TRUST BOARD
31 October 2019

	15.3
TITLE OF PAPER	Emergency Preparedness Resilience & Response (EPRR) Annual Assurance report
Confidential	**NO**
Suitable for public access	**YES**

PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED
Major Incident and Business Continuity committee & Trust Executive Committee

STRATEGIC OBJECTIVE(S):

Best outcomes		Ensuring patient and staff safety
Excellent experience		Ensuring core critical business continuity at all times
Skilled & motivated teams		Ensuring staff have the necessary skills and confidence to respond to any incident/business disruption which may impact on the service/care to our patients
Top productivity		To maintain essential care all times; irrespective of incident/disruption

EXECUTIVE SUMMARY	
	The Board are asked to review the Trusts EPRR self-assessment review outcome and associated work plan.
	Following this year's review ASPH have concluded an overall compliance rate of 'Substantial' - (based on the NHS England definitions). This rating acknowledges good practice and has identified one or more of the core standards which require some additional support/work in order to achieve full compliance
RECOMMENDATION:	

SPECIFIC ISSUES CHECKLIST:

Quality and safety	To ensure staff have the necessary skills to deliver appropriate levels of care during an incident (including Mass casualty presentation)
Patient impact	To maintain patient safety at all times irrespective of incident type or business disruption
Employee	In the event of any incident, all staff (Bronze, Silver & Gold) need to have the essential competence to ensure an effective response.

Other stakeholder	Multi-agency (as per the Surrey Major Incident Plan – SMIP) and national response
Equality & diversity	All people (patients/staff) to be prioritised/managed irrespective of age, gender, ethnicity etc
Finance	On-going training and support to LIVE exercise – 2018 will have associated costs (this can be managed within the current allocated EPRR budget)
Legal	NHS England Planning framework ("Everyone Counts: Planning for Patients 2013/14), the NHS Standard Contract (Section E) and through this the NHS England Emergency Preparedness Framework (2015). Reference to EPRR is also made in the Essential Standards of Quality and Safety (Outcomes 4, 6,10,13,14 & 20) and the Health & Social Care act 2012.
Link to Board Assurance Framework Principle Risk	Patient Safety
AUTHOR	Claire O'Brien, Head of Emergency Planning & Resilience
PRESENTED BY	James Thomas, Chief Operating Officer
DATE	17 October
BOARD ACTION	Assurance

Ashford and St. Peter's Hospitals **NHS**

NHS Trust

Emergency Preparedness Resilience & Response (EPRR)

Annual Report

Updated Oct 19

Contents

Appendices

Foreword

Ashford & St Peters Hospitals NHS Foundation Trust (ASPH) is recognised as a Category 1 (CAT1) responder. The Civil Contingencies Act (CCA-2004) requires that all Cat1 organisations are able to demonstrate they can plan for and respond to a wide range of incidents and emergencies; whilst ensuring core critical business and safe care to patients and staff is maintained.

Incidences are graded according to levels of risk/severity and include; prolonged periods of surges in demand, extreme weather, outbreak of infectious disease, critical incidences, internal business continuity & Major Incidents

The Emergency Preparedness Resilience and Response (EPRR) core standards have been designed to help all Cat1 responding organisations understand their roles and responsibilities relating to incident management. The following report sets out where ASPH are against these core standards

Introduction

The Emergency Preparedness Resilience & Response (EPRR) annual assurance process looks to assess Category 1 (CAT 1) organisations (& the NHS as a whole) against the NHS EPRR Core standards.

The process follows a self-assessment against the core standards including;
- NHS England Planning Framework ("Everyone Counts: Planning for Patients 2013/14),
- NHS Standard Contract (Section E)
- NHS England Emergency Preparedness Framework (2015).
- Reference to EPRR is also made in the Essential Standards of Quality and Safety (Outcomes 4, 6,10,13,14 & 20) and the Health & Social Care Act (2012), 'Working in partnership with other organisation/providers, ensuring co-operation and sharing of information in order to facilitate effective planning and response to Major Incident and incidents affecting business continuity/resilience'.

NHS Core Standards

NHS EPRR Core Standards identifies that providers of NHS funded care will:
- **Nominate an Accountable Executive Officer (AEO)** who will be responsible for EPRR and business continuity management. For ASPH the AEO is the Chief Operating Officer (COO); reporting to the Chief Executive. EPRR duties (including Business Resilience) are delegated to the Head of Emergency Planning & Resilience. (**See appendix B)** for EPRR reporting structure & MI/BC meeting ToR.
- **Mutual Aid**: Sharing resources as necessary in the event of a significant incident or emergency.
- **Incident Preparedness and Response**: Contribute to an annual NHS England (NHSE) report on the health sector's EPRR capability and capacity in responding to national, regional and Local Resilience Forum (LRF) incidents.
- **Planning:** Have plans in place which set out how we plan for, respond to and recover from disruptions, significant incidents and emergencies.
- **Incident Control Centre**: Provide suitable environment for managing a significant incident or emergency (incident control room). This must include a suitable space for making decisions (including break-out rooms); for collecting and sharing information quickly and efficiently.
- **Business Continuity**: Develop, maintain and continually improve business continuity management processes. This means having suitable plans which set out how ASPH will maintain continuity of its critical services (from assessment of local and national risks) and how they will recover delivery of key services in line with ISO 22301.

ASPH are required to self-assess (against the EPRR Core standards), and publish their level of compliance against the EPRR assurance process (**See appendix A**)

Core standard domains used to self-assess NHS provider compliance include:
- Duty to assess risk
- Duty to maintain plans
- Command & Control
- Training & Exercising
- Response procedures
- Warning & Informing
- Cooperation
- Business Continuity
- Chemical Biological Radiological Nuclear (CBRN)
- Deep Dive

Assurance rating:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant*	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

In order to minimize/negate identified risks, areas of non-compliance form part of an on-going EPRR work plan (**see appendix C**). This board report, (including the core standards assurance ratings and work-plan) will be submitted to the Clinical Commissioning Group (CCG) and the Local Health Resilience Partnership (LHRP) board for review/further scrutiny. Evidence of plans, training and exercising have been uploaded to Resilience Direct

Accountability & Responsibility:
The Head of Emergency Planning & Resilience works closely with all divisional leads/heads of depts to ensure robust business continuity plans/MI and internal incident response plans are in place. All plans are accessible via the Trustnet; reviewed annually (supported by the Emergency Planning Officer). Training, including incident response; for operational (bronze), tactical (silver) and gold (strategic) on-call staff forms an integral part of ensuring staff have the necessary confidence and competence to manage all incidences.

Training & Exercising requirements under the CCA:
- Annual table top exercises,
- Regular Commex - Communications Exercises (6 monthly)
- 3 yearly – Live Exercise.

For Training & Exercising undertaken during 2018/19 to date: **(see appendix D)**

Lessons learnt:
The Trust carries-out hot and debrief following all planned and unplanned incidences. These allow the Trust to share learning and make changes to policy and procedure in light of the lessons learnt. Some of the key lessons learnt include:

- **Business Continuity**: We continue to ensure (during planned downtime) that all relevant depts are engaged and any risks identified are communicated and where possible mitigated.
- (**See Appendix E for BC Risk Assessment**)
- **Evacuation:** We continue to carry-out a rolling programme for evacuation training. This enables staff to familarise themselves with use of the evacuation equipment and make changes to local fire exit routes/strategies post these exercises. The evacuation exercises have been extended to cover WCH; enabling staff to improve fire response procedures (both in & OOHs). Fire exit routes (internal and external) have also been updated.
- **Action Cards:** Director and Senior Support Manager 'action cards' have been updated to include **METHANE** (an acronym used by all emergency responders in the event of an incident); taken from the Joint Emergency Services Inter-operability Principles (JESIP). Following 'Exercise Buzzard' the Trust has made a number of changes to all action cards including the development of a Commanders action card (to be used by Ortho/Surgeons) in the event of a mass casualty incident as well as a 'tracking log' to ensure casualties are tracked (at all times) during an incident

Updated/reviewed Policies/Plans/Procedures
- Major Incident Plan (MIP): The Trusts MIP (including relevant action cards) are

reviewed and updated annually. Key additions include Mass casualty Response and new NHS England definition for MI

- On-call Policy (Silver & Gold)
- Flu Plan
- Corporate Business Continuity Plan
- Fuel Vehicle Plan
- Lockdown Plan
- Evacuation Plan
- Adverse Weather Plan
- Countermeasures Plan
- Trauma Delivery Group Meetings: Monthly to monitor/audit Trauma Unit clinical delivery
- Bronze, Silver & Gold Core competencies
- Trauma Operational Policy

Non-compliant EPRR Core standards/work-plan 19/20

Following the EPRR assurance self-assessment process the trust has scored green in the majority of the core standards requirements. Over-all the Trust has achieved a rating of **SUBSTANTIAL.** The below standards were considered non-compliant. The Head of EPRR with relevant personnel will continue to work on the below areas (as part of an on-going work plan for 19/20); to address the identified gaps. Monitoring of progress will be via the monthly Major Incident and Business Continuity monthly meetings

Ref	Standard	Rating	Commentary
CS40	LHRP attendance	Partial	AEO to have attended the annual assurance meeting and a Director to attend 75% of LHRP Exec meetings.
CS48	Business Continuity – BCMS Scope and Objectives	Partial	Agreement with the organisations self-assessment
CS49	Business Continuity – Business Impact Analysis	Partial	Review of current process to be undertaken.

Deep Dive			
DD12	Risk assess	Partial	Severe weather to be added to risk register
DD16	Risk assess	Partial	Climate change risk to be added to register
DD19	Flooding	Partial	Outcomes of site reviews to be implemented

Conclusion:

The board is asked to agree the core standards self-assessment rating.

Ref	Domain	Standard	Detail
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.
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.
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.
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.
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.
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.
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.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.

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.
	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).
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).
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.
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.
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.
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.
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 dependent on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.
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.
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.

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.
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.
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.
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.
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.
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.
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.

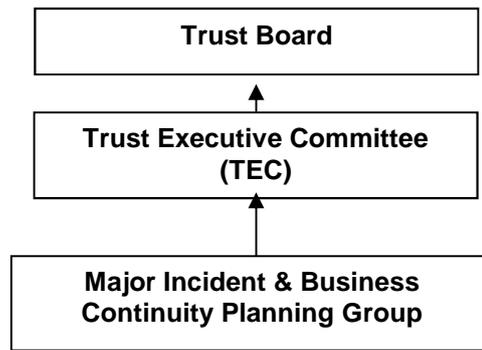|			
27	**Training exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • 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.
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
29	**Training and exercising**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems have been tested annually
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.
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.
32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.
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.
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.
35	**Response**	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.

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.

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.
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.
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.

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.
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.
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).
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.
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.
45	**Cooperation**	**LHRP**	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) meets at least once every 6 months.
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.

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).

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.
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).
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.
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.
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.
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.
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.
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.

Domain 10: CBRN

56	**CBRN**	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).
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.
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.

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.londonccn.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/
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.
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.
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
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training
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.
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.
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.
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.

EPRR Reporting Structure:

```
                    ┌─────────────────────────┐
                    │       Trust Board       │
                    └─────────────────────────┘
                                 ▲
                    ┌─────────────────────────┐
                    │ Trust Executive Committee│
                    │          (TEC)          │
                    └─────────────────────────┘
                                 ▲
              ┌──────────────────────────────────┐
              │   Major Incident & Business       │
              │   Continuity Planning Group       │
              └──────────────────────────────────┘
```

MAJOR INCIDENT & BUSINESS CONTINUITY PLANNING GROUP - Terms of Reference (ToR)

Constitution
The Trust Executive Committee (TEC) hereby resolves to establish a group to be known as the Major Incident & Business Continuity Planning Group (MIBCG).

Authority
This Group is authorised by the TEC to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Group.

Membership
1. Head of Emergency Planning & Resilience - Chair
2. Head of Communications
3. Estates/CSNP rep
4. Facilities Manager
5. A&E Consultant/Lead Nurse/manager (Major Incident Lead)
6. Emergency Services Rep
7. Therapies Representative
8. HR Representative
9. Emergency Planning Officer
10. Infection Control Consultant Nurse
11. Pathology Manager
12. Maternity – rep
13. Ortho, Med & Surgery – service managers
14. PGEC Manager
15. SABP/Runnymede Emergency Planning Managers
16. Theatres rep
17. Pharmacy Manager
18. Vol Services
19. Optivio housing Rep

Quorum
A quorum of 10 is required to conduct the meeting to exercise all or any of the authorities, powers and discretions invested in or excisable by the group. It is essential that the following are in attendance at all meetings:
- Head of Emergency Planning or Emergency planning Officer
- Representative from Operations
- Representative from A&E

Frequency and Conduct
The Group will meet monthly. The meetings will be no more than 1 hour. The frequency could be increased as external events direct.

Items for the agenda should be submitted to the Emergency Planning Officer a minimum of 10 days before the meeting. The agenda is to be distributed to all members one week before the meeting.

Duties
1. To ensure the Trusts ability to respond to major incidents and emergencies of all types – CBRNE, Flu Pandemic, Heat wave, Adverse Weather, Flood, Fuel Shortage, etc whilst maintaining business continuity as far as is reasonably practicable.
2. To ensure that the arrangements made by the Trust meet the requirements of the Civil Contingencies Act, national and Surrey Local Resilience Forum guidance in respect of;
    2.1 Plan Contents
    2.2 Testing
    2.3 Training
    2.4 Exercising of plans
    2.4.1 A live exercise every three years
    2.4.2 A table top exercise every year
    2.4.3 A communications cascade every six months
3. To develop and revise the Trust's Major Incident Plan (MIP) and Business Continuity Plans (BCP), ensuring that the Trust can respond effectively to a Major Incident/Internal Incident, on any day and at any time. Ensuring any organisational changes are reflected in the plan.
4. Ensure that the Trust meets its requirements of the Civil Contingencies Act, that being:
    - Assess local risks and use this to inform emergency planning
    - Put in place emergency plans
    - Put in place Business Continuity Management arrangements
    - Put in place arrangements to make information available to the public about protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
    - Share information with other local responders to enhance co-ordination
    - Co-operate with other local responders to enhance co-ordination and efficiency
5. To ensure that all communications systems are in place to support the Major Incident Plan.
6. To be the focal point for all matters related to emergency planning.
7. To report to the TEC on an annual basis regarding emergency planning, exercise reports, training and testing the Trust.

Key Responsibilities
1. To ensure that all Divisions and Departments provide effective input into the development of the Major Incident Plan and other associated plans, and that the individual responsibilities of managers and departments are identified.
2. To ensure that all Trust staff are aware of and understand their role in the event of a Major Incident and receive appropriate training to fulfil those roles.
3. To agree and plan all major incident exercises (as noted in point 2.4), and to ensure debriefs take place. To receive reports following all exercises and build lessons learned into the relevant Trust's plans.
4. Identify resource implications by ensuring the Trust is able to discharge its statutory responsibilities in respect of responding to major incidents and emergencies.
5. Ensure effective 2 way communications with the Surrey Local Resilience Forum.

Reporting Lines
This Group will report to the Trust Executive Committee (TEC)
The Group will receive reports from the Pandemic Flu Groups and Winter Planning meetings as required.

Monitoring The Chair is to provide an annual report to the Trust Executive Committee (TEC).

Appendix C

Training/ Exercise/ Briefing/sessions	Priority rating *High/ Medium*	Staff Groups	Dates	Comments
Clinical Site Team MI Training	High	Bronze	24th Sept 18 27th March 19	Review of action cards and MI response
Senior Support Manager MI Training	High	Silver	Monthly	Monthly training meetings for SSM group Competency training x 3 sessions for new SSMs
Director on call MI Training	High	Gold	Monthly	Monthly training meeting Initial training X3 sessions for new DOCs
Introduction to Major Incident Response - Staff Induction	High	Bronze, Silver & Gold	Monthly	Monthly presentation at induction. Information leaflet & staff member at the induction market place.
CBRN: PRPS training	High	Bronze	18th July 18, 1st April 19	Donning & Doffing of PRPS (ED)
CBRN: Decontamination (Dry/Wet)	High	Bronze	18th July18, 1st April 19	Dry & Wet Decon capability inc Tent ED, Porters, estates)
UTC MI/CBRNe Training	High	Bronze	6th March 19	Dry & Wet Decon capability
Call Centre Training	medium	Bronze	16th, 23rd & 24th April 18	Training of staff to man additional call centre in event of large scale incident
Brexit (BCP)/Table top	Medium	Bronze, Silver & Gold	5th Nov 18, 6th Dec 18 10th Jan 19 30th Jan 19 28th Feb 19 27th March	Planning, exercising and debrief for Brexit preparedness
Commex (6 monthly)	High	Bronze, Silver & Gold	24th Sept 18 & 27th March 19	Communications exercise
Fire Evacuation Exercises	High	Bronze, Silver	21st May 18 22nd May 18 11th June 18 7th Aug 18 25th Sept 18 18th Oct 18 6th March 19 23rd April 19	Falcon Swan Woking community Hosp Cardiac, Birch & In Health NICU & labour ward ITU Department

Loggist Training	Medium	Bronze Silver & Gold	14th Dec 18 On-going On-going	Frimley park Hosp Refresher Training sessions for loggists on-going Online working with your loggist
External Exercises	Medium	Silver	25th Oct 18 25th Sept 18 14th Feb 19	Exercise Radialm Observer for MI Exercise (Surrey & Sussex Health Care) LHRP Brexit table Top
Table Top MI exercises (annual)	High	Silver & Gold	28th Feb 19	Brexit Table Top Brexit Debrief
MI LIVE Exercise (3 years)	High	Bronze, Silver & Gold	3rd July 18 4th July	Exercise Buzzard (exercising PHE & management of Trauma as per the SWL&S Trauma Network MI Plan) Cold Debrief
Jessip Principles	High	Silver & Gold	30th Oct 18 16th Nov 18 26th Nov 18 11th Dec 18 23rd Jan 19 13th & 21st Mar 19 13th May 19	For all on-call managers METHANE now included in action cards
RDN (EPRR)	Medium	Silver	Quarterly	RDN EPRR Group
MI & BCP Meetings	Medium	Bronze & Silver	Monthly	MI meeting with dept heads including review of BCP and action cards
SWL&STN meetings	Medium	Silver	Quarterly	Review of TU policy & procedures with MTC (SGH)

Appendix D

Title – BUSINESS CONTINUITY RISK ASSESSMENT

Introduction

Areas affected - The following activity areas have been identified as possibly being affected:

Contingency plan

Risk assessment

What are the hazards	Who might be harmed and how	Existing control measures	Further action	Action by whom

Escalation

Leads Contact:-

Conclusion/Required Action:

Report By:
Signed-off by:
Head of Emergency Planning & Resilience……
Director……….