NHS Rotherham Clinical Commissioning Group

Operational Executive – 27th August 2021

AQUA – 7th September 2021

Clinical Commissioning Group Governing Body – 1st September 2021

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2021-22

Lead Executive:	**Chris Edwards, Chief Officer**
Lead Officer:	**Ruth Nutbrown, Assistant Chief Officer** **Alison Hague, Corporate Services Manager**
Lead GP:	**Dr Jason Page, GP Lead**

Purpose:

To inform Governing Body of the annual assurance process for NHS England against the EPRR Core Standards.

Background:

The letter attached at 'Appendix 1' outlines the annual assurance process for EPRR required by NHS England. Stage 1 relates to the self-assessment which has been completed by NHS Rotherham CCG 'Appendix 2' and requires sign off by Governing Body in October to allow us to hit the **29th October 2021** deadline for submission.

Analysis of key issues and of risks

The EPRR assurance process usually uses the NHS England Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review, therefore, a small number of standards have been removed to accommodate this year's assurance process.

This year's the Deep Dive element to the assurance process focusses on internal piped oxygen systems which is not applicable to the CCG.

The CBRN standards at the bottom of the spreadsheet are also not applicable to the CCG these have been included on the template in error.

The full self-assessment document is attached at 'Appendix 2' the table below shows the summary, and narrative.

Core Standards	Total Standards applicable in 2019	Total standards applicable 2021/22	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	6	0	0
Duty to risk assess	2	2	2	0	0
Duty to maintain plans	9	9	9	0	0
Command and control	2	1	1	0	0

Training and exercising	3	0	0	0	0
Response	5	5	5	0	0
Warning and informing	3	3	3	0	0
Cooperation	4	4	4	0	0
Business continuity	9	7	7	0	0
CBRN	0	0	0	0	0
Total	43	37	37	0	0

The recommendation for EPRR Core Standards is **fully compliant**.

Patient, Public and Stakeholder Involvement:

NA

Equality Impact:

NA

Financial Implications:

NA

Human Resource Implications:

NA

Procurement Advice:

NA

Data Protection Impact Assessment

NA

Approval history:

NA

Recommendations:

Governing Body is asked to:

- Approve the EPRR Core Standards 2021 to enable submission to NHSE by 29th October 2021.

Paper is for Approval

APPENDIX 1

Classification: Official
Publication approval reference: PAR628

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

22 July 2021

To:

- NHS accountable emergency officers
- NHS England and NHS Improvement:
  - Regional directors
  - Regional heads of EPRR
  - Regional directors of performance and improvement
  - Regional directors of performance
  - LHRP co-chairs

CC:

- NHS England and NHS Improvement Business Continuity team
- CCG accountable officers
- CCG clinical leads
- CSU managing directors
- Clare Swinson, Director General for Global and Public Health, Department of Health and Social Care
- Emma Reed, Director of Emergency Preparedness and Health Protection Policy Global and Public Health Group, Department of Health and Social Care

Dear Colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2021-22

I would like to reiterate my thanks to you and your teams for your leadership and delivery of patient care during the last 18 months. During this time the NHS has not only responded to the COVID-19 Pandemic, but also a number of concurrent incidents, through which the resilience of the NHS has been exceptional. Our ability to respond so effectively to so many concurrent issues is a direct result of the years of dedicated focus on Emergency Preparedness and the hard work of our EPRR teams.

As our work now moves from response to recovery, we will all be using this time to reflect on the last 18 months, so that we can identify lessons for the future. This work will lead to the development of local, regional and national workplans to ensure that we embed the lessons into practice at an appropriate pace.

NHS England maintains its statutory duty to seek formal assurance of both its own and the NHS in England's EPRR readiness. This is discharged through the EPRR annual assurance process. Due to the demands on the NHS, the 2020 process was much reduced and focused on learning from the first COVID-19 wave and the preparation for future waves and winter.

The 2021 EPRR assurance aims to return some of the previous mechanisms to the process, but also acknowledges the previous 18 months and the changing landscape of the NHS.

This letter notifies you of the start of the EPRR assurance process and the initial actions for organisations to take.

Core standards

The EPRR assurance process usually uses the NHS England Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. We have, therefore, removed a small number of standards to accommodate this year's assurance process, until we undertake a full review. The adapted standards being used for this year's assurance process are attached to this letter.

Organisations are asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each.

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with core standard.
Partially compliant	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.
Non-compliant	Not compliant with the standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Through our response to the COVID-19 pandemic we have identified a number of factors that inhibit our ability to increase inpatient capacity. One of these factors is internal piped oxygen system capacity, which have a number of interdependent components to increasing volume and flow rates. In order that we better understand the resilience of our internal piped oxygen systems the 2021-2022 EPRR annual deep dive will focus on this area.

The deep dive will be applicable to all providers of NHS funded care that utilise internal piped oxygen systems, including acute, community and mental health trusts.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Action to take/next steps

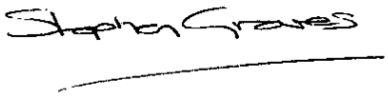
- All NHS organisations should undertake a self-assessment against the 2021 amended core standards (attached) relevant to their organisation. These should then be taken to a public board or governing body meeting for agreement.
- LHRPs to work with their constituent organisations to agree a process to gain confidence with organisational ratings and provide an environment to promote

the sharing of good practice. This process should be agreed with the NHS England and NHS Improvement regional Head of EPRR and ICS leaders.

- NHS England and NHS Improvement regional Heads of EPRR to work with LHRP co-chairs to agree a process to obtain organisation level assurance ratings and provide an environment to promote the sharing of good practice across their region.
- NHS England and NHS Improvement regional heads of EPRR to submit the assurance ratings for each of their organisations and description of their regional process to myself before Friday 31 December 2021.

If you have any queries, please contact your regional head of EPRR in the first instance.

Yours sincerely,



Stephen Groves
National Director of EPRR
NHS England and NHS Improvement

North East & Yorkshire Annual EPRR Assurance Process for 2021-22

Dear Colleagues

Please find below details in regard to this years annual EPRR Assurance Process within the North East & Yorkshire region.

Accompanying this letter, you will find three additional documents –

- B0628_2021 EPRR Annual Assurance Letter from Stephen Groves
- B0628_2021 EPRR Assurance Standards (excel document)
- NEY Regional Statement of Compliance template

You will note that this year we are collecting assurance on a reduced number of standards.

This does not replace your statutory responsibility to be compliant with the full set of standards applicable to your organisation, but in recognising the demands over the last 18 months, we will not be seeking to obtain assurance on your compliance against a number of those standards previously issued.

The timeline for submission of this year's standards within the North East & Yorkshire region will be as follows:

Colleagues are asked to send copies of the following back to myself (sarah.tomlinson8@nhs.net) by Friday 29th October 2021 in order that we can undertake the thematic reviews and prepare for our learning sessions in November 2021.

Many Thanks as always for your continued support

Paul Dickens
Regional Head of EPRR for the North East & Yorkshire and North West Regions

Ref	Domain	Standard	Detail	Clinical Commissioning Group	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	EPRR Policy	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Our Chief Officer Chris Edwards is our Emergency Accountable Officer. He receives overarching assurance on our EPRR work programme and signs our annual EPRR Statement of Assurance after it has been presented to Governing Body for approval. Mrs Ruth Nutbrown - Assistant Chief Officer - has responsibility for ensuring EPRR requirements are embedded within provider contracts. .
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Our Emergency Preparedness Resilience & Response Policies cover all the core standards required of CCGs and are published on our websites. The Policy: • Has a change control process via the Corporate Governance Teams which includes version control (see coversheet and following page). • Takes account of changing business objectives and processes via annual review by the Accountable Emergency Officer and refresh if needed (delegated on coversheet). • Takes into account any changes in our functions and/or organisational structural and staff changes by listing job titles rather than individuals (action cards). • Makes clear our contracting responsibilities (section 3.2 of procedure). • Takes account of any updates to risk assessment(s) by the LHRP or
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	GB Minutes 1st July 2020 - EPRR Assurance Process. GB Minutes 7th October 2020 - EPRR Core Standards GB Minutes 2nd December 2020 - SYB CCG On Call Test Incident Co-ordination Team meetings weekly Covid Debrief Reviews	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Corporate Governance/Assurance Reports are received by our Governing Body on a Quarterly basis which capture EPRR assurance, including any response to incidents. Weekly Incident Co-ordination Team meetings. Covid Debrief Reviews
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	The AEO is supported by the Assistant Chief Officer. Approval of the EPRR Policy is through Governing Body.
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	EPRR Policy	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	We receive feedback via the LHRP on local incidents so that lessons can be learned - RAAC Tabletop, Learning for COVID 19 an winter 2020. any learning for CCGs from the incidents is taken into the organisation for internal action. We participate in local exercises such as COMAH exercises, and learn any lessons from these. Our EPRR Policy confirms the
Domain 2 - Duty to risk assess											
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	EPRR LRF Community Risk Register Rotherham CCG System Wide Escalation Plan	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant	NA	Our EPRR risk assessments take account of the community risk register as detailed within the LHRP feedback. We participate in local
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Policy Risk Management Policy Risk Register	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Our EPRR risk assessments take account of the community risk register as detailed within the LHRP feedback. We participate in local COMAH exercises and wider NHS and local health & social care economy EPRR exercises and embed any identified risks back within our internal processes. Our risk assessment is specific local risks is captured in our Emergency Preparedness, Resilience & Response Policy: Fuel shortage, Flooding, Evacuation & shelter, Pandemic, Heatwave, Severe Winter Weather, Diverts, The policy is reviewed by the author annually to identify and change as required. Our usual risk management processes allow us to consider if there are any further internal risks that would threaten the performance of the organisation's functions in an emergency - via the Assurance Framework and Risk Register.
Domain 3 - Duty to maintain plans											
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 defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	EPRR Policy BCM Policy	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Our EPRR Policy supported us to respond to each of these areas. Our EPRR Policy covers: - Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) - Severe weather (heatwave, flooding, snow and cold weather) - Pandemic Influenza - Infectious Disease Outbreak (also supported by the Health protection Agency (HPA) agreement - Evacuation Our Business Continuity Policy & Plan, underpinned by team specific operational plans covers: - Corporate and service level Business Continuity - Fuel Disruption - Utilities, IT and Telecommunications Failure
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 defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	EPRR Policy BCM Plans Major Incident Plan At Place - Bronze Silver and Gold command set up Incident Co-ordination Team meeting weekly	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Our EPRR Policy supported us to respond to each of these areas. Our EPRR Policy covers: - Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) - Severe weather (heatwave, flooding, snow and cold weather) - Pandemic Influenza - Infectious Disease Outbreak (also supported by the Health protection Agency (HPA) agreement - Evacuation Our Business Continuity Policy & Plan, underpinned by team specific operational plans covers: - Corporate and service level Business Continuity - Fuel Disruption - Utilities, IT and Telecommunications Failure At Place - Bronze Silver and Gold command set up Incident Co-ordination Team
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 heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NHS England National heatwave Plan - on CCG website RMBC Heatwave Plan TRFT Heatwave Plan BCM Policy and Plan Public Health MOU	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Our EPRR Policy supported us to respond to each of these areas. Our EPRR Policy covers: - Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) - Severe weather (heatwave, flooding, snow and cold weather) - Pandemic Influenza - Infectious Disease Outbreak (also supported by the Health protection Agency (HPA) agreement - Evacuation The CCG will seek assurance that commissioned services have plans in place to manage local heatwave incidents, will cascade local heatwave communications, and will work with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) on wider community resilience. Local Risk identified will be escalated appropriately.
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 (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Public Health MOU RCCG System Wide Escalation Plan EPRR Policy Driving for Work Standard Operating Procedure	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Our EPRR Policy supported us to respond to each of these areas. Our EPRR Policy covers: - Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) - Severe weather (heatwave, flooding, snow and cold weather) - Pandemic Influenza - Infectious Disease Outbreak (also supported by the Health protection Agency (HPA) agreement - Evacuation BCM Policy and Plan Rotherham CCG System Wide Escalation Plan includes severe winter weather framework - All organisations have a winter plan in place, the identification of vulnerable groups and people at risk in severe weather forms part of the winter planning. The Plan incorporates Rotherham's response to the national Cold Weather Plan.

18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	A&E Delivery Board RMBC Severe Winter Weather framework NHS England Incident Response Plan Rotherham CCG System Wide Escalation Plan - signed off at Health and Wellbeing Board which all health and social care partners attend. Heatwave Plan Pandemic Flu Plan	Fully compliant	NA	Executive Place Director	NA	RMBC has a Severe Winter Weather Framework which is an overarching document designed to deal with an extreme winter weather event at an authority level. It contains what is expected of Directorates, how this links in with Local Resilience Forum and national structures, and reporting routes. It has a series of trigger points based on the Cold Weather Alert Levels issued by the Met Office. It is reviewed annually to coincide with the annual publication of the PHE Cold Weather Plan, which historically is issued at the end of October. In particular there is a section on winter maintenance and transport. EPRR Policy The CCG is a partner in a number of specific plans which have been developed across the health community in order to respond to emergencies and escalate actions
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	NA	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NA		NA	NA	NA	NA
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	RCCG Fire Safety Policy NHS PS Fire Action Procedure RCCG Risk Assessment GB Minutes BCM Policy and Plan	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Rotherham CCG Fire Safety Policy - The Assistant Chief Officer is the Responsible Person as defined by the Regulatory Reform (Fire Safety) Order 2005 and is responsible for the implementation of the Fire Safety Policy. Evac Chair in situ in the building. Property Service have issued a Fire Action procedure for NHS Rotherham CCG for Oak House - this is included in the RCCG Fire Safety Policy.
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	NA	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NA		NA	NA	NA	NA
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	NA	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NA		NA	NA	NA	NA
Domain 4 - Command and control											
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate 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.	SY&B CCG On Call Procedure BCM Plans EPRR Policy SY&B CCG On Call Tests	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	A shared rota across the South Yorkshire & Bassetlaw CCGs enables providers to contact a representative of their commissioning CCG in an urgent situation outside of normal business hours. The CCGs participating in the shared arrangement have clear authorisation to act on behalf of each other outside of normal business hours. This may include, but is not limited to, making decisions and committing expenditure on behalf of the other CCGs. Our EPRR Policy contains activation action cards and incident manager action cards in place in the event of incidents. Our Business Continuity Plan contains an activation flowchart. Our on-call Procedure and supporting On Call Pack contains an activation and escalation framework.
Domain 5 - Training and exercising											
Domain 6 - Response											
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		EPRR Policy Incident Co-ordination Team meetings weekly during Covid 19	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Incident Control Centre is identified in the EPRR Policy. The CCG Incident Control Centre is not kept on permanent stand-by and will be enacted by the Accountable Emergency Officer or their nominated Deputy. The CCG Incident Control Centre is located in: 2nd Floor Oak House Moorhead Way Bramley Rotherham S66 1YY The decant plan, should the Incident Control Centre be compromised, will be the premises of one of the South Yorkshire & Bassetlaw CCGs. This has been agreed with partner CCGs under mutual aid. Staff working from home throughout covid 19. All meetings held via MS
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	BCM Policy and Plan Covid 19 Debriefs and learning Incident Control Team Meetings weekly	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant	NA	Incident Co-ordination Team meetings weekly with all Senior Team
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	EPRR Policy Dedicated Email In Box for Incidents Sitreps submitted re covid 19 when requested Sitreps submitted when requested re Brexit	Fully compliant	NA	Executive Place Director	NA	Situation report arrangements for the South Yorkshire & Bassetlaw CCGs are determined by the Incident Lead Executive in line with the escalation action card and the Incident Lead Executive action card. Reports on the local situation will be made, as required, to NHS England. If an incident is
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	NA	• Guidance is available to appropriate staff either electronically or hard copies	NA		NA	NA	NA	NA
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection' guidance.**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	NA	• Guidance is available to appropriate staff either electronically or hard copies	NA		NA	NA	NA	NA
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	Communication Strategy included in the BCM Policy and Plan.. SY&B CCG On Call System Pack. A&E Delivery Board Public Health MOU. At Place - Gold Silver bronze command set up	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Communication Strategy included in the Business Continuity Policy and Plan. SY&B CCG On Call System Pack A&E Delivery Board - all the partners across the health and social care attend. Public Health MOU Emergency communications response arrangements in place. At Place - Gold Silver bronze command set up
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	BCM Policy and Plan EPRR Policy Communication Strategy included in the BCM Policy and Plan. SY&B CCG On Call Procedure Pack - Cascade Tests Covid 19 debriefs and learning Virtual Media - used throughout Covid 19	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Communication Strategy included in the Business Continuity Policy and Plan. Cascade Tests undertaken to inform all staff. These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They include testing telephone, email, paging and other communications methods in use. The communications exercise is conducted both during the in-hours period and the out-of-hours period on a rotational basis and is unannounced. SYB On Call rota There is no communication staff on call 24/7. This would not be cost effective for the CCG. The Communications Lead is available to contact on a voluntary basis out of hours.
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a 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	Communication Strategy included in BCM Policy and Plan EPRR Policy Covid 19 - Place Gold, Silver and Bronze set up Covid 19 System Comms and Engagement Meeting - every two weeks	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Communication Strategy included in the Business Continuity Policy and Plan. Cascade Tests undertaken to inform all staff. These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They include testing telephone, email, paging and other communications methods in use. The communications exercise is conducted both during the in-hours period and the out-of-hours period on a rotational basis and is unannounced. The Cascade test is reported to Governing Body with any lessons learned. The senior team have received media training. The Communications Lead is available to contact on a voluntary basis out of hours. Head of Communications also
Domain 8 - Cooperation											
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	MOU Mutual Aid CCGs Formal request for military aid to NHSE Place - Gold, Silver and Bronze command set up Silver Command - Operational - mutual aid	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Mutual Aid Agreements are in place with partner organisations across South Yorkshire and Bassetlaw CCG's. Our EPRR Policy clearly details the processes for requesting mutual aid of our partner CCG's across South Yorkshire and Bassetlaw. Place - Gold, Silver and Bronze command set up Silver Command - Operational - mutual aid
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.	NA	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	NA		NA	NA	NA	NA

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.	NA	• Detailed documentation on the process for managing the national health aspects of an emergency	NA		NA	NA	NA	NA
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	We have a mutual aid agreement for premises with our partner CCGs. SY LRF Information sharing protocol for Cat 1 & 2 responders. West Yorkshire, South Yorkshire and Bassetlaw Inter Agency Information Sharing Agreement - High level public sector information sharing agreement. Place - Gold, Silver and bronze Command set up re Covid 19 Silver operational - sharing information with partners	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	s Category 2 Responders, we have a duty to share information and cooperate. In the event of an incident, we will use our generic email addresses used for EPRR as the main route of communication and the Incident Control Centre number as the main telephone number. The Communications Leads will coordinate communications. We share information via the Local Health Resilience Partnership and via local Emergency Planning Meetings. We have local Information Sharing Agreements (ISA) / Policies for "business as normal" across our local strategic partnerships which also support EPRR. We have a mutual aid agreement for premises with our partner CCGs.
Domain 9 - Business Continuity											
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	BCM Policy and Plan - Policy statement on page 5 Covid 19 response egg working from home moved to virtual meeting platform	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Covid 19 response egg working from home moved to virtual meeting platform
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	BCM Policy and Plan	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	BCM Policy and Plan
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	IG Toolkit Satisfactory Score Head of Information Governance in post	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	Head of Information Governance appointed at CCG
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	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	BCM Policy and Plan Covid 19 response working from home online meeting platform BCM plans for Brexit	Fully compliant	NA	Chief Officer/Executive Place Director/Assistant Chief Officer	NA	
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	Corporate Assurance Reports GB Minutes No Business Continuity Audit this year.	Fully compliant	NA	Chief Office/Executive Place Director/Assistant Chief Officer	NA	Our annual EPRR assurance is received by Governing Body each year, presented by the Emergency Accountable Officer.
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	EPRR Policy BCM Policy and Plans Corporate Assurance Reports Debrief Learning reports from COVID 19	Fully compliant	NA	Chief Officer/Executive Place/Assistant Chief Officer	NA	EPRR Policy and BCM Policy and Plan - Reviewed every 3 years in line with the Policy on Procedural Documents.
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	EPRR Policy BCM Policy and Plans NHS Standard Contract Quarterly meetings with providers re EPRR	Fully compliant	NA	Executive Place Director	NA	Providers are required to submit their business continuity plans as part of the annual contracting round and these are embedded in the contract between Commissioner and Provider. There's also a section in the NHS Standard Contract that is very clear in terms of what the Provider has to comply with in terms of Emergency Preparedness, Resilience and Response and from a TRFT perspective they have an Accountable Emergency Officer.
Domain 10: CBRN											
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	NA	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	NA		NA	NA	NA	NA
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	NA	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	NA		NA	NA	NA	NA
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.	NA	• Impact assessment of CBRN decontamination on other key facilities	NA		NA	NA	NA	NA
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	NA	• Rotas of appropriately trained staff availability 24 /7	NA		NA	NA	NA	NA
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/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	NA	• Completed equipment inventories; including completion date	NA		NA	NA	NA	NA
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	NA	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	NA		NA	NA	NA	NA
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	NA	• Completed PPM, including date completed, and by whom	NA		NA	NA	NA	NA
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	NA	• Organisational policy	NA		NA	NA	NA	NA
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	NA	• Maintenance of CPD records	NA		NA	NA	NA	NA
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.	NA	• Maintenance of CPD records	NA		NA	NA	NA	NA
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.	NA	• 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/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	NA		NA	NA	NA	NA
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	NA	NA	NA		NA	NA	NA	NA