Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	13 March 2024
Title of paper	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Report
Presented by	Craig Harris, Chief Operating Officer, and Accountable Emergency Officer
Author	Alison Whitehead, Head of EPRR
Agenda item	14
Confidential	No

Executive summary

The purpose of this report is to provide Lancashire and South Cumbria Integrated Care Board (L&SC ICB) with an update on the self-assessment and check and challenge process against the NHS England core standards for emergency preparedness, resilience and response (EPRR) and subsequent improvement plan.

There has been a significant change in the assurance process for the Northwest for 2023 / 24 as we have adopted a revised and more rigorous analysis of evidence and compliance against each core standard.

A robust action plan has been developed to improve compliance levels for 2024 onwards, cognisant of ongoing pressures with industrial action and incident response management.

The action plan will be monitored, enhanced, and improved through the EPRR Committee, which will subsequently support the core standards assurance process for 2024 / 25 and onwards, and provide enhanced assurance around compliance to the Board.

Recommendations

L&SC ICB Board is requested to:

1. Note the contents of the report and
2. Approve the proposed EPRR Core Standards Action Plan

Which Strategic Objective/s does the report relate to:		Tick
SO1	Improve quality, including safety, clinical outcomes, and patient experience	✓
SO2	To equalise opportunities and clinical outcomes across the area	x
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	x
SO4	Meet financial targets and deliver improved productivity	x
SO5	Meet national and locally determined performance standards and targets	✓
SO6	To develop and implement ambitious, deliverable strategies	x

Implications				
	Yes	**No**	**N/A**	**Comments**
Associated risks		x		
Are associated risks detailed on the ICB Risk Register?		x		
Financial Implications		x		

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
Executive Team	5 March 2024	Approved

Conflicts of interest associated with this report
Not applicable

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data privacy impact assessment completed			x	

Report authorised by:	Professor Craig Harris, Chief Operating Officer (and Accountable Emergency Officer)

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Report

1. Introduction

1.1 The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 (as amended by the Health and Social Care Act 2022), both place emergency preparedness, resilience, and response (EPRR) duties on the NHS in England.

1.2 Under the CCA 2004, the ICB is a Category One responder, subject to the full set of civil protection duties including the risk assessment of emergencies occurring, maintaining plans to reduce, control or mitigate the effects of an emergency and undertaking business continuity management arrangements.

1.3 The NHS core standards for EPRR are the basis of the assurance process on the preparedness of the NHS to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

1.4 Assurance of the preparedness of the NHS is achieved through the annual EPRR core standards assurance process. ICBs became Category One responders with effect from July 2022, and this report highlights progress in developing robust local processes for undertaking the self-assessment process as an established ICB.

1.5 It should be highlighted that there has been a significant change in the assurance process for the Northwest for 2023/24 as we adopted the approach previously taken in the Midlands in 2022. That pilot approach involved the submission of evidence and a new and more detailed analysis of that evidence. When the Midlands undertook this pilot approach, it resulted in substantial differences between the self-assessment results and the evidential review of the organisations documentation (from 7% of organisations declaring non-compliance to 30% declaring non-compliance).

1.6 The implementation of this new process has seen a reduction in EPRR core standards compliance levels across the Northwest. This is due to a revised and more rigorous analysis of evidence and compliance against each core standard.

2. NHS EPRR Core Standards Self-Assessment 2023 - 2024

2.1 L&SC ICB undertook the self-assessment process against the NHS EPRR Core Standards for 2023 – 2024.

2.2 The core standards for EPRR provide the minimum requirements commissioners and providers of NHS funded services must meet covering governance, duty to risk assess, duty to maintain plans, and command and control and testing and exercising arrangements.

2.3 There are 47 standards applicable to the ICB, which were initially self-assessed, resulting in an overall self-assessment assurance rating of *Partially Compliant,* with 79% of the core standards being fully complaint (with none of the standards being reported as non-compliant):

Self-Assessment assurance rating	Partially	Percentage compliance	79%
Core standard position after organisation self-assessment			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
47	37	10	

2.4 Overall compliance assurance ratings are as follows:

Compliance	*Percentage of compliance of applicable core standards*
Fully compliant	100%
Substantially complaint	99 – 89%
Partially complaint	88 – 77%
Non-compliant	76% or less

2.5 For the first time this year, ICBs and NHS providers in the North of England (North East and Yorkshire and the North West) were required to submit evidence to support the self-assessment process and declaration of compliance. Following the completion of the self-assessment process, the ICBs and providers were then subject to a robust *check and challenge* Panel Review, led by NHS regional EPRR colleagues. The resulting process declared the ICB as *Non-Compliant,* with 11% of the core standards being fully compliant (**Appendix A**), with none of the standards being reported as non-compliant:

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
47	5	42	

2.6 From an NHS provider perspective, all 5 acute Trusts and North West Ambulance Service (NWAS), declared themselves *substantially complaint* against the relevant core standards both in last years submission and in the previous year. Post the NHS E panel review, all were reported as *non-compliant* against the EPRR core standards.

Organisation	Number of Applicable Standards	Compliance achieved: Full / Substantial / Partial / Non		Variance
		Self assessment	Post panel review	
L&SC ICB	47	79%	11%	- 68%
ELHT	62	90%	16%	- 74%
LTH	62	94%	23%	- 71%
UHMB	62	90%	21%	- 69%
BTH	62	97%	31%	- 66%
LSCFT	58	91%	14%	- 77%
NWAS	58	93%	33%	- 60%

2.7 The reduction in compliance level for L&SC ICB from the self-assessment to NHS England post panel review is due to a number of factors including: ratification of plans / policies after the submission date (due to internal governance arrangements), insufficient level of detail in plans / policies as required by the new process, and the inability to provide evidence against some of the core standards despite work being undertaken within those areas (e.g. internal and external training). Work is ongoing to ensure that our level of compliance will improve during this process for 2024 / 25.

2.8 Whilst the ICB remains potentially 'at risk' from a non-compliance rating perspective, several actions have already been undertaken to mitigate these including:

- Recruitment of a full EPRR team
- Comprehensive training for tactical and strategic on call staff to respond to incidents and emergencies on behalf of the ICB
- A training needs analysis and personal development portfolio has been developed for on call staff to complete to ensure compliance with the minimum occupational standards (for EPRR)
- A robust on call rota is in place, with monthly meetings to share experiences and advise of any updates in relation to EPRR matters
- Review of the EPRR and Business Continuity Policies
- Business continuity training and business impact analysis has been offered to the senior leadership teams
- Development of a EPRR risk register, linked to the local and community risk registers

2.9 All 5 acute Trusts and NWAS have presented the outcome of the EPRR core standards assurance process to their Board. They have all developed comprehensive action plans to improve their compliance, and these will be monitored monthly by the ICB and quarterly at the Local Health Resilience Partnership (LHRP).

2.10 Historically, NHS E undertook this revised check and challenge process in the Midlands in 2022. This change to process resulted in a significant disparity between the self-assessment scores and those of NHS E. However, the revised process identifies opportunities to strengthen and improve the evidence base, along with providing a standard that organisations need to achieve in terms of robust governance and proactive planning to withstand scrutiny under the burden of proof e.g. during a public enquiry.

2.11 It is important to note that although this new process declares L&SC ICB (and some other ICBs and providers in the northwest) as non-compliant in relation to the EPRR core standards, the ICB continues to evolve in this area of work in terms of resources, planning, responding and improving, with a comprehensive action plan in place to improve compliance going forwards.

2.12 It should also be noted that the EPRR function has been under immense pressure over the past 12 months, including planning for and responding to significant periods of disruption due to industrial action, along with delays in recruitment and maturing as a function across the entire ICB footprint and structure.

2.13 NHS E recognise that this change to process has come at a very challenging time for EPRR professionals, and it is important to note that an organisations preparedness and ability to respond to incidents, in line with its Category 1 responsibilities, has not significantly changed. This process should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response, and resilience.

2.14 The Head of EPRR has developed a comprehensive action plan (**Appendix B**) to monitor, enhance and improve the ICBs core standards compliance going forwards, and to provide additional assurance to the Board around the commitment of the EPRR function to improve its compliance rating.

2.15 The ICB also responded effectively and efficiently to several localised incidents including a flooded building at Blackpool Hospital requiring evacuation, severe weather in South Cumbria resulting in stranded staff and patients and a suspected bomb resulting in a cordon and the identification of vulnerable individuals. On call staff have also been involved in outbreak management e.g. avian flu and exercise participation on behalf on the ICB.

2.16 NHS E have not yet announced the proposed plan for this year's EPRR core standards assurance process, although it is expected that the ICB will undertake the evidence review and check and challenge / review panel process on behalf of the NHS with all of the Lancashire and South Cumbria commissioned providers.

3. Conclusion

3.1 Whilst L&SC ICB reported partial compliance on their initial EPRR core standards assurance self-assessment, NHS E, post a vigorous check and challenge process, reported the ICB as non-complaint.

3.2 Moving forward from this baseline position, the EPRR team is committed to reflect on the outcome of this process and of the robustness of their EPRR arrangements, to improve resilience and focus and embrace opportunities to work collaboratively with system partners going forward.

4. Recommendations

4.1 L&SC ICB Board is requested to:

- Note the contents of the report and
- Approve the proposed EPRR Core Standards Action Plan (**Appendix B)**

Alison Whitehead

13 March 2024

Appendix A

EPRR Core Standards Self-Assessment and Final Check and Challenge Rating (10th November 2023)

Organisation name	Lancashire & South Cumbria Integrated Care Board			2022/23 Assurance Rating (and % compliance)		Non-Compliant – 74%
Initial self-assessment rating (2023/24)	Partially			If the organisations accept the challenges identified in the check & challenge process their compliance rating would be -		Non-Compliant
Initial self-assessment percentage compliance	79%			Check & challenge percentage compliance	11%	Variance (-) – 68%

CS	Domain	Standard	Detail of standard	Self-assessment rating	Final Check & Challenges rating	Accepted or challenged	Comments
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 within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	**G**	**G**	Accepted	
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. 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.	**G**	A	Challenged	Evidence submitted details the policy being ratified in October which is after the submission deadline of 30th September.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	**G**	A	Challenged	

4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	**G**	A	Challenged	
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	**G**	A	Challenged	Evidence submitted details the policy being ratified in October which is after the submission deadline of 30th September.
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	**G**	A	Challenged	
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 all relevant risk registers including community and national risk registers.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: Description of how risks will be assessed as part of policy documents and links to risk management policy explained Evidence of EPRR risks on the organisations risk register(s) and review sequence for these Clear evidence of alignment of assessments from the LHRP risk register and community risk registers, and how these are used to update risks Risks must have been reviewed in past 12 months Note if separate BC risk assessment is undertaken this can be provided as supporting evidence to the main EPRR risk assessment documentation provided
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	**G**	A	Challenged	Evidence submitted details the policy being ratified in October which is after the submission deadline of 30th September. Evidence submitted does not meet the following compliance criteria: Process describing who is responsible for raising risks to the Local Health Resilience Partnership and/or Local Resilience Forum Policy documents explicitly state how EPRR only risks will be managed

9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	A	A	Accepted	
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	**G**	A	Challenged	
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	**G**	A	Challenged	
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has 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.	**G**	A	Challenged	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	A	A	Accepted	
14	**Duty to maintain plans**	**Countermeas ures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	**G**	A	Challenged	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	**G**	**G**	Accepted	
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	A	A	Accepted	

20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	**G**	A	Challenged	
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	**G**	A	Challenged	On call policy is draft. Evidence submitted does not meet the following compliance criteria: On call staff are clearly identified in the Training Needs Analysis, and meet the training frequency required On call staff maintain a Personal Development Portfolio showing competency and experience for EPRR which is aligned to the Minimum Occupational Standards – June 2022 Handbook describes processes for decision making, who to inform and the need to create records Portfolio's/Competency templates have been agreed by the organisation and are available to on call staff
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: The training process needs to be set out in policy or other document and follow a Training Needs Analysis (TNA) which identifies the roles and skills needed to fulfil organisation roles Covers all aspects of the likely response and all roles – inclusive of requirements as set out in the MOS/NOS requirements for each role Identifies courses (internal and external) needed for each role to achieve the competencies and time they are applicable for (1 year for example) Training materials developed by the organisation to meet the requirements should be aligned to the NOS and have a scheme of work (Lessons plans & learner objectives etc) in order that it can be assessed for effectiveness and trained personnel will be able to use it to demonstrate their competency Personal training and exercising portfolios (PDP) are available and kept up to date for key staff (identified by TNA) Records of training are kept including who and date trained with both Portfolio compliance and training schedules reported to board Training includes the need to develop EPRR staff in skills to carry out role
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to	A	A	Accepted	

			exercise players or participants, or those patients in your care)				
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: Training for those who are responder staff is given on a regular basis Organisation has identified the number of people who need to be trained in the response role and monitors compliance with this Training records cover all roles and include exercise attendance, organisation can provide comprehensive records of training which is all in date to requirements of TNA Key roles have been assessed for MOS applicability and they have a Personal Development Portfolio (PDP) which demonstrates their training and exercise attendance Example portfolios are made available Additional training is developed to support staff identifying needs Training needs assessment should identify who needs a PDP All responder roles should be included in the Training needs assessment Training includes recovery roles
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	**G**	A	Challenged	
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: Arrangements should describe any staffing roles for your incident coordination centre (ICC), establishing hierarchy and collapsible structures where applicable Arrangements should describe the processes for running and establishing the room (in and out of hours), consideration for fall back sites and their use Should include options and procedures for virtual operations There should be records of the equipment in the ICC being tested and also the backup locations and following major infrastructure changes Maps of the room/ICC should be available to show working layout/role positions Arrangements should identify other items like name badges and tabards to be using Should describe how the ICC will interact with the command structure and organisation as a whole

			Arrangements should be supported with access to documentation for its activation and operation.				Establishment should be demonstrated as timely for the ICC (1 hour of declaration in hours) Extended operation of the ICC should be planned for in arrangements
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	**G**	A	Challenged	Evidence submitted details the policy being ratified in October which is after the submission deadline of 30th September. Evidence submitted does not meet the following compliance criteria: Arrangements should be in place to manage any official hard copies of plans including who is responsible for this Should outline how old versions will be marked to ensure they are not used in response where held (e.g. placed into archive).
28	**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).	**G**	A	Challenged	Evidence submitted details the policy being ratified in October which is after the submission deadline of 30th September.
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	**G**	A	Challenged	Evidence submitted details the policy being ratified in October which is after the submission deadline of 30th September. Evidence submitted does not meet the following compliance criteria: Clear process for calling out Loggists in organisation in place, this should be able to operate 24/7 Organisation has identified the number of Loggists required based on assessment of need and potential organisational demand and this is actively monitored Arrangements make reference on how to work with Loggists, sign off logs etc Roles indicate who will work with the Loggists and their function There is reference to the records retention periods for logs and records associated with incident response and routine on call Call out of Loggists should be part of the communications exercises testing response staff Arrangements are clear on log sign off processes – including where electronic logs have been used
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: The Situation Reporting (Sit-Rep) process is clearly described in response documents, as well as detailing any information services which may be required to supply the ICC with information for submissions recognising that information is likely to change at pace throughout an incident Process should describe who is responsible in the ICC for collation of information, and time of submissions from services or elsewhere in

							organisation if outside of ICC (information team etc) Cadence of reporting may be every 2 hours and should be planned for The sign off process and quality assurance process should be clear in arrangements Processes should reference and be clear on pre-established submission times (within an hour of declaration, by a designated time to NHSE or as agreed) Evidence should demonstrate that both internal and external processes have been exercised If the organisation is including the National SitRep template into their plan it needs to be marked and signed off as OFFICIAL-SENSITIVE Where reliant on submissions out of hours for SDCS there should be plans and contingency for this. Named roles should be accessible 24/7
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: Roles for the communication team are clearly defined in the organisations plan Action cards clearly detail the responsibilities and actions associated with the communications role Plan clearly indicates how communications fits into the wider response structures of the organisation Pre-prepared standardised communication messages should be available in the organisations incident response plans/arrangements Those needing communications training are identified in the Training Needs Analysis (TNA) Organisations should identify roles which require communications training, and hold the records to evidence who has received it
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: Pre-prepared standardised communication messages should be available in the organisations incident response plans/arrangements Aligned to the IRP in terms of roles All roles named have action cards Role within multiagency communications is clear Arrangements clearly articulate who has authority to sign off messages Clear links to regional and other agency plans where required Plans include how organisation will participate in warning campaigns as part of wider warning & informing activities
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements Specific role in the multiagency communications groups documented

36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: Arrangements clearly articulate how media will be managed in an incident including any pre-prepared messages Arrangements should also establish a media reception centre with the required access and egress considerations and security arrangements Identifies the role(s) that have responsibility for the management and monitoring of social media, and plans for use of this during the incident Demonstrates consideration of the need for a media trained Trust spokesperson Sign off process for media messages clearly defined Training Needs Analysis (TNA) aligns to roles indicated for media briefings Training records for those in media roles
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	**G**	**G**	Accepted	
38	**Cooperation**	**LRF / BRF Engagement**	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.	**G**	**G**	Accepted	
39	**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. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	**G**	A	Challenged	
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	**G**	A	Challenged	

40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	**G**	A	Challenged	
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	**G**	A		Evidence submitted does not meet the following compliance criteria: Has system in place to reach out to organisations not meeting their duties under Core Standard 37
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	**G**	A	Challenged	
44	**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) that aligns to the ISO standard 22301.	**G**	A	Challenged	Evidence submitted details the policy being ratified in October which is after the submission deadline of 30th September.
45	**Business Continuity**	**Business Continuity Management Systems (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. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	**G**	A	Challenged	Evidence submitted does not meet the following compliance criteria: Organisation has a document which establishes the Business Continuity Management System (BCMS) which includes establishing the requirements for core standards 46 – 53 (BIA, BCP, Testing and Exercise, Evaluation and monitoring, BC Audit and Supplier audits)) BCMS should establish the processes to follow and any standards to be met Should outline the roles of those in the BCMS including responsibilities, competencies and authority Should establish governance and authorities for sign off of documents

46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	A	Accepted	
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has 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	A	A	Accepted	
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	**G**	A	Challenged	
49	**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.	**G**	**G**	Accepted	
50	**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.	A	A	Accepted	
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	A	A	Accepted	

52	**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.	A	A	Accepted	
53	**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 align and are interoperable with their own.	A	A	Accepted	

Appendix B

EPRR Core Standards Action Plan

	Action Plan						
Ref	**Domain**	**Standard name**	**Standard Detail**	**Action to be taken**	**Lead**	**Timescale**	**Comments**
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. 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.	Policy ratified past the submission date - will be compliant on review		Nov-23	Compliant
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Comprehensive Board report to be submitted post core standards assurance submission	Head of EPRR	Jan-24	Compliant - report to be submitted in March 2024
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Comprehensive work programme to be developed post core standards assurance submission	Head of EPRR	Apr-24	Underway

Ref	Domain	Standard name	Standard Detail	Action to be taken	Lead	Timescale	Comments
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Establishment of an EPRR Committee to support governance arrangements	Head of EPRR	Apr-24	Underway
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Amend the EPRR Policy and review Board reports	Head of EPRR	Jan-24	EPRR Policy under review - to go to Exec / Board in May (full agenda in March)
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 all relevant risk registers including community and national risk registers.	Review process of assessing EPRR risks	Head of EPRR	Apr-24	Underway
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Review process of assessing EPRR risks	Head of EPRR	Apr-24	Underway
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Need to formalise collaboration with stakeholders for internal planning	Head of EPRR	Apr-24	Underway
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	IRP needs to be signed off by appropriate committee	Head of EPRR	Apr-24	Underway

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11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Review Action Cards in IRP	Head of EPRR	Apr-24	Underway
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has 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.	Review on call arrangements for the management of HCID escalations	Head of EPRR	Apr-24	Underway
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Establish an ICB wide infectious disease plan	Head of IPC	Apr-24	Underway
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Review counter measures arrangements	Head of EPRR	Apr-24	Underway
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Establish evacuation arrangements and formalise as required	Estates and Facilities	Jan-24	Underway
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	On Call Policy in draft and needs to be finalised	Head of EPRR	Jan-24	Underway - deferred due to industrial action

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21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	On Call Policy in draft and needs to be finalised Review TNA and personal development portfolios	Head of EPRR	Apr-24	Underway
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Review TNA and personal development portfolios and review EPRR policy	Head of EPRR	Apr-24	Underway
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Undertake an annual table top exercise and live exercise and develop training schedule for 2024 / 2025	Head of EPRR	Apr-24	Underway
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Review training records / attendance in line with the MOS	Head of EPRR	Apr-24	Underway
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	To include exercise and training information in the annual report to Board	Head of EPRR	Apr-24	Underway

Ref	Domain	Standard name	Standard Detail	Action to be taken	Lead	Timescale	Comments
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	ICC arrangements to be reviewed both internally and externally (resilience)	Head of EPRR	Jan-24	Underway - options being explored
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Policy ratified past the submission date - will be compliant on review			Compliant
28	**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).	Plan ratified past the submission date - will be compliant on review			Compliant

Ref	Domain	Standard name	Standard Detail	Action to be taken	Lead	Timescale	Comments
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Plan ratified past the submission date - will be compliant on review			Compliant
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Review sit rep process	Head of EPRR	Apr-24	Underway
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Comms toolkit and plan requires version control and date	Comms Team	Jan-24	Underway
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Review Comms Plan in line with requirements	Comms Team	Apr-24	Underway
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Review Comms Plan in line with requirements	Comms Team	Apr-24	Underway

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36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Review Comms Plan in line with requirements	Comms Team	Apr-24	Underway
39	**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. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Develop mutual aid / memorandum of understanding for L&SC providers and put MACA process into the IRP	Head of EPRR	Apr-24	Underway
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Formalise cross border mutual aid arrangements	Head of EPRR	Apr-24	Underway
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	Review LHRP Terms of Reference	Head of EPRR	Apr-24	Compliant
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Develop a information sharing SOP / protocol	Head of EPRR / IG Team	Apr-24	Underway

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44	**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) that aligns to the ISO standard 22301.	Policy ratified past the submission date - will be compliant on review			Compliant
45	**Business Continuity**	**Business Continuity Management Systems (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. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Review BCPlan and Policy to meet requirements	Head of EPRR	Apr-24	Underway
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	BIA to be undertaken to identify critical functions across the ICB. This will then be reviewed annually	Head of EPRR	Apr-24	Underway
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has 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	Further work to be done with departments and commissioned services regarding BCPs to ensure compliance with this standard	Head of EPRR	Apr-24	Underway

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48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Review testing / exercising process for the BC plan (s)	Head of EPRR	Apr-24	Underway
50	**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.	Introduce a formal BCMS monitoring process and report to the Board as required	Head of EPRR	Apr-24	Underway
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Once BCPs are in place, an audit tool and process will be developed	Head of EPRR	Apr-24	Underway
52	**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.	Formalise the continuous improvement cycle in the Policy and across the organisation	Head of EPRR	Apr-24	Underway
53	**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 align and are interoperable with their own.	Formalise procurement arrangements relating to BCMS	Procurement	Apr-24	Underway

Ref	**Domain**	**Standard name**	**Standard Detail**	**Action to be taken**	**Lead**	**Timescale**	**Comments**

DD3	**EPRR Training**	**EPRR staff training**	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	TNA to be developed for EPRR staff	Head of EPRR	Apr-24	Underway
DD4	**EPRR Training**	**Senior Leadership Training**	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	TNA to be developed for the AEO	Head of EPRR	Apr-24	Underway
DD7	**EPRR Training**	**Monitoring**	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	EPRR governance arrangements to include TNA monitoring via the EPRR Committee and to Trust Board and to the LHRP	Head of EPRR	Apr-24	Underway
DD10	**EPRR Training**	**Evaluation**	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Process to be developed to support evaluation post training	Head of EPRR	Apr-24	Underway