EPRR – Core Standards Annual Self-Assessment Process 2024

Meeting Title	Board of Directors		
Date	11/12/2024	**Agenda Item**	13
Lead Director	Mark Greatrex, Deputy Chief Executive & Chief Finance Officer		
Author(s)	Mick Blease LSMS/EPRR Lead		

Action required (please select the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☒

Purpose

To provide assurance to Board that the Trust has completed the annual core standards assurance process.

Executive Summary

The Trust is required to complete an annual self-assessment against 58 core standards that are attributed to community providers. In addition to these standards there are 11 further standards associated with Cyber Security as part a deep dive process.

This process has now been completed and provides an overall percentage compliance of 86% with an overall assessment of “Partially Compliant.

Risks and opportunities:

There are no risks associated with this report

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Financial/resource implications:

There are no additional financial or resource implications associated with this report.

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
- People – We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Populations - Safe care and support every time	Place - Make most efficient use of resources to ensure value for money	Place - Make most efficient use of resources to ensure value for money

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Not applicable

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☐

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

To note that the trust has completed the annual EPRR core standards self-assessment assurance process

Report history (Please include history of where the paper has been presented prior to reaching this meeting, including the title of the meeting, the date, and a summary of the outcome)

Submitted to	**Date**	**Brief summary of outcome**
Quality & Safety Committee	**11 September 2024**	**Committee was assured.**

Wirral Community Health and Care NHS Foundation Trust

EPRR – Core Standards

Annual Self Assessment - 2024

Purpose

To provide assurance to the Board of Directors that the Trust has completed the annual core standards assurance process and to report that a rating of **"Partially Compliant"** has been reached in the process.

Compliance level	Definition
Fully Compliant 100%	Fully compliant with the core standard
Partially Compliant 77%-88%	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-Compliant <77%	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Background

NHS England is responsible for gaining assurance that the NHS is prepared to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

The assurance process requires the Trust to undertake a self-assessment against the core standards.

As a community provider the Trust is asked to self-assess against 58 pre-determined standards.

Self-Assessment Process 2023

The WCHC submission for 2023 was subject of a rigorous "check and challenge" process by NHSE. That process provided an overall compliance level of **"Non-Compliant**" with a rate of 5% compliance with only 3 standards rated as fully compliant.

Following this assessment the EPRR lead developed a comprehensive action plan that addressed the concerns raised by NHSE. The plan was presented to the board of Directors in December 2023 and a target of "**Partially Compliant**" was set for the 2024 self-assessment process.

The plan was subject to oversight by the Quality and Safety Committee on a bi-monthly basis and in August 2024 all actions were marked as complete.

Self-Assessment Process 2024

The self -assessment process for 2024 has now been completed by the EPRR lead. The initial self-assessment has been subject of a check and challenge process conducted by the Cheshire and Merseyside ICB EPRR Team.

As a result of the self-assessment submitted and the associated evidence provided, the ICB has agreed that WCHC has an overall assessment of "Partially Compliant" and an overall compliance percentage of 86%.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	3	0	1
Response	5	5	0	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business Continuity	10	7	3	0
Hazmat/CBRN	10	9	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	50	7	1

There is one standard where the Trust has been assessed as "**Non-Compliant**"

Standard 25 relates to EPRR training and specifically staff awareness of EPRR. There is a requirement to complete an EPRR awareness training package to be included in the Trust "On Boarding" programme.

There are seven standards that have been assessed as "**Partially Compliant".**

Standard 2 relates to EPRR Policy Statement. The ICB have requested that the role of the Operation Commander is included in the policy together with an enhanced description of arrangements for key suppliers and contractors and debriefing processes.

Standard 16 relates to Evacuation and Shelter. An exercise needs to be completed to test the evacuation and shelter procedures for the CICC.

Standard 33 relates to Warning and Informing and specifically to identify how the Trust will provide 24 hour communication and support to On Call managers.

Standard 50 relates to the Business Continuity Managements System. The Key Performance Indicators relating to the completion of BCP's needs to be included in the the Business Continuity Policy and the performance in this area to be included in the Annual EPRR report to board.

Standard 51 relates to the audit of BC Plans. An Audit of BC plans for 24/25 needs to be completed.

Standard 53 Assurance of Commissioned providers/suppliers Business Continuity Plans. Samples of a number of suppliers BC Plans to be tested to seek assurance.

Standard 66 Exercising of CBRN arrangements. A CBRN Exercise to be developed and delivered to relevant staff.

A new action plan will be developed by the EPRR lead that will address these standards to ensure that they are fully compliant for the 2025 process. This action plan will be monitored through the Quality and Safety Committee.

A summary of the Cheshire and Merseyside area performance is included at **Appendix A.**

Deep Dive

The "Deep Dive" element of this years Core Standards Self-Assessment process addresses Cyber Security.

There are 11 standards associated with Community Trust providers within the Deep Dive section and the Trust is assessed as follows: -

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	8	2	1
Total	11	8	2	1

DD 8 Relates to EPRR Training and the general awareness of Cyber Security. The Trust has self-assessed as non-compliant in this area. As with Standard 25 there is a requirement to develop a Trust EPRR training awareness package for all staff to complete on Recruitment.

The full self-assessment process is included at **Appendix B** (Excel).

Recommendation

1. The Board of Directors is assured that the trust has completed the annual EPRR core standards self-assessment assurance process and that an overall compliance of "**Partially Compliant"** has been agreed with the ICB which equates to a level of 86%.

Name: **Mick Blease**

Job Title: **LSMS/EPRR Lead**

Date: **29th November 2024**

Wirral Community Health and Care NHS Foundation Trust

Appendix A

Acute Trusts	Compliance Level	Compliance Trend from 2023/24	Fully compliant standards	Partially compliant standards	Non-compliant Standards	Overall compliance percentage
Alder Hey	Non	Increased %	42	20	0	68%
Countess of Chester	Partial	Increased	50	12	0	81%
East Cheshire	Partial	Increased	50	10	2	81%
Liverpool University	Substantial	Increased	55	7	0	89%
Mersey & West Lancashire	Partial	Increased	50	12	0	81%
Mid Cheshire	Non	Increased %	47	15	0	76%
Warrington and Halton	Non	Increased %	42	20	0	68%
Wirral University Hospitals	Partial	Increased	52	10	0	84%
Specialist Trusts						
Clatterbridge Cancer Centre	Substantial	Increased	56	3	0	95%
Liverpool Heart and Chest	Partial	Increased	51	8	0	86%
Liverpool Women's Hospital	Non	Increased %	43	16	0	73%
The Walton Centre	Partial	Increased	46	13	0	78%
Community and Mental Health Trusts						
Bridgewater	Partial	Increased	47	9	2	81%

Cheshire and Wirral Partnership	Partial	Increased	49	9	0	84%
Mersey Care	Substantial	Increased	56	2	0	97%
Wirral Community	Partial	Increased	50	7	1	86%
ICB						
NHS Cheshire and Merseyside	Partial	Increased	41	6	0	87%

Please select type of organisation: **Community Service Providers**

Click button to format the workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	3	0	1
Response	5	5	0	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business Continuity	10	7	3	0
Hazmat/CBRN	10	9	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	50	7	1

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	8	2	1
Total	11	8	2	1

Overall assessment:	Partially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 6: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 7: In the Action Plan tab, click on the 'Format Action Plan' button.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
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 within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	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 and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	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 and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • 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/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
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 all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans				
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • 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
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • 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 • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	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 Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	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
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	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 Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	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 Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	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
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	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
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	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

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • 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
Domain 4 - Command and control				
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • 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. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising				
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • 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

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	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. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response				
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and 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 • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
Domain 7 - Warning and informing				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation				
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
Domain 9 - Business Continuity				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	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 • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. 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. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
Domain 10 - CBRN				
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident
60	Hazmat/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. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed 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	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning

Ref	Domain	Standard	Deep Dive question	Supporting evidence- including examples of evidence	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in EPRR arrangements. Amber (partially compliant) = Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Cyber Security and IT related incident response (NOT INCLUDED WITHIN THE ORGANISATION'S OVERALL EPRR ASSURANCE RATING)										
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness	Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy	5, 10, 76.	Fully compliant				The Trust employ's the services of a dedicated Cyber Security Officer forms part of the Information Technology Team. Information Technology is represented at the Trust HSSR group by ICT Operations Manager. Please see HSSR Minutes(76) Cyber is also included as an Inherent Risk (10) and is managed routinely by the Cyber Security Officer. The EPRR work plan is included in the Trust Annual Report(5) which includes reference to a Cyber Security exercise.
DD2	Deep Dive Cyber Security	Cyber Security & IT related incident response arrangements	The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.	Arrangements should: -consider the operational impact of such incidents -be current and include a routine review schedule -be tested regularly -be approved and signed off by the appropriate governance mechanisms -include clearly identified response roles and responsibilities -be shared appropriately with those required to use them -outline any equipment requirements -outline any staff training needs -include use of unambiguous language -demonstrate a common understanding of terminology used during incidents in line with the EPRR framework and cybersecurity requirements.'	77, 78, 79, 80,91	Fully compliant				Group formed by senior IT staff an the Cyber Security Officer. The Group meets every two months. The group are responsible for developing and implementing specific recovery response plans. The overall Cyber Incident Response Plan (78) is reviewed annually and signed off by the group. Other Recovery Plans provided as evidence of developing threat specific response arrangements include the Recovery Of Cloud Group Plan (77)The Back Up Restore Procedure (79) and the Physical Bare Metal Restore process (80). All plans are in date and are placed in a single depository and accessible by all IT staff. The Incident Response Plan was last reviewed on the 1st of August 2024 and addresses training arrangements and roles and responsibilities. The latest IT Security Group Report for August 24 can be found at (91)
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your response arrangements 3. ensure diversity of technical solutions 4. adopt layered fall-back arrangements 5. plan for appropriate interoperability https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf	81	Partially compliant	Review Incident Communi	Phil Lang	01.02.2025	The Trust communications team has developed an Incident Communication Plan (81) and addresses how the organisation communicates between stakeholders and partners. In order for the Trust to be fully compliant in this area additional information specific to an IT related issue needs to be included in the plan and focus on layered fall back arrangements.
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	81, 82, 83,	Fully compliant				The Trust Incident Communications Plan (81) recognises Cyber Security Incidents when communicating with regional and national teams. The Trust Social Media SOP (82) and Media SOP (83) addresses staff activity on Social Media platforms and outlines the process for responding to General Enquiries. Major incidents, including Cyber incidents, is addressed at section 6 of the media SOP.

DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	10, 85,	Partially compliant	Conduct Cyber Security Ex Phil Lang	01.12.2025	The Trust EPRR annual Exercise and Testing Plan is included in the Annual Board Report (10) and references Cyber Security Exercise. The Trust last conducted a Cyber Security Exercise on the 21st May 2023. A post exercise action plan was produced (85) The Cyber Security Officer attends regional exercises and attended the ICS Cyber Incident Management Exercise 21st March 2024. (84).
DD6	Deep Dive Cyber Security	Continuous Improvement	The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises	- Cyber security and IT colleagues participation in debriefs following live incidents and exercises - lessons identified and implementation plans to address those lessons -agreed processes in place to adopt implementation of lessons identified - Evidence of updated incident plans post-incident/exercise	86,	Fully compliant			The Trust conducts "Microsoft Patch Tuesday" . This process ensures that the Trust stays ahead of potential cyber security risks. The Trust also incorporates an additional check process ensure that any recommended patches does not have an adverse affect on Trust systems before fully activating. Following any Cyber Incident the Trust IT Security Team will convene in order to address and limit the impact of attack on Trust IT systems. Following the CrowdStrike incident (July 18th 2024 the group met to review trust vulnerabilities and Process. Email (86)
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	87,	Fully compliant			The Trust has developed a specific Training and Awareness Needs Analysis dated 28th February 2024 (87)
DD8	Deep Dive Cyber Security	EPRR Training	The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package		Non compliant	Develop EPRR Awareness Mick Blease	01.12.2025	
DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisations's critical functions and the dependencies on IT core systems and infrastrucure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	88, 89, 90	Fully compliant			The IT Security Team continually review the IT Critical functions as part of its routine business. Once a critical function has been identified the team will produce a restore plan procedure that will be placed in the IT EPRR depository for reference to all IT staff. Examples of these plans include, Cisco Switch Disaster Recovery(88), Paxton backup Restore Procedure, (89) and Wheelchair Service Server Recovery (90)
DD10	Deep Dive Cyber Security	Business Continuity Management System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments		Fully compliant			The IT Service Has developed its own Business Continuity Plan (92) The plan has identified all critical IT services and produced separate documentation / recovery plans for each of those critical functions. An Inherent Cyber Risk Assessment is included on the Trust Risk Register. (10)
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	10, 92 92,	Fully compliant			The IT Service Has developed its own Business Continuity Plan (92) The plan has identified all critical IT services and produced separate documentation / recovery plans for each of those critical functions

Overall self assessment rating:

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's 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 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										
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	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 and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	2	Partially compliant	Policy to to incluc	EPRR Lead	45748	The Trust EPRR Policy was Reviewed February 2024. (2) The review included lessons learned from the Core Standard Check and Challenge process 2023. The Policy outlines Roles and Responsibilities including AEO in Section 5. The Trust governance structure model is included at Appendix 5. Page 1 and 2 outlines the review schedule and version control. Section 6 of the policy outlines the process including risk assessment. Section 8 of the policy references EPRR Training and Exercising requirements.
Domain 2 - Duty to risk assess Domain 3 - Duty to maintain Plans										
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	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	37,38	Partially compliant	Test the Evacuat	Mick Blease	01.12.2034	The Trust has an Evacuation and Shelter Standard Operating Procedure reviewed July 2024 (37). The review included the inclusion of a Patient Tracker Form and the latest guidance issued 2023. The evacuation element is tested regularly as port of the Fire Safety strategy. The latest evacuation test took place at Marine Lake Health Centre (38) on the 26th July 2024. The Trust still needs to test the evacuation and shelter element of the plan at the CICC 77 bedded unit.
Domain 4 - Command and control Domain 5 - Training and exercising										
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board		Non compliant	Develop a Trust t	Mick Blease	01.02.24	
Domain 6 - Response Domain 7 - Warning and informing										
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	104, 94, 18	Partially compliant	Identify how Trus	EPRR Lead/Comi	45748	A new Incident Response Communications Plan has been developed. (104) The Plan includes a roles and responsibilities of the Communications and Marketing team at section 5 of the plan. The Structure of the team is outlined at Appendix 4 of the plan. A Communication lead action card is included in the plan at Appendix 1. The plan outlines the role of the Strategic On Call Manager who will be the SPOC for communication issues during out of hours. A number of the Strategic On Call managers have been trained in media skills. This is outlines in section 8 of the plan along with other training requirements. The Trust EPRR Training Needs (94) Analysis (outlines the communication training requirements for On Call staff. The role of ICB Communications is included at section 6.10 of the plan. In Addition to the above there is an action card outlining the role of communications in a Major Incident included in the Major Incident Plan (18). A media enquiry form is included at appendix 2 of the plan. This is utilised to record any media enquiry and to track and record the response to that enquiry.
Domain 8 - Cooperation Domain 9 - Business Continuity										
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	3, 69, 121,	Partially compliant	Include KPI Refe	EPRR Lead	45748	The Annual EPRR Report (3) submitted to board includes reference to BC Performance and Exercising Compliance at Section 2 of the Report and also plan status at Section 1.7 of the report. The Business Continuity Policy (69) GP62 outlines the monitoring process of the policy at Section 10 and a Monitoring tool is included at Appendix C of the policy. The BC Audit process is outlined in the 2023 Audit report at (121)
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	69, 121,	Partially compliant	Conduct Audit of BC Plans 2024	EPRR Lead/Audit	01.12.2024	The BC Policy (69) outlines the audit requirements at Section 7.10 of the policy. All BC Plans have been reviewed utilising the amended version of the BC template however due to the lateness on the completion of this process, those PC Plans have not yet been subject of an Audit. The previous BC Plans reviewed in 2023 where subject of an internal Audit in June 2023. (121)
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	114,116,117, 69	Partially compliant	Test a sample sı	EPRR Lead/Proc	01.02.202S	The Trust Procurement Process includes the request for Business Continuity Plans from prospective suppliers as part of any Tender process prior to the award of any contract. Examples include the BCP for Eric Wright who provide the Trust's Soft Facilities Management. (115) and BCAS Biomedical who provide he Trust with its medical devices. (116) The process is supported by the Procurement Supplier Questionnaire (117). Section 4.14 Part 3 of the questionnaire relates to Business Continuity Plans. Section 6.14 of the Business Continuity Policy (69) outlines the responsibilities of the Head of Procurement service in seeking assurance of those supplier BC Plans.
Domain 10 - CBRN										
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	74,3	Partially compliant	Conduct table top exercise in order to test the PLAN FOR THE INITIAL MANAGEMENT OF SELF PRESENTERS FROM INCIDENTS SUSPECTED TO INVOLVE HAZARDOUS MATERIALS	Mick Blease	01.12.24	CBRN Exercising is included in the Annual EPRR board report (3) A new HAZMAT/CBRN self Presenters plan (74) has been developed and training sessions commenced with regards to decontamination and isolation of self presenter's. Once this training has been completed an exercise to test the plan and individuals knowledge will be conducted.
Deep Dive - Cyber Security and IT relate	0	0	0	0	0					
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your response arrangements 3. ensure diversity of technical solutions 4. adopt layered fall-back arrangements 5. plan for appropriate interoperability https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf	81	Partially compliant	Review Incident r	Phil Lang	01.02.202S	The Trust communications team has developed an Incident Communication Plan (81) and addresses how the organisation communicates between stakeholders and partners. In order for the Trust to be fully compliant in this area additional information specific to an IT related issue needs to be included in the plan and focus on layered fall back arrangements.
DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	10, 85,	Partially compliant	Conduct Cyber S	Phil Lang	01.12.202S	The Trust EPRR annual Exercise and Testing Plan is included in the Annual Board Report (10) and references Cyber Security Exercise. The Trust last conducted a Cyber Security Exercise on the 21st May 2023. A post exercise action plan was produced (85) The Cyber Security Officer attends regional exercises and attended the ICS Cyber Incident Management Exercise 21st March 2024. (84).
DD8	Deep Dive Cyber Security	EPRR Training	The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package		Non compliant	Develop EPRR A	Mick Blease	01.12.202S	

Board of Directors Declarations of Interest - 2024-25 - Updated December 2024

Meeting Title	Board of Directors		
Date	11/12/2024	**Agenda Item**	14
Lead Director	Alison Hughes, Director of Corporate Affairs		
Author(s)	Karen Lees, Head of Corporate Governance		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☒

Purpose

To provide the Board of Directors with assurance on the maintenance and updating of the annual declarations of interests for members of the Board made in line with the Trust's Policy for Managing Conflicts of Interest

Executive Summary

In accordance with Standing Order 8 'Declaration of Interests and Register of Interests' in the Trust's Corporate Governance Manual (updated in March 2018) and General Policy 7 'Managing Conflicts of Interest' (approved at the Board of Directors meeting - April 2022) all members of the Board of Directors must declare interests which are relevant and material on an annual basis.

Following the guidance from NHS England in June 2017, this principle has also been extended to all senior and decision-making staff in the organisation.

Further, as an authorised Foundation Trust and in accordance with the Trust's constitution, paragraph 35.5 requires that "the trust shall have a register of interests of the directors". Furthermore, paragraph 36 states that "the trust shall make the registers available for inspection by members of the public…. The trust shall not make any part of it registers available for inspection by members of the public which shows details of any member of the trust, if the member so requests".

A 'conflict of interest' is:

"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

In the Trust's self-assessment against the Government Functional Standard 013 for Counter Fraud assessment 2023-24, a green rating (supported by the Audit Committee and Anti-Fraud Specialist) was agreed confirming that the policy and register are in place and reference the requirements of the Bribery Act 2010 which are communicated to all staff.

The register for 2024-25 for members of the Board of Directors has been updated to include the recent changes to the Chair and Chief Executive positions and is included at appendix 1.

All declarations included have been approved for publication on the Trust's public website.

These interests will also be reported in the Trust's Annual Report 2024-25.

In addition, at each meeting of the Board of Directors, and its committees, members are asked to declare any further interests since the date of the last declaration and to notify of any conflicts of interest in relation to the agenda items for discussion (for which they may need to abstain). Any such declaration is recorded in the minutes.

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

The potential risks associated with any declared interests are considered by line managers with advice, when required from the Head of Corporate Governance or the Director of Corporate Affairs. The appropriate mitigation is put in place, and this is recorded on the declaration of interests register.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Not applicable

Financial/resource implications:

None

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
- People – We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Populations - Safe care and support every time	Place - Make most efficient use of resources to ensure value for money	Place - Improve the health of our population and actively contribute to tackle health inequalities

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Not applicable

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☐

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

To receive this report and be assured of the processes in place to ensure compliance with Trust Policy and the subsequently updated register of interests for members of the Board of Directors 2024-25, and to approve the publication of the register on the Trust's website.

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

Submitted to	Date	Brief summary of outcome
Board of Directors the Annual Declarations of Interest - Board of Directors 2023-24	21 June 2023	The Board received the report and were assured by the processes in place to ensure compliance with the Trust Policy, and the register of interests for the members of the Board was approved.
Board of Directors the Annual Declarations of Interest - Board of Directors 2024-25	21 August 2024	The Board received the report and were assured by the processes in place to ensure compliance with the Trust Policy, and the register of

		interests for the members of the Board was approved

Declarations of interest April 2024 - March 2025

Updated December 2024

Wirral Community Health and Care NHS Foundation Trust

First Name initial	Surname	Job Title	Board/Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
A	Bennett	Chief Strategy Officer	Board	Indirect	Family member is Communications Manager for Knowsley Council.	03/02/2020	Ongoing
C	Bentley	Non-Executive Director	Board	Financial	Professor Chris Bentley Consulting Ltd	01/02/2019	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial Personal Interest	Orbis Programme and Medical Advisory Committee (the programme involves several countries and reviews and approves promising cancer treatments)	2018	Ongoing
C	Bentley	Non-Executive Director	Board	Financial and Professional	visiting lecturer teaching on public health modules - Liverpool University	2013	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial and Professional	Visiting lecturer teaching on public health modules - Sheffield Hallam University	2010	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial and Professional	Visiting lecturer teaching on public health modules - Sheffield University	2009	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial personal	Chairman of Trustees - Sheffield Health International Partnerships - small charity providing	2012	Ongoing

First Name initial	Surname	Job Title	Board/Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
				interest	links between Sheffield NHS/social care and the developing world, particularly Uganda at present		
C	Bentley	Non-Executive Director	Board	Financial and Professional	Research advisory role - co-applicant - NIHR (National Institute for Health Research) funded research study into unmet need in health & social care. Funded programme including Liverpool, Manchester and York Universities	2020	Ongoing
C	Bentley	Non-Executive Director	Board	Non-Financial professional	Member of the National Advisory Committee on Resource Allocation, the chair of the Technical Advisory Group. DHSC/NHS England/NHS Improvement	2008	Ongoing
C	Bentley	Non-Executive Director	Board	Financial and Professional	Kings Fund Associate Professional	April 2023	Ongoing

First Name initial	Surname	Job Title	Board/Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
M	*Brown	Chairman	Board	Financial	Executive Chairman, Switch2Support Ltd (a start-up company designed to support charities by getting their supporters to switch their utilities, broadband, mobile phones, etc. through a dedicated comparator site)	September 2021	September 2024
J	*Chwalko	Chief Operating Officer	Board	Financial	Visiting lecturer at The University of Chester	August 2020	July 2024
M	David	Non-Executive Director	Board	Non-financial	Chair of the Board for the University of Chester	1 August 2022	31 July 2025
M	David	Non-Executive Director	Board	Financial	Director of TEMD Solutions, an education leadership consultancy	1 May 2018	1 May 2025
M	David	Non-Executive Director	Board	Non-financial professional	Deputy lieutenant, Cheshire Lieutenancy	12 December 2017	19 June 2030
M	*Greatrex	Chief Financial Officer/Deputy Chief Executive	Board	Indirect	Family member is a Director at Merseycare NHS FT	April 2022	31 May 2024
M	*Greatrex	Interim Chief Executive	Board	Indirect	Family member is a Director at Merseycare NHS FT	April 2022, Interim CE role began June 2024	30 November 2024
M	Greatrex	Chief Financial Officer/Deputy Chief Executive	Board	Indirect	Family member is a Director at Merseycare NHS FT	December 2024	Ongoing
D	Henshaw	Chair	Board	Financial	Chair National Museums Liverpool	01/04/2020 Chair at the Trust from November 2024	Ongoing

First Name initial	Surname	Job Title	Board/Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
D	Henshaw	Chair	Board	Financial	Chair Natural Resources Wales	01/04/2020 Chair at the Trust from November 2024	Ongoing
J	Holmes	Chief Executive	Board	NIL	NIL		
A	Hughes	Director of Corporate Affairs	Board	NIL	NIL		
B	Jordan	Non-Executive Director	Board	Non-financial - personal	Fund raiser, St Ann's Hospice, Greater Manchester area	2015	Ongoing
B	Jordan	Non-Executive Director	Board	Non-financial -	Campaign support for new legislation - guide dogs	2015	Ongoing
B	Jordan	Non-Executive Director	Board	Non-financial professional	Chair and Trustee at Citizens Advice for Wigan Borough	27/10/2022	Ongoing
B	Jordan	Non-Executive Director	Board	Financial	Advisory Board Member for Quantum Base Limited	Sep-15	Ongoing
B	Jordan	Non-Executive Director	Board	Non-financial professional	Trustee at Morts Astley Heritage Trust	24/10/2023	Ongoing
B	*Jordan	Non-Executive Director	Board	Financial	Non-Executive Director representative of the MHLDC Board	19/11/2023	July 2024
C	*Madsen	Chief People Officer	Board	Non-Financial	Family member is a clinical homecare nurse for a private company in the North West.	April 2023	June 2024

First Name initial	Surname	Job Title	Board/Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
G	*Meehan	Non-Executive Director	Board	Indirect interests	Liverpool City Council, Chair of Local Authority Improvement Board for Children and Families in the City.	18/09/2023	Interim Chair role began September 2024
G	*Meehan	Non-Executive Director	Board	Financial	Non-Executive Director Alder Hey Children's NHS Foundation Trust	1 March 2024	Interim Chair role began September 2024
G	*Meehan	Interim Chair	Board	Indirect interests	Liverpool City Council, Chair of Local Authority Improvement Board for Children and Families in the City.	18/09/2023 Interim Chair role began September 2024	Interim Chair role ended November 2024
G	*Meehan	Interim Chair	Board	Financial	Non-Executive Director Alder Hey Children's NHS Foundation Trust	1 March 2024 Interim Chair role began September 2024	Interim Chair role ended November 2024
G	Meehan	Non-Executive Director	Board	Indirect interests	Liverpool City Council, Chair of Local Authority Improvement Board for Children and Families in the City.	18/09/2023 Resumed Non-Executive role November 2024	Ongoing
G	Meehan	Non-Executive Director	Board	Financial	Non-Executive Director Alder Hey Children's NHS Foundation Trust	1 March 2024 Resumed Non-Executive role November 2024	Ongoing

First Name initial	Surname	Job Title	Board/Staff	Type of Interest	Description of Interest	Date Interest Relates from	Date Interest Relates to
D	*Miles	Interim Chief Finance Officer Returned to substantive post of Deputy Chief Finance Officer December 2024	Board	NIL	NIL		
D	Murphy	Chief Digital Information Officer	Board	NIL	NIL		
B	Palin	Interim Chief Operating Officer from 15 July 2024	Board	NIL	NIL		
E	Roche	Interim Medical Director from April 2024 Clinical Director – Urgent Primary Care	Board	Financial	Clinical Lead and CQC Registered Manager for One Wirral CIC.	April 2024	Ongoing
P	Simpson	Chief Nurse	Board	Non-financial / personal	A family member works as an auditor at Mersey Internal Audit Agency.	01/04/2018	Ongoing
P	Simpson	Chief Nurse	Board	Non-financial / personal	A family member works in an administrative role within the L&OD team	July 2023	Ongoing

* Interest has ended, and will remain on the register for 6 months in line with the Policy GP07 Managing Conflicts of interest

Summary of committee's self-assessment of effectiveness 2024-25

Meeting Title	Board of Directors		
Date	11/12/2024	**Agenda Item**	15
Lead Director	Alison Hughes, Director of Corporate Affairs		
Author(s)	Karen Lees, Head of Corporate Governance		

Action required (please select the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☒

Purpose

The purpose of this presentation is to provide the Board with a summary of the results from the five committees self-assessment of effectiveness, completed in September 2024

Executive Summary

In accordance with ToRs, all committees of the Board have invited members and regular attendees to complete a self-assessment of effectiveness and performance during September 2024.

Overall, the feedback from each of the surveys was positive including the quality of the debate and the effective role of each of the Chairs. The length of the meetings with long agendas that led to time pressures was raised several times.

The response rate for all of the surveys was lower than anticipated, and next year the approach to improve the response rate will be considered and will include a facilitated discussion and a smaller survey.

In accordance with the Audit Committee Terms of Reference the committee has a role in *"reviewing the findings of other significant assurance functions (e.g., reports from external regulators and arm's length bodies, the work of other committees)".*

At its meeting in October 2024, the Audit Committee received a summary of the results from each of the committees and discussed the findings and agreed the following actions to further improve the effectiveness of the committee meetings:

- Improve the level of details within the executive summary in the cover sheet, and include any additional information in the supporting report/presentation
- In the agenda include the timing at section level rather than for each individual report
- All the updates on actions in the decision & action log provided, as far as possible in writing

- Provide the policy position to each committee twice a year (rather than each meeting) and request extension to the expiry date via e governance (e-mail)
- The risk report is noted at the meetings unless there is a high-level risk to be discussed
- The audit recommendations in the Audit Tracker is noted at the meetings, unless there is high risk action that is delayed
- When a committee undertakes a deep dive into an area, the outcomes are reported to the Audit Committee for assurance

.

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

The work of the committees supports the Trust in managing operational and strategic risks.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Not required

Financial/resource implications:

No financial implications

The Trust Vision - To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations - We will support our populations to thrive by optimising wellbeing and independence
- People - We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Place - Make most efficient use of resources to ensure value for money	Place - Improve the health of our population and actively contribute to tackle health inequalities	Populations - Safe care and support every time

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☒

Representative workforce and access to quality work ☐ **Increasing wellbeing and health equity** ☒ **Reducing environmental impact** ☐
Board of Directors is asked to consider the following action
The Board is asked to be assured by the completion of self-assessments for each of the committees and the proposed actions to further improve the effectiveness of the committees.
Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

Submitted to	Date	Brief summary of outcome
No previous reporting history of this paper but it is worthy of note that committees have or will receive results	- FPC reviewed results on 2 October 2024 - PCC reviewed results on 16 October 2024 - Audit Committee reviewed results on 16 October 2024 - Quality and Safety Committee will review results on 6 November 2024 - Remuneration and Terms of Service Committee - review date to be agreed.	See above recommendations.

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NHS Foundation Trust

Summary of all committee annual reviews of effectiveness

Reported to;

Finance & Performance Committee - October 2024
People & Culture Committee - October 2024
Audit Committee - October 2024
Quality & Safety Committee - November 2024
Remuneration & Terms of Service Committee - next meeting

Methodology

- In accordance with Terms of Reference, all committees of the Board have invited members and regular attendees to complete a self-assessment of effectiveness and performance during September 2024.

- The self-assessments were completed via Smart Survey for the
  - Finance & Performance Committee
  - People & Culture Committee
  - Audit Committee
  - Quality & Safety Committee
  - Remuneration & Terms of Service Committee

Methodology (continued)

- 14 questions posed with an opportunity for members and attendees to answer on a five-point scale, from strongly agree to strongly disagree and provide free text comments. The use of the sliding scale was a suggestion for improvement made during the self-assessment last year.
- The survey asked questions in the following areas;
    - Alignment to Terms of Reference
    - Administration of the committee
    - Use of information and data
    - Meeting etiquette

Total responses

- The detailed responses have been shared and discussed at each committee including areas for continuous improvement
- Overall, for all surveys (including Audit Committee), 29 responses were received from 48 people surveyed, this included Executive and Non-Executive Directors and Deputy Directors.
- Almost all of the responses to the questions were positive
    - 69% of replies were strongly agree, and 27% were agree

Key themes

There were fewer comments made in the survey responses this year. There were two main themes across the committee responses:

- Excellent Charing of the committees
- Extensive agendas and time pressures to finish the meeting in the allotted time

Comments

The comments included;

- The length of the meetings, with long agendas that led to time pressures
- The committees had a good system for tracking decisions and actions providing good assurance
- The meetings are chaired very effectively
- The high level of scrutiny and challenge with a high-level of support is a strength, with a culture of considering challenge constructively and seeking areas for improvement
- Thorough contribution from MAIA including anti-fraud
- Reduction in the number of meetings is welcomed (Audit Committee)
- Detailed pursuance of risk management is a strength
- TIG is important in relation to real time quality and safety management in the Trust

Feedback for continuous improvement

- Take the papers as read and to allow sufficient discussion and questions
- Non-contentious and regular items to be considered off-line e.g. policy update and Audit Tracker, to relieve some time pressures
- Annual schedule of the Remuneration & Terms of Service Committee has been reactive to urgent issues during 2023-24 and 2024-25; *there have been a number of unscheduled meetings this year due to the recent interim posts.*
- Audit Committee to complete deep dives into key strategic risks on a routine and selected basis to provide further assurance

Next steps - agreed actions

- Improve the level of detail within the executive summary in the cover sheets, and include any additional information in the supporting report/presentation
- In the agenda include the timing at section level rather than for each individual report
- All the updates on actions in the decision & action log to be provided, as far as possible in writing
- Provide the policy position to each committee twice a year (rather than each meeting) and request extension to the expiry date via e governance (e-mail)
- The risk report noted at the meetings unless there is a high-level risk to be discussed
- The audit recommendations in the Audit Tracker is noted at the meetings, unless there is high risk action that is delayed
- When a committee undertakes a deep dive into an area, the outcomes are reported to the Audit Committee for assurance
- Review methodology for 2025-26 including facilitated discussions and a shorter survey