policy. Register kept by the EPRR department. Included in the annual report and these Core Standards	Fully compliant
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand-alone Business continuity policy • Board papers • Audit reports	The Trust has an internal audit programme and EPRR is included. The	Partially compliant

						plans are to be audited this year.	
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand-alone Business continuity policy • Board papers • Action plans	Policy is version controlled and updated/revised annually. Each department revises/updates its plan annually or following an incident or BC Exercise	Fully compliant
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand-alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Procured services all have BC plans in place.	Fully compliant
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	ED staff have access to PHE numbers and also access to toxbase	Fully compliant
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	All contained within the stand-alone HAZMAT/CBRN Policy and live exercise carried out in 2017	Fully compliant
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes:	Y	• Impact assessment of CBRN decontamination on other key facilities	Covered in policy	Fully compliant

			• Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.				
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	ED has names of appropriately trained staff availability 24 /7	Fully compliant
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Completed equipment inventories; including completion date	Fully compliant
61	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	The Trust has 12 suits in date. Awaiting delivery of the remaining 12. This will take place after all trusts nationally have been uplifted to 12 suits as a minimum. Mutual aid agreement in place between the three acute hospitals. Agreement and financial strategy in place for revalidation of suits with Respirex.	Partially compliant

62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Checks are completed by ED staff. RAMGENE service is undertaken by Addenbrookes	Fully compliant
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Checks are completed by ED staff and these are recorded. RAMGENE service is undertaken by Addenbrookes nuclear medicine department. A record is kept of the expiry dates of equipment and supplies. This is monitored as above	Fully compliant
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Organisational waste management and disposal policy in place. If any doubt, appropriate body would be approached	Fully compliant
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	EEAST provide suit training and next training date is 5 Sept 2019. Leads in ED are trained	Fully compliant
66	CBRN	Training programm	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance	EEAST provide specialist	Fully compliant

		e	programmes should include training for PPE and decontamination.		• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	training for CBRN. Training records are held within the ED. Training utilises advice within Primary care HAZMAT guidance. IOR and other material. Remove posters are available. A range of staff roles are trained in decontaminatio n techniques. Training provided by NARU	
6 7	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Training provided by NARU. Records held in ED	Fully compliant
6 8	**CBRN**	**Staff training - decontami nation**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	EEAST provide specialist training for CBRN. Training records are held within the ED. Training utilises advice within Primary care HAZMAT guidance. IOR and other material. Remove posters are available. A range of staff roles are trained in decontaminatio n techniques. Training provided by NARU	Fully compliant

6 9	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		Staff have access to FFP3 protection. Staff in high risk areas are fit tested to ensure they have the correct masks available.	Fully compliant

Action plan to address areas identified as work in progress or non-compliant against 2019/20 EPRR Core Standards

Standard number	Overarching statement	Action required	Lead	Completion date
61	The organisation has the expected number of PRPS suits (sealed and in date available for immediate deployment should they be required)	Respirex is the sole provider to the NHS. Suits are commissioned nationally and distributed to hospitals. There is currently a shortage in supply. The current stock at QEH is 12. A reciprocal memorandum of understanding is in place with JPUH and NNUH should an incident occur where additional suits are needed	Emergency Planning Officer	On-going
53	The organisation has a process for internal audit, and outcomes are included in the report to the board.	The Chief Operating Officer to ensure Business Continuity is included in the Trusts Internal audit programme	COO	April 2020