Paper ref:	TB (09/18) 015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	EPPR: Board standards approval of the NHSE Core Standards		
Sponsoring Executive	Rachel Barlow, Chief Operating Officer		
Report Author	Rachel Barlow, Chief Operating Officer		
Meeting	Trust Board	**Date**	6th September 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The Trust Board is asked to discuss:

- The self-assessment against the core emergency planning standards
- Not partial compliance with 2 criteria which will be resolved this year – with an overall rating of substantially complaint

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	
Quality Plan	x	Research and Development		Estates Plan	x
Financial Plan		Digital Plan		Other *2020 vision*	x

3. Previous consideration *[where has this paper been previously discussed?]*

Annual report to Trust Board

4. Recommendation(s)

The Trust Board is asked to:	
a.	Approve self-assessment so this can be reported to the Local Health Resilience Partnership before the end of November.
b.	
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):						
Board Assurance Framework		Risk Number(s):						
Equality Impact Assessment	Is this required?	Y	x	N	x	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y	x	N	x	If 'Y' date completed		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 6 September 2018

EPPR: Board standards approval of the NHSE Core Standards

1. Introduction

1.1 The Trust is assessed annually against compliance of NHS England's Core Standards for Emergency Preparedness, Resilience and Response guidance.

1.2 The submission due on the 31st August is assessed against 10 domains and 69 standards. Each year there is a 'deep dive' subject to be assessed; this year that is 'Command and Control'.

2. Outcome of self- assessment

2.1 The Accountable Officer for Emergency Planning, Rachel Barlow the Chief Operating Officer has assessed the Trust as substantially compliant with Dr. Nick Sherwood, the Clinical Emergency Planning Lead, Caroline Rennalls, Head of Operations and Resilience and Phil Stirling Emergency Planning Officer.

The Trust overall self-assessment is compliance against the standards.

2.2 Of the 69 criteria 2 have been assessed as partially complaint:

- The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.

- The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.

2.3 The table below summarises the key elements of evidence and compliance in the return appendix 1. A separate evidence folder will be supplied with the return.

No	Domain	Summary notes of self-assessment / progress this year
1	Governance	The Trust has continued to further strengthen the governance arrangements for emergency planning – appendix 2 outlines governance structure. The new role of Clinical Emergency Planning Lead has been introduced this year to enhance clinical leadership in this area. The business continuity group over sees learning from continuity events as well as planned tests and audits.

2	Duty to risk assess	Risks are both documented locally in clinical groups and or corporate directorates. The EPRR risk register pulls all risks assessed with the Trust and also documents national risks in a local context.
3	Duty to maintain plans	The Trust has the following plans, some of which have been activated this year: • Critical incident – activated internally • Major incident – live test completed this year • Heatwave – activated • Cold weather – activated • Pandemic influenza • Infectious disease • Mass Countermeasures • Mass Casualty - surge • Mass Casualty - patient identification • Shelter and evacuation • Lockdown – activated • Protected individuals • Excess death planning
4	Command and control	A call out mechanism is in place and tested regularly. All necessary staff are trained to lead strategic, tactical and key operational roles.
5	Training and exercising	Training and exercise plans in place.
6	Response	The Incident Command Centres are all in place. Testing has resulted in recommendations to enhance the strategic ICC. Work should be completed by end September.
7	Warning and informing	The Trust has stakeholder and media strategies to support emergency planning.
8	Cooperation	1 criteria partially met : The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum. The Accountable Emergency Officer has agreed delegation of this to the Head of Operations and Resilience to ensure future compliance of attendance no less than 75% of Local Health Resilience Partnership (LHRP) meetings per annum. This will now be complaint.

9	Business continuity	<u>1 criteria partially met :</u>The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own. Given the potential scale of providers and suppliers, this is a massive evidenced based piece of work. A request on clarity of evidence for this criterion has been asked of NHSE through the Locality Lead. In the absence of no response we have assessed partial compliance. We do engage with 3rd parties/ suppliers via a well governed and recognised procurement and tendering process which includes emergency plans, but we do not have a centralised log of these. Over 2018-19 we will concentrate on maturing our coordination of this element with advise from NHSE and the LHRP lead. _____ The Business Continuity Management Committee (BCMC) continues to cascade the concept of continuity planning, information and learning throughout the workforce. There is now a scheduled debrief and learning time each month to ensure real time learning from incidents and activation of business continuity plans as close to real time as possible. Groups continue to train, inform and advise staff of Business Continuity plans with wards, departments, directorates and groups. Groups and departments have RAG rated themselves through a self-assessment as amber and acknowledge more needs to be done to ensure all aspects of their workforce are familiar with the concepts, what it means in day to day operations and where to access their BCP folders and assistance if required. In 2017/18, 20 unannounced BCP audits were carried out there were some recurring themes • Senior staff on IP wards had a greater understanding of what Business Continuity meant for their area, where their BCP folder was kept and how staff could access it 24/7

		• Junior staff were unaware of what 'Business Continuity 'meant but when prompted about different situations that could be considered as business continuity, insufficient staffing, loss of electricity, flooding etc. they were able to articulate what they would do to keep their patient and team safe. • Senior staff in bespoke outpatient and day case services were unable to engage in the discussions and the time was spent teaching the staff and walking through their BCP folder. Activities since have bene completed to improve this and this will be re-audited in September. Further BCP unannounced audits in 18/19 Q3 are planned to test all clinical and corporate directorates. These will report monthly to the Emergency Planning Resilience and Response Committee.
10	CBRN (Chemical, biological , radiological and nuclear defence)	The Trust has changed the protective mask product this year and training is in place over Q2/3 to ensure the transition to new equipment is underpinned by staff competency.

2.4 This year's Core Standards Deep Dive focus is on Command and Control arrangements. We are fully compliant with the 8 domains and have strong evidence of how we activate Command and Control, meet good practice guidance, respond to, and recover from the several internal Critical Incidents managed over the last 12 months.

3. Recommendations and conclusion

3.1 The submission to NHS England was made on the 31st August, with a completed Core Standards template appendix 1, a copy of this Trust Board paper and a covering letter of confirming self-assessment of substantial compliance, pending Trust Board approval.

3.2 The Trust Board are asked to receive and acknowledge the submission of compliance against the NHS England's Core Standards for Emergency Preparedness, Resilience and Response.

3.3 If this recommendation is accepted a letter will then be sent to the Local Health Resilience Partnership confirming the Trust Board has received and approved the report.

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	4	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	3	1	0
Business Continuity	9	8	1	0
CBRN	14	14	0	0
Total	64	63	2	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments (including organisational evidence)
1	Governance	Appointed AEO	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	Rachel Barlow - Chief Operating Officer (AEO)	Fully compliant		Rachel Barlow		Rachel Barlow COO
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 making sure the 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.	Fully compliant		Philip Stirling		EPRR Policy statement contained within SWBH Major Incident Plan. Established governance structure - see attached evidence.
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 • business continuity, critical incidents and major incidents • the organisation's position in relation to the 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	Fully compliant		Rachel Barlow		Reports are taken through the EPRR committee. Trsut Baord receives compliance standardsa ans other relevant papers in year from the COO
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant		Philip Stirling		EPRR Action Tracker Business Continuity Management Committee Action Tracker Clinical Management of Mass Casualties Action Tracker (Commenced after Exercise Sandstorm February 2018) Both BCMC and CMMC report into the AEO who chairs the EPRR Group, who in turn reports to Trust Board.
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 fulfill 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	Fully compliant		Philip Stirling		see attached EPRR structure
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant		Philip Stirling		As in questions 1 - 5 Hot & Cold debriefs to identify learning opportunities, we have groups and departments carrying out Business Continuity Internal Audits and they report back to BCMC, we also have corporate unannounced audits we review log books regularly and create action plans and teaching points from these, which are fed into BCMC or CMMC.
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	Fully compliant		Philip Stirling		EPRR Risk Register - see attached
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	Fully compliant		Philip Stirling		Well established proscess of Incident and Risk management system within SWBH, this includes any incidents that relate to BCM and EPRR. The EPRR risk register is reported regualry to the EPRR committee.
Domain 3 - Duty to maintain plans										
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	Fully compliant		Philip Stirling		LHRP, LHRF, coordinate through NHS England, any plans that are written are available to be shared within Cat 1 & 2 responders, we consider best practice examples and draw from these. We attend conurbation wide exercises.
	Duty to maintain plans	Planning arrangements	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the following risks / capabilities:							
11	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 per 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	Fully compliant		Philip Stirling		Major Incident Plan Business Continuity Plan Tabletop exercising circa of 10 business continuity incidents within the last 12 months for which we have activated command and control and our ICC's we have considered workforce needs, equipment, the requirement for Mutual Aid, Communication strategies within and outwith SWBH, training needs etc.
12	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 per 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	Fully compliant		Philip Stirling		MIP v3 March 2019 review Testing of Plan : Exercise Sandstorm 4/2/18 Live Incidents Tabletop exercises
13	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 heat wave 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	Fully compliant		Philip Stirling		Severe weather plan - dated tested in December 2017 when activated for BC incident (snow) activated during summer months for Extreme weather (heatwave)
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	Fully compliant		Philip Stirling		Severe weather plan - dated tested in December 2017 when activated for BC incident (snow) activated during summer months for Extreme weather (heatwave)
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 as described in the National Risk Register.	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	Fully compliant		Dr Tranprit Saluja		PanFlu Plan DipCI Control of Infection committee FFP3 fit testing ongoing, plan is to have all front line staff tested. Working on inpatient vaccination campaign Operational Infection Control Meeting Executive IPCAC Infection Prevention and control advisory board committee

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 Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	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	Fully compliant		Dr Tranprit Saluja		Ongoing education and training is in place for Ebola mock sessions dedicated Cat 4 PPE kits and donning and doffing posters
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 the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant 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	Fully compliant		Philip Stirling		Strategy is part of annual flu preparations stockpile of flu vaccine in trust Major Incident Plan PanFlu Plan Mass Casulaty Plan The joint leadership of the Trust Clinical Lead for EPRR through CMMC and the DipSi would support the coordination of this operationally to meet guidance and legislation.
18	**Duty to maintain plans**	**Mass Casualty - surge**	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 increase capacity by 10% in 6 hours and 20% in 12 hours.	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	Fully compliant		Nick Sherwood		MIP Mass Casualty Plan Activate ICC's preparatory work is included in CMMC established close working with Cat 1 & 2 providers review use of our estate in line with surge and the Dynamic Risk Assessment Black Country Mass Fatalities Plan and SWBH Mortuary Expansion Plan in place.
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally 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	Fully compliant		Nick Sherwood		Mass Casualty Plan Dummy Dummy RXK numbers for Major Incident Casualty Registration. Pathology MIP process revised after testign I major incident exercise.
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	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	Fully compliant		Philip Stirling		SWBH Evac and Shelter Plan (v2). Full site evacuation addendum in draft TBC Q3.
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the '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	Fully compliant		Philip Stirling		Current Lockdown Procedure with revised lockdown paln in draft to be signed off in October
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including 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	Fully compliant		Ruth Wilkin		In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage protected individuals, including VIPs, high profile patients and visitors to the site.
23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	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	Fully compliant		Jonathan Walters		The Mortuaries at both City and Sandwell sites have overflow capacity to use in the event of excess deaths. Total additional body storage space is around 50 spaces. In excess of this number, the contingency plan would be to utilise other mortuaries within the surrounding area as part of the Black Country Pathology integration plans.
Domain 4 - Command and control										
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	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.	Fully compliant		Philip Stirling		Oncall arrangements have been revised from February 2018 to include a) Strategic Commander, b) Executive Directors, c) Senior Managers (Tactical) 24/7. Incident Commander packs for all participants and training prior to going live on the on call rota Strategic and Tactical training completed and annual refresher training ongoing
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 on 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	Fully compliant		Philip Stirling		Training provided on annual workplan and prior to commencing on call commitments training records attached
Domain 5 - Training and exercising										
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	Fully compliant		Philip Stirling		Training details attached in evidence folder
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	Fully compliant		Philip Stirling		Annual work programme Exercise sandstorm Reports from Reach for Catastrophic IT failure and IT critical Incidnt
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	Fully compliant		Philip Stirling		held locally and centrally
29	**Training and exercising**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems have been tested annually		• Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully compliant				Not Applicable for Acute Trust Providers
Domain 6 - Response										
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • 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	Fully compliant		Philip Stirling		ICC's x 4 ICC Grab Bags x 5 training schedule in annual workplan
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Fully compliant		Philip Stirling		held within ICC, updated regularly with latest iterations, oncall management team have hard copies of key plans see attached oncall packs

32	Response	Management of business continuity incidents	The organisation incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans	Fully compliant		Philip Stirling		BCMC - all groups and services represented by senior managers, self assessment (monthly Basis) incidents, learning identified lessons and peer reviews that have occurred. BCM Folders in each department within the whole organisation (refreshed annually)
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.	Y	• Documented processes for accessing and utilising loggists • Training records	Fully compliant		Philip Stirling		Loggist Training, Strategic and Tactical trained loggists Site team provide 24/7 Loggist cover made by Clinical Nurse Practitioners and Capacity Team Annual Loggist Training included in Annual Workplan Increasing loggist pool by providing training to all suitable administrative Band 4 and 5's within SWBH starting in Quarter 3 of 2018/19
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	Fully compliant		Philip Stirling		SBARR, ETHANE, METHANE and also a governance around Information distribution via COO/director on call
35	Response	Access to 'Clinical Guidance for Major Incidents'	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant		Philip Stirling		Hard Copy availbale in both ED's and on Connect
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	Fully compliant		Philip Stirling		Hard Copy availbale in both ED's and on Connect
Domain 7 - Warning and informing										
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 • 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	Fully compliant		Ruth Wilkin		the organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident. Have emergency communications response arrangements in place - see attached Comms protocol Social Media protocal 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 Having a systematic process for tracking information flows and logging information requests and being able to deal with mutlipe 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 organisations warning and informing work.
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public 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	Fully compliant		Ruth Wilkin		The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents have emergency communications response arrangements in place - see attached BCP for Comms The Trust maintains a database of media who have (following new privacy regulations - GDPR) consented to be contacted by us. This list includes titles which cater for non English speaking communities The Trust press offices has KPIs which track performance in the development of social media channels, ensuring that in a major incident those channels will afford as widespread coverage as possible, directly to our communities The Trust press office works with local media to seek their advice on what they would need from the press office in the event of an incident, and use the learning as part of the table top exercise to keep all comms team members regreshed in comms response to a major incident.
39	Warning and informing	Media strategy	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a 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'	Fully compliant		Ruth Wilkin		The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokeperson able to represent the organisation to the media at all times. The Trust press office maintains a cohort of appropriately trained and tested media spokespeople, covering our Trust executive, managers and clinicians.
Domain 8 - Cooperation										
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings	Partially compliant	Caroline Rennalls is now in attendance at LHRP with agreed delegation for attendance	Caroline Rennalls		delegated responsibilty from AEO for SWBH attended from July 2018
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 other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	Fully compliant		Philip Stirling		attendence at Sandwell Resilience Group by EPO Minutes of meeting attached
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Fully compliant		Philip Stirling		Mutual Aid Handbook (active participant in publishing the handbook) Attend LHRF Black Country Alliance Closely alligned with local authorities
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs					not applicable for Acute Trust Providers
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency					not applicable for Acute Trust Providers
45	Cooperation	LHRP	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas					not applicable for Acute Trust Providers
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	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'.	Fully compliant		Kam Dhami		We have an Information Sharing Policy which is available Trust wide via Connect. Latest itteration is awaiting approval and will be available once signed off. Susbmitted by Allison Binns
Domain 9 - Business Continuity										
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Fully compliant		Philip Stirling		Over arching Business Continuity Plan with Departmental Business Continuity Folders including Business Impact Analysis for each Service.
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, 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 ensure they are aware of their roles • Stakeholders	Fully compliant		Philip Stirling		Business Continuity Management Committee (BCMC) Terms of Refernce for BCMC, Minutes, Action Tracker, and self assessment audits, corporate unnanounced audits, 17/18, 18/19. BCMC reports to EPRR Group chaired by AEO, which in turn reports to Trust Board. Business Continuity Folders trust wide bespoke for each individual department/service.
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.	Fully compliant		Philip Stirling		see questions 47/48
50	Business Continuity	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Fully compliant		Mark Reynolds		all trusts have until March 2019 to comply with the DP & S. The Trust is looking towards compliance within this periods. - Submitted by Mark Reynolds CIO

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 updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Fully compliant		Philip Stirling		detailed in all BCP Trust wide which incur an annual validation sign off outcomes of which reported through BCMC to EPRR Group
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against the 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	Fully compliant		Philip Stirling		BCMC held on a monthly basis, paper for unannounced visits (attached in evidence folder) local audits and peer reviews
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	Fully compliant		Philip Stirling		see question 53 see board report 7th Sept 2017 (attached in evidence folder)
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess 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	Fully compliant		Philip Stirling		Annual assurance process, BCP and BIA's reviewed annually by local managers with validation and sign off corporately reports of compliance submitted to BCMC / EPRR
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 arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Partially compliant		Rachel Barlow		Standalone Business Continuity Policy is in place. We have provider/supplier business continuity arrangements that are secured through procurement. There is no central record of contracts and business continuity plans, test cycles and assurance - hence the partial compliance self assessment. The AEO will seek further advise from NHSE on the evidence to meet full complaince and over see actions to reach full compliance through the EPRR Committee .
Domain 10: CBRN										
56	CBRN	Telephony advice for CBRN exposure	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Fully compliant		Philip Stirling		via Trust Tactical Oncall and expertise through WMAS and WMFS
57	CBRN	HAZMAT / CBRN planning arrangement	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	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	Fully compliant		Philip Stirling		Major Incident plan with designated training schedules for Emergency Departments overseen by CBRN lead in SWBH
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Fully compliant	Still awaiting WMAS to carry out 2018.2019 audit for CBRN.	Philip Stirling		Major Incident Plan Decontamination process tested monthly at City Decon Tent at SGH set up weekly with last live test of patients in August 2017 Decontainer live test of patients on 15th September 2018
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	Fully compliant		Philip Stirling		IORP process in place across organisation, static decontainer at City, Tent at SGH
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 Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.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	Fully compliant		Philip Stirling		see attached decontamination document in evidence pack
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	Fully compliant		Philip Stirling		see attached PRPS document in evidence pack
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • 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.	Fully compliant		Philip Stirling		see attached decontamination document in evidence pack
63	CBRN	Equipment PPM	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Fully compliant		Philip Stirling		Sandwell - GRS maintenance programme 18/19, PRPS suits maintained annually in line with NHS England, Equipment checked monthly City - Decontainer maintained by Trust Estates, with weekely water and visual checks
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	Fully compliant		Philip Stirling		MIP and PHE guideline
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	Fully compliant		Philip Stirling		EPO is Trust CBRN lead with departmental trainers in both ED's
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	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/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Fully compliant		Philip Stirling		Detail contents of Training - staff welfare, management etc
67	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	Fully compliant		Philip Stirling		EPO is Trust CBRN lead with departmental trainers in both ED's
68	CBRN	Staff training - decontamination	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.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Fully compliant		Philip Stirling		ED Reception staff are trained in STEPS 1,2 3 + ED Clinical Teams are trained in above and CBRN Assessment Units and Maternity are trained in doning and doffing for Cat 4 pathogens
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	Y		Fully compliant		Paul Hooton		Currently undergoing a trust wide testing programme using trust standard masks. Organisation has 'stock' of masks within central stores should the need arise in addition to the individual ward and department areas stock being depleted rapidly.

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Director Commissioning Operations Team	NHS England Regional Team	NHS England National Team	NHS Improvement	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control																								
Domain: Incident Coordination Centres																								
1	**Incident Coordination Centres**	**Communication and IT equipment**	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Fully compliant		Philip Stirling		PC's, Networked Printers, Designated incoming / outgoing telephones, TV's, Videoconferencing Facility, teleconferencing facility, break out rooms, HF radio (cross site)
2	**Incident Coordination Centres**	**Resilience**	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Up to date training records of staff able to resource an ICC	Fully compliant		Philip Stirling		Oncall arrangements have been revised from February 2018 to include a) Strategic Commander, b) Executive Directors, c) Senior Managers (Tactical) 24/7. Incident Commander Pack for all participants and training prior to going live on the oncall rota Strategic and Tactical training completed and annual refresher training ongoing.
3	**Incident Coordination Centres**	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Post test reports Lessons identified EPRR programme	Fully compliant		Philip Stirling		used regularly for incidents, checked on a monthly basis with tick off sheet for replenishments, stocks ordered centrally
4	**Incident Coordination Centres**	**Functions**	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant		Philip Stirling		Major Incidnet Plan Action Cards (Tactical) ICC Set Up guide
Domain: Command structures																								
5	**Command structures**	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant		Philip Stirling		Oncall arrangements have been revised from February 2018 to include a) Strategic Commander, b) Executive Directors, c) Senior Managers (Tactical) 24/7. Incident Commander Pack for all participants and training prior to going live on the oncall rota Strategic and Tactical training completed and annual refresher training ongoing. EPRR Action Tracker, BCMC Action Tracker in place, CMMC Action Tracker (formed from Exercise Sandstorm)
6	**Command structures**	**Stakeholder interaction**	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR policy statement and response structure	Fully compliant		Philip Stirling		LHRF, LHRP, Sandwell Resilience Group, command and control in line with NHS England guidance and JESIP principles. Networking with EPO's and other AEO's/CEO's of Cat 1 & 2 responders.
7	**Command structures**	**Decision making processes**	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant		Philip Stirling		follow the JESIP decision making process which is included in our Major Incident Plan, Training records attached we keep and maintain a record of all Critical Incidents and Logbooks and any related documents for these.
8	**Command structures**	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant		Philip Stirling		detailed within Major Incident Plan, where appropriate we invite external agencies to Hot and Cold debriefs. Recovery begins alongside response.

Overall assessment:			#REF!						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	• Minutes of meetings	Partially compliant	Caroline Reannalls now in attendance at LHRP.	Caroline Rennalls		delegated responsibilty from AEO for SWBH attended from July 2018
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 arrangements work with their own.	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Partially compliant		Rachel Barlow		Standalone Business Continuity Policy is in place. We have provider/supplier business continuity arrangements that are secured through procurement. There is no central record of contracts and business continuity plans, test cycles and assurance - hence the partial compliance self assessment. The AEO will seek further advise from NHSE on the evidence to meet full complaince and over see actions to reach full compliance through the EPRR Committee .

Appendix 2

Emergency Preparedness Response and Recovery (EPRR) Governance Structure