Title:	Emergency Preparedness Resilience and Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V2.0

Emergency Preparedness, Resilience and Response

Annual Report 2021 – 2022

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Presented by: **Lucy Parsons,** Deputy Chief Operating Officer

Executive Summary

University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect the safe and effective operation of services. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

Under the Civil Contingencies Act (2004) (CCA), NHS organisations must show that they can effectively respond to emergencies and business continuity incidents while maintaining critical services to patients. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

The Civil Contingencies Act 2004 places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 responders.

Category 1 responders are those organisations at the core of an emergency response. As a Category 1 responder, the Trust is required to prepare for emergencies in line with its responsibilities under the following:

- The Civil Contingencies Act 2004,
- The Health and Care Act, 2022 and
- NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) 2022.

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

In addition to the civil protection duties of the CCA 2004, the Trust must ensure it is compliant with Service Condition 30 of the NHS Standard contract for Emergency Preparedness, Resilience and Response as outlined below:

- Comply with EPRR Guidance if and when applicable.
- Identify and have in place an Accountable Emergency Officer.
- Notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 Operational Days following:
    a) The activation of its Incident Response Plan and/or Business Continuity Plan or.
    b) any risk or any actual disruption to Commissioner Requested Service (CRS) or Essential Services.

Part of the Trust is positioned centrally in what is known as a 'Core' city. This position places an even greater emphasis on there being robust up to date emergency plans in place. This report outlines the position of the Trust in relation to Emergency Preparedness, Resilience and Response and how the Trust will meet the duties set out in legislation and associated guidance, as well as any other issues identified by way of risk assessments and identified capabilities.

The Trust was rated partially compliant to the EPRR core standards in the annual assurance process for 2021/2022 this is a reduction in previous assurance audits from a position of substantial compliance. There is an action plan in place to support increasing this position for the next assurance audit in late 2023.

The impact of responding to the Covid19 worldwide pandemic had halted much of the business-as-usual activity for EPRR in 2021. The focus for the next year will be on ensuring the restoration of a solid base line from which to progress.

Strategic priorities update set for 2021/2022

Theme	Action	Progress 2021-2022
The new organisation	Continued alignment of the new UHBW organisation into Trust's EPRR plans.	All EPRR plans and policies reflect the new organisation and the principles of how the Trust does its business, including on call processes and escalation routes internally and externally.
NHSE/I Assurance process	Maintain substantial compliance in the 2021 EPRR assurance process	The Trust was rated as partially compliant for the 2022 NHS England EPRR Audit, achieving 86% compliance to the core standards. This is a reduction in overall compliance from the previous year's 96%. An action plan is in place to regain the previous compliance rating in conjunction with the Integrated Care Board (ICB).

Training	Continuing to ensure delivery of training in the emergency departments for the on-going CBRN training programme. Support in the delivery of a shelter and evacuation training schedule Trust wide with certified fire advisors. Design and deliver a Trust wide business continuity training programme to support Trust preparedness and resilience	CBRN response and capability training has continued, with the annual CBRN Assurance audit carried out by SWASFT on behalf of NHS England identifying no non-compliances to the core standards. Shelter and evacuation training has been delivered by the fire team throughout 2021-2022 including delivering training to Sirona staff at South Bristol Community Hospital. Business continuity response training has been delivered throughout 2022 including a joint exercise with North Bristol NHS Trust. Live responses to incidents have acted as training vehicles and superseded the need for a full training programme for 2022.
System working	Support to develop a system wide mass counter measure distribution plan, taking learning from mass vaccinations centres set up from Covid19 response.	This action was on hold throughout 2021-2022 due to system integration.
Shaping the future	Embed EPRR into the development of the new "Integrated Care System" (ICS) to shape future local, regional and national preparedness actions.	BNSSG ICS came into being on 1 July 2022. The UHBW EPRR Manager is deputy chair of the local health resilience partnership business management group (tactical planning group).

EPRR Strategic plan for next 2 years

Phase activity	Outcome

Phase 1(July – November 2022): Assess position in new heath landscape. Complete	Understand UNBW's EPRR position against the following the strategic drivers: • CCA 2004 • NHS England EPRR Core standards, 2022 audit • Recovery from Covid to include lessons embedded (local and national) • NHS long term plan ICS/ICB • NHS England Southwest EPRR Strategy and move to regional Health resilience partnerships • ASW EPRR Audit (External Audit) • UHBW Divisional declarations of preparedness as part of Audit • Integration of Weston hospital into UHBW divisional management structure • Revised training needs analysis against national minimum occupational standards for EPRR and relevant guidance.
Phase 2 (Nov - Dec 2022): Identify strategic priorities Complete	• Requirement to implement a robust Business Continuity Management System • Develop Training and exercising Programme • Revise On-call arrangements post Weston hospital integration • NHS England Core Standards
Phase 3: (2023-2025).	Embed actions and manage change for success of strategic priorities
Phase 4: Maintain and review	• NHS EPRR Annual assurance process • Annual Internal audit as part of BCMS • Peer review ICB Partners

Acronyms and Definitions

Acronym	Definition
AEO	Accountable Emergency Officer – at UH Bristol and Weston this is the Chief Operating Officer & Deputy Chief Executive
BCMS	Business Continuity Management System
BCPG	Business Continuity Planning Group *(Internal Group)*
CBRN	Chemical, Biological, Radiological and Nuclear
EPRR	Emergency Preparedness, Resilience and Response
IRPG	Incident Response Planning Group *(Internal Group)*
ICS/ICB	Integrated care system / Integrated care board
ISO 22301	International Standardisation Organisation *(the International Standard for Business Continuity Management)*

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LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NED	Non-Executive Director
OCMF	On Call Managers Forum *(Internal Group)*
SWASFT	Southwestern Ambulance Service NHS Foundation Trust

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1. Introduction

1.1 Purpose

This report outlines the Trust's EPRR activities during the period April 2021 to Dec 2022 that relate to the requirements of the Civil Contingencies Act 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the Trust's Quality Outcomes Committee in line with UHBW's internal EPRR policy. This document and associated papers will additionally be presented to the Trust Board in line with the national requirements of the NHS Core Standards for Emergency Preparedness, Resilience and Response.

1.2 Background

The CCA 2004 sets out a single framework for civil protection in the United Kingdom. The CCA provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work and places a set of duties on each.

Category 1 responders are those organisations at the core of emergency response. Acute Trusts are identified as Category 1 responders and are subject to the full set of civil protection duties.

UHBW is therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity plans,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance co-ordination,
- Co-operate with other local responders to enhance co-ordination and efficiency.

In addition to the civil protection duties of the CCA 2004, the Trust must ensure it is compliant with Service Condition 30 of the NHS standard contract for Emergency Preparedness, Resilience and Response as outlined below:

- Comply with EPRR guidance if and when applicable.
- Identify and have in place an Accountable Emergency Officer.
- Notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 operational days following:
  a) The activation of its Incident Response Plan and/or Business Continuity Plan or.
  b) any risk or any actual disruption to Commissioner Requested Service (CRS) or Essential Services.

As a Category 1 responder UHBW is required to prepare for emergencies in line with its responsibilities under:

- The Health and Care Act, 2022, and
- NHS England Core Standards for Emergency Preparedness Resilience and Response 2022.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response are the minimum standards which NHS organisations and providers of NHS funded care must meet. **(Appendix 1).**

The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

1.3 Pandemic National and local Context

During 2021 – 2022 Covid -19 remained the main challenge for the NHS nationally and locally.

April - July 2021 saw the January lockdown restrictions eased with the continuation of the vaccination programme, reducing hospital admissions and deaths related to Covid-19. Government focus moved from “responding” to “recovering” from impacts of the pandemic on the health service and economy with the “Covid -19 response: living with covid -19”.

August – September 2021 focused on continued restoration of services and recovery from previous waves of the pandemic, whilst the NHS simultaneously prepared for the next wave of the pandemic monitoring variants of concern and looking at ways to recover elective surgery programmes.

October – November 2021 activity focused on the release of the Government’s “Covid-19 response: Autumn and winter plan” (**Appendix 2**, UK Government, 2021) which identified two alternative scenario-based plans for managing the pandemic:

- Plan A - maintaining general social movement with minimal restrictions focussing on vaccinations, boosters, testing and isolation of potentially infected persons and protective measures at the UK border.
- Plan B – Returned use of greater restrictions including mandatory face coverings, working from home and the use of Covid-19 Passes.

The vaccination programme was extended to cover 12 – 15 year olds and the booster programmes began for over the 50's and those in high-risk groups.

December 2021 – Feb 2022 saw significant impacts on the NHS due to the omicron variant leading to increased hospital admissions in conjunction with predictable winter pressures triggering a return to the declaration of a national incident level 4.

During Feb – Apr 2022 the Russia / Ukraine conflict resulted in a UK national response to provide relocation and specialist cancer treatment for 22 child refugees and their families. Bristol Royal Hospital for Children participated in this response and provided care and support for three families affected by the conflict.

May - July 2022 led to the de-escalation of the previous declared national incident to level 3, meaning co-ordination at a regional level. This was also the period of transition from Clinical Commissioning Groups (CCG's) to Integrated Care Boards (ICBs) with the recovery from Covid19 impacts focusing on delivering timely urgent and emergency care, discharge and providing more routine elective and cancer tests and treatments.

During August-October 2022 health and social care recovery continued.

From November – December 2022 system control centres were set up in ICSs to provide co-ordination of the system response to the increased pressure on NHS due to Covid-19 and concurrent influenza cases surging. Rising case rates affected the supply of workforce and increased hospital attendances of patients with respiratory illness. Industrial action commenced with Royal College of Nursing members. Other union ballots planned throughout the health service including Charted society of Physiotherapists, British Medical Association, Unison and Unite.

1.4 Progress on Strategic priorities from 2020-2021

Theme	Action	Progress 2021-2022
The new organisation	Continued alignment of the new UHBW organisation into Trust's EPRR plans.	All EPRR plans and policies reflect the new, merged organisation and the principles of how the Trust does its business, including on call processes and escalation routes internally and externally.
NHSE/I Assurance process	Maintain substantial compliance in the 2021 EPRR assurance process	The Trust was rated as partially compliant for the 2022 NHS England EPRR Audit, achieving 86% compliance to the core standards. This is a reduction in overall compliance from the previous year's 96%. An action plan is in place to regain the previous compliance rating in conjunction with the Integrated Care Board (ICB).

Training	Continuing to ensure delivery of training in the emergency departments for the on-going CBRN training programme. Support in the delivery of a shelter and evacuation training schedule Trust wide with certified fire advisors. Design and deliver a Trust wide business continuity training programme to support Trust preparedness and resilience	CBRN response and capability training has continued, with the annual CBRN Assurance audit carried out by SWASFT on behalf of NHS England identifying no non-compliances to the core standards. Shelter and evacuation training has been delivered by the fire team throughout 2021-2022 including delivering training to Sirona Staff at South Bristol Community hospital who manage the inpatient bed base. Business continuity response training has been delivered throughout 2022 including a joint exercise with our acute partners at North Bristol NHS Trust. Live responses to incidents have acted as training vehicles and superseded the need for a full training programme for 2022.
System working	Support to develop a system wide mass counter measure distribution plan, taking learning from mass vaccinations centres set up from Covid19 response.	This action was on hold throughout 2021-2022 due to system integration and response to the ongoing unprecedented operational pressure in the health economy
Shaping the future	Embed EPRR into the development of the new “Integrated care system” (ICS) to shape future local, regional and national preparedness actions.	BNSSG ICS came into being on 1 July 2022. The UHBW EPRR Manager is deputy chair of the local health resilience partnership business management group (tactical planning group).

2. Governance and Assurance

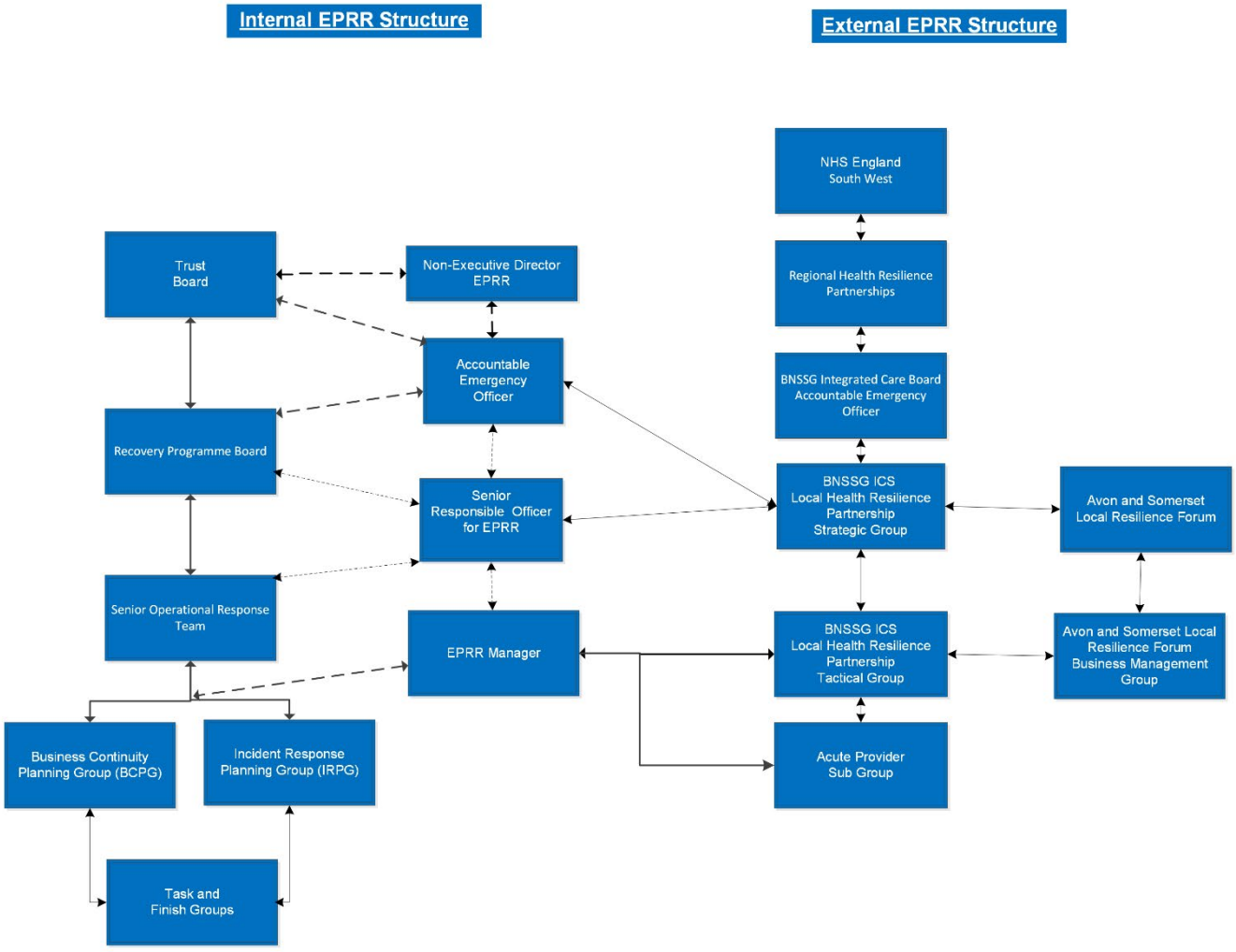
EPRR within the Trust is overseen by the Chief Operating Officer (COO) who acts as the Emergency Accountable Officer (AEO), supported by a Non-Executive Director (NED) to give impartial challenge to the organisation. The Trust has in place a senior responsible officer (SRO) for EPRR, this role is undertaken by the Deputy Chief Operating Officer. The SRO deputises at the strategic level in the local health resilience partnership (LHRP) in the absence of the AEO.

There is an EPRR Manager at 1.0 WTE 8a who is supported by an EPRR Officer at band 5 1.0 WTE, reporting to the Deputy Chief Operating Officer.

The EPRR workplan will be presented to the internal operational management group “Senior Operational Response Team” (SORT) which is a cross divisional group that meets weekly. Under SORT are two substantive EPRR working groups chaired by the EPRR Manager. These are the Incident Response Planning Group (IRPG) and the Business Continuity

Planning Group (BCPG). The work of both groups was impacted by Covid19 and industrial action response planning, which required an all-staff reaction.

The diagram below represents the internal and external Emergency Planning, Resilience and Response governance structure and the link with external partners through the LHRP.



In the 2021/22 NHS England EPRR Core Standards review the Trust was deemed to be partially compliant. This was the first full NHSE audit post Covid19 and required the Trust to self-assess against each of the core standards for EPRR. This self-assessment was subsequently reviewed by NHS England and the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group and a final rating assigned. (**See Appendix 3** for BNSSG ICS assurance outcomes).

2.1 Gap analysis in the new health Landscape

The Resilience manager undertook a gap analysis to establish the strategic direction for UHBW EPRR in light of the changed health landscape both regionally and nationally because of the new ICBs and the move to a regional approach from NHS England. **(Appendix 4)** The table below outlines the outcome of this activity noting that phase 3 is

underway and includes the action plan from the internal audit completed by ASW **(Appendix 5)**

Phase activity	Outcome
Phase 1(July – November 2022): Assess position in new heath landscape. Complete	Understand UNBW's EPRR position against the following the strategic drivers: • CCA 2004 • NHS England EPRR Core standards, 2022 audit • Recovery from Covid to include lessons embedded (local and national) • NHS long term plan ICS/ICB • NHS England Southwest EPRR Strategy and move to regional Health resilience partnerships • ASW EPRR Audit (External Audit) • UHBW Divisional declarations of preparedness as part of Audit • Integration of Weston hospital into UHBW divisional management structure • Revised training needs analysis against national minimum occupational standards for EPRR and relevant guidance.
Phase 2 (Nov -Dec 2022): Identify strategic priorities Complete	• Requirement to implement a robust Business Continuity Management System • Develop Training and exercising Programme • Revise On-call arrangements post Weston hospital integration • NHS England Core Standards
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Phase 4: Maintain and review	• NHS EPRR Annual assurance process • Annual Internal audit as part of BCMS • Peer review ICB Partners

3. Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

3.1 Community Risk Register

University Hospitals Bristol and Weston NHS Foundation Trust contributes to the development and maintenance of the Avon and Somerset Community Risk Register (CRR) through the BNSSG Local Health Resilience Partnership (Tactical Group) where,

amongst other areas, health related risks to the community are reviewed and updated and taken into the Avon and Somerset local resilience forum for multiagency review.

3.2 Trust Risk Register

EPRR risks are recorded on the Trust risk register. Risks assessed as scoring 12 or above are reviewed by the Trust Risk Management Group and Trust Board.

ID	Title	Description	Rating (inherent)	Controls in place	Adequacy of controls	Rating (current)	Rating (Target)
199	Risk that incidents at Massed Gatherings event could cause disruption to Trust operational services	If an incident occurred at massed gathering events in Bristol E.g., St Paul's Carnival, Bristol Balloon, Ashton Court, Maritime Festival, Bristol Half Marathon Then this could cause severe pressure on operational services Resulting in a major incident declaration impacting on the Trusts ability to operate normally	4= Moderate Risk	1. The Trust has in place Incident Response and Mass Casualty plans; these plans are exercised annually in line with the requirements of the Civil Contingencies Act 2004. 2. The Trusts EPRR unit receives notifications from the Safety advisory group of Bristol city council, south Gloucestershire and North Somerset council on planned events and the mitigations that will be in place. 3. The Trust will be exercising Mass casualty incident response plan May/ June 2023 as part of an EMERGO exercise led by the resilience manager as part of a 3-year exercise cycle. 4. NHS England exercise scheduled for March 9th, 2023, to test trauma network response	Adequate	4 = Moderate Risk	4 = Moderate Risk

210	Risk to Trust business and operations as a result of adverse weather conditions e.g., ice and snow	If climate change continues to affect weather, Then there may be an increase in adverse weather (including ice, snow, flooding), Resulting in disruption to travel networks and infrastructure and potential increase of slips and falls and may impact negatively on the ability of staff and patients to travel to site.	6= Moderate risk	Internal resources for gritting roads and paths within all sites. Relationship with Community Pay Back teams to provide additional gritting and snow clearance., Monitoring weather reports from the MET Office to flag any deterioration in weather and trigger severe weather plan (as appropriate), emergency access to Wessex 4x4 to provide 4x4 capability to for the purposes of saving life in times of adverse weather, The trust has a severe weather plan in place. Estates are reviewing the current Planned Preventative Maintenance schedules, to ensure all rooves are covered and at the right frequency. Climate adaption planning is included through NHS estates and sustainability teams to reduce trust impacts on climate.	Adequate	6 = Moderate Risk	6 = Moderate Risk
800	Risk that Trust operations are negatively impacted by (COVID-19) pandemic	If there is a national pandemic influenza outbreak (including any Novel Respiratory Disease such as COVID-19), Then there may be a significant increase in staff sickness rates at a time when activity is likely to increase and time pressures increase. a loss of available beds capacity due to introduction of social distancing measures and specific patient pathways based on infection status as	25 = Very High Risk	The Trust has a comprehensive Pandemic Influenza plan that was developed in consultation with UKHSA, other local health providers and internally the DIPC. This was utilised for covid-19. A management group will be activated to oversee oversee the response reporting to recovery programme board with a number of sub-groups managing specific workstreams. Divisional leads will be appointed to coordinate divisional	Adequate	9= High Risk	9 = High Risk

		opposed to Clinical presentation requirements. Resulting in the Trust being under severe pressure and operationally disrupted.		planning and cascade information to staff. TOR for group attached. An incident log will be maintained and can be reported on for assurance purposes.			
802	Risk that a heatwave could have adverse impact on UHBW business and operations	Heatwave - Resulting in prolonged periods of raised temperatures within trust premises that may potentially impact on attendances, admissions, patient condition and staff working environment	6 = Moderate Risk	The Trust has a heatwave plan that is updated annually following heatwave guidance from NHSE, Receive and assess Met Office weather reports and cascade to operational planning teams as necessary. Internal temperature monitoring in place and process for obtaining temporary air conditioning also in place.	Adequate	6 = Moderate Risk	6 = Moderate Risk
1909	Risk that the Trust is unable to respond to major or business continuity incidents	If there are extreme bed pressures in an extended period of a major or catastrophic internal or external incident, then the Trusts business continuity response may be hampered resulting in delay to normal operations	16 =Very High Risk	1. Effective and up to date business continuity plans/escalation plans to deliver a coordinated and timely response in place across most of the organisation. 2. Winter planning work 3. Up to date and effective incident response plans 4. Senior operational response team (SORT) bridges the gap between OPEL 4 and operational pressures incidents (OPI) to maintain patient flow over "Winter period" and high OPEL 5. SORT remains a capability when de-escalation from OPI to prevent rebound into ICI. 6. Full Capacity protocol in place to ensure full use of all boarding capacity at Bristol 7. Emergency Ambulance release plan completed by	Inadequate	9= High Risk	6 = Moderate Risk

				emergency departments to plan for the release of 100% of any SWASFT resource that is queued at any UHBW Emergency department should a major incident occur by deliberate intent or accident resulting in mass casualties			
2031	Risk that contaminated patient self-presenting to one of the Trusts Emergency Departments is not identified	If Patent(s) self-presenting to Weston or the Adult or Children's Emergency Departments In Bristol are contaminated by an unknown substance (either chemical, biological, radiological or nuclear from a malicious incident or an industrial accident) and if the patient is not identified and decontaminated then they pose an increased risk to themselves as well as the other staff and patients within the department resulting in patient harm, staff harm and disruption to normal operations	5 = Moderate Risk	The trust has a Chemical, Biological, Radiological and Nuclear (CBRN) response plan which covers the Adult and Children's ED in Bristol with a separate plan for the Weston site to account for the geographical and Estate differences. Key elements covered in these are: - Actions on identification and isolation of a potentially contaminated patient(s) - Contact details to access specialist advice - PPE for staff - Decontamination protocols including wet and dry decontamination processes - Quarterly training and maintenance for specialist CBRN kit -UHBW linked are in with SWASFT for a protective suit train the trainer programme 2022	Adequate	3 = Low Risk	3 = Low Risk
2453	Risk that outdated major incident plans would not deliver a coordinated network response to a major incident	If a large-scale incident were to happen, then there is the risk of a lack of coordination across these networks if capacity was stretched beyond individual Trusts ability to respond. Whilst the Trust, and other neighbouring Trusts, have major incident plans the equivalent plans for the trauma, critical care and burns network are not up to date. Resulting in significant impact to	9 = High Risk	The Trust is working with networks to inform local planning as well as supporting the networks develop and update their plans. Work includes support to a Burns network Emergo exercise, developing the mass casualty distribution plan with Severn trauma network and support to the critical care network in development of their plans.	Adequate	4 = Moderate Risk	4 = Moderate Risk

		trauma, critical care and burns services and delayed treatment.					

3.2 Risk 1909 - Risk that the Trust is unable to respond to major or business continuity incidents inadequate controls.

There are gaps in business continuity (BC) plans across organisation. The EPRR team undertook an audit as part of divisional declarations of preparedness in 2021-2022. Divisional triumvirates were requested to assure themselves that all services within their division had business continuity plans, that staff knew where these could be accessed, and that individual staff understood their role as part of local inductions.

Work is now underway to effectively coordinate the delivery of service level BC plans for hospital services to ensure a response is structured and effective even in periods of escalation. External audit recommendations are also being taken forward regards business continuity management system gaps **(Appendix 5).**

4. Maintaining Plans

This section details the activities undertaken to develop and maintain arrangements for responding to incidents. Planning activities are ongoing, informed by identifying risks as per the above risk register and the guidance available from NHSE/I (**Appendix 6).**

4.1 Incident Response Plan

The Trust responded to several local incidents by activating the incident response plan and declaring “Major incident- Standby “. This highlighted a knowledge gap in key responder groups and a planning gap in the notification, escalation and activation of the plan. A review of the initial decision-making process and options for timely co-location both in and out of hours was undertaken in November 2022. The outcome identified an early step change in the plan to ensure the activation of the Trust response to a major incident has clear governance built into the process. This additional step allows for the context of pressure at the front door to be considered in live time to support decision making and provide early shared situational awareness for a proportionate response.

The plan will have a full review in 2023 to include greater detail on mass casualty arrangements for the Trust’s pre-determined response.

4.2 Overarching Business Continuity Plan

The Trust's overall BC response plan was revised to incorporate the audit recommendations from ASW and embed learning from previous events and exercises.

4.3 Severe cold weather plan

The severe cold weather plan was revised to ensure a Trust wide response to disruption is embedded and took lessons learned from the response to Storm Eunice in February 2022, ensuring that the Trust's logistics cell could operate remotely to support accommodation and transport bookings for staff.

4.4 Escalation plan

The inpatient escalation plan is reviewed at least six monthly with the latest version of the plan reflecting increased escalation capacity at Weston hospital. This captured actions that were needed to respond to increased operational pressure and increased numbers of patients attending with respiratory illness. The next review in February 2023 will capture further mitigations to allow the use of all available space and reflect the fluidity of patient flow and actions to reduce ambulance handover times.

5. Business and Service Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

The standard for Business Continuity that has been adopted worldwide is known as ISO22301. NHS Specific supporting guidance is available to supplement the principles of the international standard **(Appendix 7).**

Over the course of 2021- 2022 there has been a continued focus on ensuring plans are updated to adhere to this standard, as well as being fit for operational use at the service delivery level. The template for BC plans across the Trust has been revised to include the requirements of this standard in addition to learning from incidents to ensure that clear escalation pathways and communication of disruptive incidents is embedded in all plans.

BC planning requirements are part of the annual NHS England EPRR assurance process. The Resilience Manager has identified the following actions to embed a business continuity management system into the organisation:

- Deeper and wider understanding across the organisational of impact assessments to ensure critical, essential and non-essential services are identified correctly. Impacts require documented risk assessments signed off at divisional board level should services be scaled back or stopped to support a response elsewhere in the organisation or ICS.

  This has been largely completed in response to industrial action during December 2022.

- Audit of plans against the impact assessments to ensure that all services identified have plans in date, tested and validated as per EPRR Policy.

- Exercise schedule for plans to be exercise and staff to be trained in the response as an ongoing continuous process.

6. Training and Exercising

Guidance set out by NHSE stipulates that exercises must be carried out and provides a time frame for the type and frequency of exercises. See table 1 below:

Exercise type	Minimum Frequency	Undertaken
Communications exercise	6 monthly	Not required as completed in live incidents
Tabletop	12 monthly	Not required as completed in live incidents
Live play	3 yearly	Nov 2019 – Planned June 2023
Command Post	3 Yearly	2022 Industrial action response

Table 1: EPRR exercises and frequency (Adapted from NHS England, 2022)

The response to industrial action in December 2022 has fulfilled the command post and tabletop requirements where the Trust had in place command and control structures and an incident co-ordination centre at both Weston Hospital and Bristol.

Below is a summary of EPRR training and exercising which has taken place over the past 18 months.

6.1 System wide Mass casualty exercise

This exercise consisted of a Major Incident Cascade prior to day of the exercise to test the BNSSG major incident cascade process. The exercise was designed to test what would happen if an acute provider had to decant quickly into the community

- Test how would the system and community partners respond
- Test how would Home First patients be managed
- Test safety netting processes

The incident scenario explored acute Trusts initiating a mass casualty discharge process of 10% of bed base within six hours of declaration. Additional aims were to test the response to multiple burns casualties in both acute Trusts.

6.2 Business continuity exercise

A collaborative exercise was designed and delivered between UHBW and NBT for the loss of piped medical oxygen supply to act as a training vehicle for tactical decision makers within UHBW and NBT with the following aims and outcomes:

- To ratify the revised incident response action cards
- To support mutual aid across the two Trusts
- To support the dovetailing of business continuity plans between the two Trusts
- To have an operational service level business continuity plan

6.3 Escalation plan and winter operational business continuity

The aim of the exercise was to prepare the organisation for increasing pressure in the health and social care system against predictable operational challenges for the winter period. To achieve this the exercise had 5 objectives:

- Support divisions and services to review and identify any additional available inpatient capacity
- To explore extraordinary response arrangements that are required to maintain a safe organisation during significant operational pressure
- To explore the sustainability of mitigating actions to identified risks
- To act as a training vehicle for operational and tactical decision makers within UHBW
- Identify opportunities to ensure a safe balance of inpatient admissions against discharges to prevent overcrowding at the front door whilst continuing to manage patient safety throughout the period

6.4 National Business continuity and operational pressure exercise

UHBW staff participated in a nationally developed exercise designed to explore the health response to multiple, concurrent operational and winter pressures in England, and the interdependencies with Local Resilience Forum (LRF) partners in responding to these pressures. The aim of the exercise was:

- To exercise the EPRR arrangements in place at Integrated Care Boards (ICBs) as a category one responder facing concurrent operational issues and winter pressures.
- To identify the likely type and range of decisions that would need to be made by senior leaders across health and partner organisations when responding to multiple, concurrent operational issues and winter pressures.
- To explore the practicalities of mutual aid support from resilience partners, to identify areas for further development, and to explore the response to simultaneous operational issues and winter pressures that reduce the facility for mutual aid.
- To identify options for maintaining patient flow during multiple, concurrent operational issues and winter pressures.
- To explore business continuity arrangements at Trust and ICB level in relation to potential medical supply disruption, energy supply disruption, prolonged and significant industrial relations action, including strikes, and reduced staffing numbers resulting from multiple concurrent operational issues and winter pressures.

7. Warning and Informing

As a category one responder under the Civil Contingencies Act 2004 the Trust has a “duty, in partnership with others to warn and inform the public of emergencies”.

The Trust Communications Team continues to work in partnership with NHS England and the ICB to inform and warn the public when circumstances warrant it. The Communications Team issue messages either directly or in collaboration with the ICB and UK Health Security Agency (previously Public Health England) and are part of a local network of NHS

Communications Teams. In the event of a major incident NHS England would ensure communications are coordinated and will link into the Trust communications department.

8. Cooperation

This section details how the Trust engages with local EPRR planning groups.

8.1 BNSSG Local Health Resilience Partnership (LHRP)

The Local Health Resilience Partnership, chaired by the ICB, brings together all NHS organisations to ensure coordinated and joined up planning across BNSSG. There are separate LHRP's for Bath, Swindon and Wiltshire (BSW) and for Somerset. Between these 3 LHRP's at least 1 ICB will attend the Avon and Somerset LRF and represent all of health in the area.

There is a strategic group that meets quarterly and is attended by the Accountable Emergency Officers (AEO) from all organisations in the BNSSG area. The Chief Operating Officer is the UHBW Accountable Emergency Officer (AEO) supported by the Deputy Chief Operating Officer. This group defines the strategic direction, the priorities and actively monitors the progress of the Tactical Planning Group.

8.2 Local Health Resilience Partnership Sub-groups

There are normally several LHRP subgroups and task and finish groups; membership of these groups is dependent on the area of focus of the group.

8.3 Local Resilience Forum (LRF)

The LRF is a statutory planning group attended by Category 1, 2 and uncategorised responders in Avon and Somerset, as defined by the Civil Contingencies Act 2004. Health is normally represented by the ICB, which acts in the interests of all providers. This group also informs some of the planning activity undertaken by the BNSSG LHRP.

9. Recent Major or Significant Events

The Trust has experienced the following emergency incidents and disruptive events whilst responding concurrently to the pandemic during the April 2021 to Dec 2022 period.

Title	Date
NHS Supply chain disruption	May – June 2021
Water supply BC incident South Bristol	7 June 2021
Heat wave	15 – 25 July 2021
Digital services BC incident Weston	6 August 2021
National fuel Supply BC incident	27-29 sept 2021
CSSD BC incident	3 Nov 2021
Digital services BC incident Weston	31 Jan 2022
Storm Eunice severe weather	17-20 Feb 2022
Radiology BC Incident	25 Feb 2022
Diagnostics and therapy BC incident	3-4 March 2022
NBT Major incident suspicious package	10 March 2022
Relocation of children with cancer from Ukraine conflict	March -April 2022
NHS Supply Chain disruption	May 2022
Monkeypox Outbreak	May – June 2022
NHS Supply Chain disruption	June 2022
Weston radiology BC incident	21-22 June 2022
Heatwave	17-19 July 2022

BC incident mains water main burst and flooding	20 July 2022
Heat wave	9-14 August 2022
Operation Bridges – Death of HRH Queen Elizabeth II	8 -20 September 2022
Major incident - Tower block fire Bristol city	25 Sept 2022
CSSD BC incident	14 October
Major incident – Tower block fire Bristol city	20 October 2022
BC incident Industrial action	December 2022

Debriefs have been undertaken as part of the EPRR policy with learning and lessons identified being used to improve the Trust's response.

10. Conclusions

For the period of April 2021- Dec 2022 the EPRR workplan was impacted by the global pandemic response and recovery activity alongside responding to numerous incidents both internally and externally to the Trust.

There is now an opportunity for the organisation's EPRR team to have a "reset" as part of the new health landscape and drive the EPRR agenda forward through the organisation. The newly formed Integrated Care System provide an opportunity to create more collaborative system plans to support the response to incidents and emergencies in a cohesive way taking greater account of the local nuances including the specialist services delivered by individual organisations or shared services across the patch.

Classification: Official

Publication reference: PAR1609_i

NHS England

NHS core standards for emergency preparedness, resilience and response guidance

Version 6.0, 29 July 2022

Contents

1. Purpose

The purpose of the NHS core standards for EPRR is to:

- enable health agencies across the country to share a common approach to EPRR
- allow co-ordination of EPRR activities according to the organisation's size and scope
- provide a consistent and cohesive framework for EPRR activities
- inform the organisation's annual EPRR work programme.

2. Relevant legislation and guidance

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

3. Relevant legislation and guidance

The NHS England Board has a statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. This is provided through the EPRR annual assurance process and assurance report. This report is submitted to the Department of Health and Social Care and the Secretary of State for Health and Social Care.

As the NHS core standards for EPRR provide a common reference point for all organisations, they are the basis of the EPRR annual assurance process.

Providers and commissioners of NHS-funded services complete an assurance self-assessment based on these core standards. This assurance process is led nationally and regionally by NHS England and locally by integrated care boards.

4. NHS core standards EPRR

The NHS core standards for EPRR cover 10 domains:

1. governance
2. duty to risk assess
3. duty to maintain plans
4. command and control
5. training and exercising
6. response
7. warning and informing
8. co-operation
9. business continuity
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

The applicability of each domain and core standard depends on the organisation's function and statutory requirements. Where organisations provide services across multiple organisation types, all the standards in all the applicable organisation types will apply; for example, an NHS111 service provider that also provides urgent treatment services (community) is required to comply with all the standards applicable to NHS111 services **and** community service providers.

An 11th domain is only applicable to NHS ambulance trusts and covers the 'interoperable capabilities' they must have in place.

4.1 Governance

An EPRR policy or statement of intent outlining the organisation's commitment to deliver EPRR must be in place. This statement should be supported by an annual EPRR work programme to ensure all NHS core standards for EPRR are delivered.

Organisations must have an appointed accountable emergency officer (AEO) who is a board-level director and responsible for EPRR in their organisation. Following a national review of non-executive director (NED) champions, the requirement for a non-executive board member to support the AEO has been removed, recognising

that the responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.

The AEO must provide reports to the public board on EPRR activity no less frequently than annually and must publicly state its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

Organisations that do not have a public board must instead publicly state their readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

4.2 Duty to risk assess

Organisations should have provision in place to regularly assess the risks to the population they serve. This process should consider the community and national risk registers.

A supporting risk management system must be in place to ensure a robust method of reporting, recording, monitoring, communicating and escalating EPRR risks internally and externally with partners.

4.3 Duty to maintain plans

Appropriate and up-to-date plans must set out how the organisation plans for, responds to and recovers from major incidents, critical incidents and business continuity incidents. These should be developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.

4.4 Command and control

A robust and dedicated EPRR on-call mechanism should be in place to receive notifications relating to EPRR. This facility should be 24 hours a day, seven days a week, and provide the ability to respond or escalate notifications to executive level.

Personnel performing the on-call function should be appropriately trained in major incident response.

4.5 Training and exercising

EPRR training should be carried out in line with a training needs analysis to ensure staff are competent in their role.

Arrangements must be exercised through, as a minimum, a:

- communications exercise every six months
- tabletop exercise once a year
- live exercise every three years
- command post exercise every three years.

4.6 Response

Staff trained in incident response should be available to respond to incidents from within an incident co-ordination centre (ICC). This includes having processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings. These arrangements should also include an alternative ICC, should the primary location be affected by the incident itself or be unavailable at the time of response.

4.7 Warning and informing

EPRR and communications planning activity should be co-ordinated to ensure communications align with organisational requirements during an incident. This includes ensuring access to trained communications support for senior leaders during an incident.

Communications plans should be tested alongside incident plans to support communication with partners and stakeholders, and warning and informing public and staff when responding to major incidents, critical incidents and business continuity incidents.

Organisations should also have appropriate media and social media strategies to enable communication with the public. This should include identification of, and access to, trained media spokespeople who can represent the organisation.

4.8 Co-operation

Arrangements should be in place to share appropriate information with stakeholders. This includes participation in local health resilience partnerships (LHRPs) and with local resilience forums (LRFs) and other multiagency planning forums to demonstrate engagement and co-operation with other responders.

4.9 Business continuity

Organisations must set out their intention and methods of undertaking business continuity in a policy and/or business continuity management system (BCMS).

The BCMS is part of the overall management system that establishes, implements, operates, monitors, reviews and improves business continuity.

The system allows organisations to identify prioritised/critical activities by undertaking a business impact analysis (BIA). In addition, it contributes to ensuring an organisation has business continuity plans in place to respond to business continuity incidents.

Each organisation should have in place a process to measure the effectiveness of the BCMS and take corrective action where necessary.

The BCMS should be in line with the International Standards for Organisations (ISO) 22301.

4.10 Chemical, biological, radiological, nuclear (CBRN) and hazardous materials (HAZMAT)

Acute, specialist, mental health and community healthcare providers are required to have planning arrangements in place for the management of CBRN incidents. NHS ambulance trusts also share this requirement and their specific responsibilities in relation to CBRN are set out in 'interoperable capabilities'.

4.11 Interoperable capabilities

NHS ambulance trusts in England are required to maintain a set of specialist capabilities. These capabilities are nationally specified under the NHS England EPRR Framework.

These capabilities are interoperable between services. They must be maintained according to strict national standards to ensure they can be combined safely to provide an effective national response to certain types of incidents.

The interoperable capabilities include:

- hazardous area response teams (HART)
- marauding terrorist firearms attack (MTFA)
- chemical biological radiological nuclear (CBRN)
- mass casualty vehicles (MCV)
- command and control
- joint emergency services interoperability principles (JESIP).

5. Climate adaptation planning

Under the adaptation reporting powers of the Climate Change Act, the Greener NHS programme has been invited by the Department for Environment, Food and Rural Affairs to produce the health and care adaptation reports on behalf of the sector.

The third health and care adaptation report includes the recommendation for adaptation planning to be considered for inclusion in the latest revision of the EPRR core standards to increase systematic scrutiny.

This has been reflected across several existing relevant domains and standards including:

- the consideration of reasonable worst-case scenario and extreme events for adverse weather as a core component of community risk registers
- adverse weather arrangements should be reflective of climate change risk assessments and cognisant of extreme events
- climate change adaption planning to be considered as a longer-term impact on an organisation as part of a business continuity policy statement.

As with all the core standards, it will be important for EPRR leads to engage with relevant local leads for the Greener NHS programme or climate adaptation planning, not only to seek local assurance of these relevant areas, but also to align longer-term planning arrangements.

6. Equality and health inequalities

In complying with the core standards for EPRR, organisations must ensure all EPRR arrangements and planning consider the needs of people with protected characteristics and vulnerable groups, particularly with regard to: access to information, services and premises; increased risk based on health factors; safeguarding implications; and the management of restoration of services.

Equality and health inequalities impact assessments (EHIAs) are tools that can be used to assess the impact of arrangements and plans on the communities and populations the organisation serves.

The use of EHIAs, and any subsequent recommendations made as a result of EHIAs, will assist organisations in developing EPRR plans and arrangements that improve the care and safety, health and wellbeing of all patients, staff, visitors and populations from protected characteristic groups. Their use contributes to the assurances that NHS organisations are meeting their legal duties around equalities and health inequalities under the Equality Act 2010 and the Health and Social Care Act 2012.

7. Reviews and updates

The NHS core standards for EPRR are subject to an annual review. This review includes minor amendments and updates according to recent learning and changes in legislation and/or guidance.

A full review of the core standards occurs every three years, involving consultation with a working group. This was last conducted in 2022. The working group for the 2022 review consisted of representatives from a variety of NHS organisations and independent providers of NHS services from across the country, including commissioners, acute, specialist, mental health, community, patient transport and NHS111 service providers.

Any amendments/recommendations to future NHS core standards for EPRR can be directed to: england.eprr@nhs.net

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This publication can be made available in a number of alternative formats on request.

HM Government

COVID-19 RESPONSE: AUTUMN AND WINTER PLAN

September 2021

HM Government

COVID-19 RESPONSE: AUTUMN AND WINTER PLAN

September 2021

CONTENTS

1. INTRODUCTION

1. Steadily, over the course of this year, the whole United Kingdom (UK) has seen life return closer to normal. Between March and July this year, the Government's roadmap for England reopened the economy and lifted restrictions in four steps. Scotland, Wales and Northern Ireland have also emerged from lockdown on similar timetables. The country is learning to live with COVID-19, and the main line of defence is now vaccination rather than lockdown. The Test, Trace and Isolate system is reducing the number of positive cases mixing in the community. Rules and regulations have mostly been replaced with advice and guidance on the practical steps people can take to help manage the risks to themselves and others.

2. The spread of the more transmissible Delta variant in the spring drove rapid growth in COVID-19 cases in England, leading to a peak of 43,910 cases (7 day average) on 16 July.[1] Though incidence subsequently declined sharply to a low of 23,002 cases (7 day average) by the end of July, cases have since been gently rising, and are significantly higher than at this point last year.[2] The return of students to schools and universities and workers to workplaces after the summer holidays is likely to put further upward pressure on case numbers. The latest data from Scotland suggests that, in addition to increased infections following the lifting of most restrictions, there has also been an impact from the return to schools and workplaces.[3]

3. Data continues to show that the link between cases, hospitalisations, and deaths has weakened significantly since the start of the pandemic.[4] In England, the number of deaths and hospital admissions due to COVID-19 has remained relatively stable over the last month, and although hospital admissions and deaths sadly increased at the beginning of the summer, they have remained far below the levels in either of the previous waves.[5]

4. This has been thanks to the success of the UK's vaccine programme. As of 9 September, more than 92 million doses of the vaccine have been given across the UK.[6] The vaccines are highly effective against the Delta variant, providing around 95% protection against severe disease.[7] Latest Public Health England (PHE) estimates suggest that 143,600 hospitalisations (up to 22 August), 112,300 deaths and 24,702,000 infections had been prevented as a result of the vaccination programme, up to 27 August 2021.[8]

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1 Cases in England, coronavirus.data.gov.uk
2 Cases in England, coronavirus.data.gov.uk
3 Daily Case Trends By Age and Sex, Public Health Scotland
4 UK summary, coronavirus.data.gov.uk
5 Deaths in England, coronavirus.data.gov.uk
6 UK Vaccinations Summary, coronavirus.data.gov.uk
7 Vaccine Effectiveness Expert Panel – 27 August
8 Public Health England,COVID-19 vaccine surveillance report Week 36, 9th September

5. The public's continued willingness to get vaccinated, to test and self-isolate if they have symptoms, and to follow behaviours and actions that mitigate all methods of transmission has played a key role in lifting restrictions. Although rules vary slightly in England, Scotland, Wales and Northern Ireland, the UK is now managing COVID-19 without most of the restrictions on lives and livelihoods that have had heavy economic, social, and health impacts. The reopening of closed settings, and the removal of social distancing and all gathering limits, has helped people to reconnect with their friends and family, while supporting jobs and the country's economic recovery. In the second quarter of 2021, Gross Domestic Product (GDP) grew by 4.8%,[9] leaving the level of GDP in June nearly 4 percentage points higher than the Office for Budget Responsibility had forecast in March.[10]

6. Over autumn and winter, the Government will aim to sustain the progress made and prepare the country for future challenges, while ensuring the National Health Service (NHS) does not come under unsustainable pressure.

7. The Government plans to achieve this by:

    a. **Building our defences through pharmaceutical interventions:** vaccines, antivirals and disease modifying therapeutics.

    b. **Identifying and isolating positive cases to limit transmission:** Test, Trace and Isolate.

    c. **Supporting the NHS and social care:** managing pressures and recovering services.

    d. **Advising people on how to protect themselves and others:** clear guidance and communications.

    e. **Pursuing an international approach:** helping to vaccinate the world and managing risks at the border.

8. This is the Government's Plan A – a comprehensive approach designed to steer the country through autumn and winter 2021-22. However, the last 18 months have shown the pandemic can change course rapidly and unexpectedly and it remains hard to predict with certainty what will happen. There are a number of variables including: levels of vaccination; the extent to which immunity wanes over time; how quickly, and how widely social contact returns to pre-pandemic levels as schools return and offices reopen; and whether a new variant emerges which fundamentally changes the Government's assessment of the risks.

9. In addition, winter is always a challenging time for the NHS. This winter could be particularly difficult due to the impacts of COVID-19 on top of the usual increase in emergency demand and seasonal respiratory diseases such as influenza (flu). It is a realistic possibility that the impact of flu (and other seasonal viruses) may be greater this winter than in a normal winter due to very low levels of flu over winter 2020-21.[11] There is considerable uncertainty over how these pressures will interact with the impact of COVID-19.

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[9] ONS, GDP first quarterly estimate, UK: April to June 2021, 12 August 2021

[10] OBR, Economic and fiscal outlook – March 2021, 3 March 2021

[11] Academy of Medical Science, COVID-19: Preparing for the future, 15 July 2021

10. The Government will remain vigilant and monitor the data closely, taking action to support and protect the NHS when necessary. In preparation, the Government has taken the responsible step of undertaking contingency planning in case Plan A is not sufficient to keep the virus at manageable levels. So that the public and businesses know what to expect, this document outlines a Plan B in England which would only be enacted if the data suggests further measures are necessary to protect the NHS. The Government remains committed to doing whatever it takes to prevent the NHS from being overwhelmed.

2. BUILDING OUR DEFENCES THROUGH PHARMACEUTICAL INTERVENTIONS

Vaccines

11. The high level of vaccine protection has allowed the country to live with COVID-19 without stringent restrictions on society, the economy, and people's day-to-day lives. Going further on vaccination will help ensure this remains the case. The Government has secured sufficient supplies to support further vaccination across the whole UK. It will provide the Devolved Administrations with vaccine supplies to deploy to the people of Scotland, Wales, and Northern Ireland. The Government has three priorities for the COVID-19 vaccination programme in England for the autumn and winter:

    a. **Maximising uptake of the vaccine among those that are eligible but have not yet taken up the offer.**

    b. **Offering booster doses to individuals who received vaccination in Phase 1 of the COVID-19 vaccination programme (priority groups 1-9).**

    c. **Offering a first dose of vaccine to 12-15 year olds.**

12. First, the Government will continue to make vaccines easily available to everybody to maximise uptake among those that are eligible but have not yet taken up the offer. In England, 11.3% people aged 16 and older – over 5.5 million – remain unvaccinated and this heightens the risk of rising hospitalisations, particularly when prevalence is high.[12] Take up so far varies by ethnicity, age, and deprivation, with some groups recording lower rates of vaccine uptake. The Government and clinical advisors recommend that everybody accepts the offer of vaccination as a way of maximising protection for themselves, the people around them, and society as a whole.

13. In addition to the protection they provide, there are other benefits of being fully vaccinated:

    a. On 16 August, the Government amended the rules that were in place to ensure that people who are fully vaccinated do not need to self-isolate after being in contact with somebody who tests positive for COVID-19.

    b. Since 19 July, those fully vaccinated through the UK vaccine programme, or participating in a UK vaccine clinical trial, have not needed to quarantine on returning to the UK from any country not on the red list.

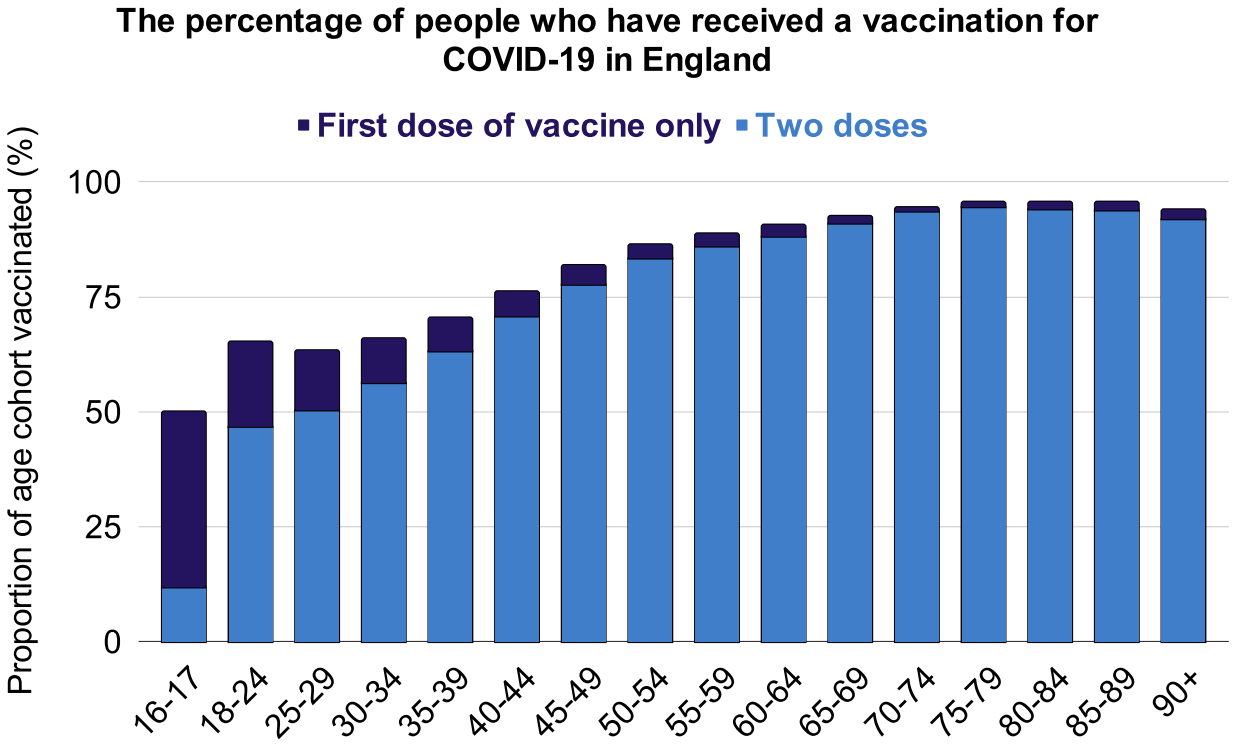
    c. Over 60 countries around the world now recognise the NHS COVID Pass covering vaccines administered in the UK. That number is growing, allowing vaccinated UK citizens to benefit from any vaccine-enabled freedoms in these countries.

[12] UK vaccinations summary, coronavirus.data.gov.uk

14. The Government will continue to support those communities with lower rates of COVID-19 vaccine uptake. An additional £23.3 million for a network of 'Community Vaccine Champions' will be provided to local authorities and voluntary and community sector organisations to ensure that access to the vaccine is as easy as possible.

15. Building on lessons learned through Phases 1 and 2 of the vaccine rollout, the Government is also working closely with the NHS to make it as easy as possible to get a vaccine, including through 'grab a jab' pop-up vaccine sites across the country with an easy to use walk-in site finder on the NHS website. The Government has also been partnering with transport providers such as Uber and FREENOW to ensure access to vaccine sites is easier than ever before.

Figure 1: The percentage of people who have received a vaccination for COVID-19 in England by age cohort[13]



16. Second, the NHS will offer booster doses to individuals who received vaccination in Phase 1 of the COVID-19 vaccination programme (Joint Committee on Vaccination and Immunisation (JCVI) priority groups 1-9).[14]

17. As is common with many other vaccines, there is early evidence that the levels of protection offered by COVID-19 vaccines reduce over time, particularly in older individuals who are at greater risk from the virus. The JCVI has consequently advised that those in priority groups 1-9 should be offered a COVID-19 booster, no earlier than 6 months after completion of their primary course. A booster shot of a COVID-19 vaccine will ensure protection is maintained at a high level throughout the winter

[13] UK Vaccinations Summary, coronavirus.data.gov.uk

[14] Joint Committee on Vaccination and Immunisation: advice on priority groups for COVID-19 vaccination, 30 December 2020

months in adults who are more vulnerable to severe COVID-19 and strengthen the vaccine wall of defence. The NHS is preparing to start offering booster doses next week, the week commencing 20 September.

18. Separately to the booster programme, the NHS is already offering a third vaccine dose to people aged 12 and over with severely weakened immune systems as part of their primary schedule, as recommended by the JCVI.[15] They will be contacted either by their hospital consultant or GP if eligible.

19. Third, following advice from the JCVI and UK Chief Medical Officers, the NHS will offer those 12-15 year olds not covered by previous advice with a first dose of the Pfizer vaccine. The NHS, working with school immunisation teams, will offer a first dose of vaccine to 12-15 year olds from next week, the week commencing 20 September. The Government will consult the Royal Colleges and other professional groups on how best to present the risk-benefit decisions about vaccination in a way that is accessible to children and young people as well as their parents.

20. **The Government is also taking steps to ensure that the UK has the best protection available from vaccines beyond this autumn and winter**. It is possible that further doses of the COVID-19 vaccine may be offered in the future to reinforce protection. Subject to advice, this may include annual vaccination programmes – as is the case with the flu vaccination – for those who need additional protection. Reformulated vaccines to target new variants of the virus and new ways of administering vaccines could play a role in future vaccination programmes. The UK Vaccine Taskforce has already procured vaccines to run further booster programmes in autumn 2022 if necessary, and will continue to look to future deployment needs.

Antivirals and therapeutics

21. Advances in antivirals and therapeutics will continue to provide additional tools to manage COVID-19. Several treatments are already available through the NHS for patients with COVID-19, including dexamethasone and tocilizumab which reduce morbidity and mortality.

22. The Medicines and Healthcare products Regulatory Agency (MHRA) has recently approved casirivimab and imdevimab as the first monoclonal antibody combination product indicated for use in the prevention and treatment of acute COVID-19 infection for the UK in some individuals.[16] The Government is now working with the NHS and expert clinicians to ensure this treatment can be rolled out to NHS patients as soon as possible.

23. In April, the Prime Minister launched the Antivirals Taskforce. The aim of the Taskforce is to identify treatments for UK patients who have been exposed to COVID-19 to stop the infection spreading and speed up recovery time. The Taskforce is leading the search for new antivirals, which disrupt how the virus replicates in the body and can reduce the number of patients who are hospitalised, and potentially help to break chains of transmission when administered responsibly.

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[15] Third primary COVID-19 vaccine dose for people who are immunosuppressed: JCVI advice
[16] Press Release: Regulatory approval of ronapreve

24. The Government will continue to work with the life sciences sector to ensure that effective therapeutics, including antivirals, complement the vaccination programme to enable the long-term management of COVID-19 and its clinical impacts. The Government and NHS will set out more details on the availability and administration of further treatments in due course.

3. IDENTIFYING AND ISOLATING POSITIVE CASES TO LIMIT TRANSMISSION

25. The Test, Trace, and Isolate system remains critical to the Government's plan for managing the virus over the autumn and winter. It helps to find positive cases and make sure they and their unvaccinated contacts self-isolate, breaking chains of transmission. This helps reduce pressure on the NHS, as well as enabling individuals to manage their own risk and the risk to others. Testing is also crucial to enable genomic sequencing that can identify potentially dangerous variants.

26. The Government will continue to expect everyone with COVID-19 symptoms to self-isolate and take a polymerase chain reaction (PCR) test. The legal requirement to self-isolate for 10 days if an individual tests positive for COVID-19 will remain in place in order to prevent those who are infected from mixing in the community and passing on the virus.

27. Over autumn and winter PCR testing for those with COVID-19 symptoms will continue to be available free of charge. The Government has developed one of the largest per capita testing capabilities in the world. The recent opening of the Rosalind Franklin Megalab brings total capacity to over 700,000 PCR tests daily across the four nations.[17] The Government plans to scale sequencing capacity from 39,000 tests per week currently to over 150,000 by March 2022 to establish greater levels of surveillance for disease monitoring and variant tracking. This is critical to inform effective prevention measures for breaking chains of transmission.

28. Since the asymptomatic testing programme began, it has found over 700,000 cases and, today, lateral flow devices (LFD) identify around a quarter of all cases reported daily.[18] Delivering this programme has included providing Scotland with 150 million LFDs, Wales with 75 million and Northern Ireland 50 million. Regular asymptomatic testing will continue to help find cases and break the chains of transmission. It will be particularly focused on those who are not fully vaccinated, those in education, and those in higher-risk settings such as the NHS, social care, and prisons. Community testing will continue to support local authorities to focus on disproportionately-impacted and other high-risk groups.

29. Testing in education settings has played an important role in identifying positive cases since the start of this year, helping reduce the spread by removing infected individuals from the classroom or lecture hall. In secondary schools, further education and higher education, the Government expects that testing for students will continue for the rest of this term. This will be a valuable tool in minimising the overall disruption to education, and is particularly helpful for this cohort, given its current lower level of vaccine-based protection.

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[17] Press release: new megalab opens to bolster fight against COVID-19

[18] Weekly statistics for rapid asymptomatic testing (England): 26 August to 1 September 2021

30. Rapid asymptomatic testing is an important tool to help reduce the spread of the virus, while supporting people to manage their own risk and the risks to others. The Government will therefore continue to provide the public with access to free lateral flow tests in the coming months. People may wish to use regular rapid testing to help manage periods of risk such as after close contact with others in a higher risk environment, or before spending prolonged time with a more vulnerable person. At a later stage, as the Government's response to the virus changes, universal free provision of LFDs will end, and individuals and businesses using the tests will bear the cost. The Government will engage widely on the form of this model as it is developed, recognising that rapid testing could continue to have an important, ongoing role to play in future.

31. Contact tracing will continue through the autumn and winter. This means NHS Test and Trace will continue to check with all positive cases whether they need support to self-isolate, find out who they may have passed the virus onto and alert those contacts, and ask all contacts to take a PCR test as soon as possible to help identify positive cases. Since 16 August, in England, under 18s and those who are fully vaccinated no longer need to self-isolate if they are identified as a contact. With over 80% of over 16s having received two vaccine doses,[19] the majority of adults and all children are no longer required to self-isolate. If they are identified as a contact, they are advised to take a PCR test and only need to self-isolate if positive. Where contacts are over 18 and not fully vaccinated, they will, as now, be legally required to self-isolate unless they are taking part in an approved daily contact testing scheme.

32. In addition, the Government will continue to encourage the use of the NHS COVID-19 app. The app is a key health protection tool, preventing as many as 2,000 cases a day in July.[20] It helps users by informing them if they have been exposed to COVID-19, either through direct contact with a positive case or following a check-in to a venue where there has been an outbreak, and advising on actions they can take to protect others. Since 16 August, the App has advised potential contacts who are vaccinated to take a PCR test rather than isolate.

33. As well as maintaining the current legal requirements for positive cases and unvaccinated contacts to self-isolate, the Government will continue to offer practical and financial support to those who are eligible and require assistance to self-isolate. The Government will review the future of these regulations as well as this support by the end of March 2022.

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19 UK vaccinations summary, coronavirus.data.gov.uk

20 Press release: NHS COVID-19 app updated to notify fewer contacts to isolate

4. SUPPORTING THE NHS AND SOCIAL CARE

34. Throughout the pandemic the Government has provided health and care services with the additional funding they need to respond to the unique challenges they have faced, making £63 billion available in 2020-21. The Government will continue to support the NHS to meet the challenges it faces in the coming months and years. This includes committing funding to help the NHS to reduce the elective backlog.

35. The Government announced on 6 September that there will be an additional £5.4 billion cash injection to the NHS in England to support the COVID-19 response over the next 6 months. This includes £1 billion to help tackle backlogs in elective procedures caused by COVID-19 and the delivery of routine surgery and treatments for patients. The additional funding brings the Government's total investment in health services for COVID-19 for 2021-22 to over £34 billion so far, with £2 billion in total for the NHS to tackle the elective backlog.

36. The UK Health Security Agency is continuously reviewing COVID-19 specific Infection Prevention and Control (IPC) and related social distancing measures which could safely be eased to support the ability of the NHS to manage activity levels. Higher levels of vaccination among staff in the NHS help protect staff and patients and reduce the need for additional specific IPC measures which have been introduced as a result of the pandemic. The Government has also launched a consultation on protecting vulnerable patients by making COVID-19 and flu vaccinations a condition of deployment for frontline health and wider social care staff in England.[21]

Long COVID

37. Long COVID is described by The National Institute for Clinical Excellence (NICE) as "signs or symptoms that develop during or after an infection consistent with COVID-19 that continue for more than 12 weeks and are not explained by an alternative diagnosis. It includes both ongoing symptomatic COVID-19 and post-COVID-19 syndrome".[22] The Government is also investing £50 million specifically in long COVID research to better understand the causes and potential treatments.

38. To support those with long COVID, the NHS continues to expand its long COVID services including assessment clinics, paediatric hubs and an enhanced service for general practice.[23]

Clinically Extremely Vulnerable guidance and shielding advice

39. At the start of the pandemic, on the advice of clinicians, the Government made the difficult decision to advise millions of people, who were then identified as Clinically Extremely Vulnerable (CEV), to shield in order to protect themselves from the virus.

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[21] Consultation: Making vaccination a condition of deployment in the health and wider social care sector (09 September)

[22] NICE guidance: COVID-19 rapid guideline: managing the long-term effects of COVID-19

[23] PHE Guidance: Coronavirus (COVID-19): long-term health effects

This helped keep the most vulnerable safe whilst more was learned about the risks of COVID-19, and COVID-19 vaccines were developed and deployed. Clinicians continued to assess the clinical risks of patients and add to this group, as well as to provide advice.

40. Since then, the understanding of the risks to this group has changed as more has been learnt about the virus, and as the most vulnerable have been prioritised for vaccination. Due to falling prevalence of COVID-19, shielding advice was paused on 1 April 2021 and, since 19 July 2021, people who were previously identified as CEV have been advised to follow the same guidance and behaviours as the rest of the adult population. The proven effectiveness of the vaccine rollout across the entire population has reduced the risk of serious illness from COVID-19. This also applies to CEV individuals, the majority of whom will be well-protected by the vaccine. Third doses have been offered to those with severely weakened immune systems and to maintain protection, the former CEV group will be prioritised for a booster (see Vaccines section above for more information). The effectiveness of the vaccine, the availability of evidence-based effective treatments and increased knowledge and understanding of the virus and the clinical risks it poses means that clinical advice has been updated to say that the shielding programme can now end.

41. The Government will continue to assess the situation and the risks posed by COVID-19 and, based on clinical advice, will respond accordingly to keep the most vulnerable safe. Individuals should consider advice from their health professional on whether additional precautions are right for them.

Adult Social Care

42. Care home staff provide a critical role in supporting the health and wellbeing of some of the most clinically vulnerable to the effects of COVID-19 in society, and have maintained their dedication and professionalism through highly challenging conditions.

43. The Government continues to provide guidance to care homes on enhanced IPC measures, outbreak management, and testing regimes for COVID-19. Essential care givers are able to visit care homes to attend to their loved ones' essential care needs and for companionship in most circumstances, including if the care home is experiencing an outbreak. There are now no caps in place on the number of visitors an individual can receive.

44. The Government's focus has been ensuring that the social care sector has the resources it needs to respond to the pandemic. On 27 June 2021, the Government announced a further £251 million of adult social care COVID-19 support through an extension of the Infection Control and Testing Fund.[24] This means that throughout the pandemic, the Government has made available over £2 billion in specific funding for adult social care.[25]

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[24] DHSC Guidance: Adult social care extension to Infection Control and Testing Fund 2021

[25] Press release: Adult social care given over £250 million extra to continue coronavirus (COVID-19) protections

45. Since the start of the pandemic, the Government has committed over £6 billion to local authorities through non-ring fenced grants to tackle the impact of COVID-19 on their services, including adult social care.[26]

46. To further protect individuals susceptible to COVID-19, from 11 November it will be a condition of deployment for anyone working or volunteering in Care Quality Commission-regulated care homes providing accommodation for persons who require nursing and personal care to be fully vaccinated.

Getting a vaccine for influenza (flu)

47. The Government recommends as many people as possible receive a vaccination against flu this autumn and winter. This could help to reduce overall pressure on the NHS and is especially important this year given the possibility of a substantial resurgence in flu. The NHS has begun to roll out the annual campaign for the flu vaccination from August 2021. A free flu vaccination will still be available for all previously eligible groups:

    a. Primary school children.
    b. 65 year olds and over.
    c. Vulnerable groups.
    d. Pregnant women.

48. The Government has also extended eligibility for a free flu vaccination this year to include:

    a. Secondary school children.
    b. 50-64 year olds.

49. As with the COVID-19 vaccine, flu vaccines are available from a range of different providers, including GPs, community pharmacies, and health centres. This ensures that access is as easy as possible for all, including vulnerable groups. The NHS has learned a number of lessons from the successful COVID-19 vaccination programme on reaching out to previously vaccine hesitant groups. The NHS is implementing these lessons in the flu vaccine programme this year in order to drive uptake higher than ever before.

50. For those not eligible for a free flu vaccine, some employers offer these vaccinations through workplaces, and vaccinations are available for a small fee from pharmacies. Many of the behaviours that help reduce the chance of catching COVID-19 will also reduce the risk of catching flu, such as washing your hands regularly and trying to stay at home if you are feeling unwell.

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[26] Coronavirus (COVID-19): emergency funding for local government in 2020 to 2021 and additional support in 2021 to 2022 – GOV.UK (www.gov.uk)

5. ADVISING PEOPLE ON HOW TO PROTECT THEMSELVES AND OTHERS

51. On 19 July, rules on social contact were replaced with advice to the public on the ways in which they could protect themselves and others. Since the risks from COVID-19 have not disappeared, the Government will continue to provide guidance on the behaviours and actions that reduce transmission and manage the risks. The guidance will be based on the latest scientific and epidemiological evidence.

Safer behaviours and actions that reduce the spread of COVID-19

52. It remains important for everyone, including those who are fully vaccinated, to follow behaviours and actions that reduce transmission and help to keep people safe. Following the recommended actions will also help limit the spread of seasonal illnesses, including flu.

53. The evidence suggests COVID-19 is spread in the following ways: airborne transmission, close contact via droplets, and via surfaces.[27] Developing evidence indicates that airborne transmission is a very significant way that the virus circulates.[28] The behaviours and actions recommended by the Government in guidance aim to mitigate all methods of transmission.

54. The risk of catching or passing on COVID-19 can be higher in certain places and when doing certain activities. In general, the risk of catching or passing on COVID-19 is higher in crowded spaces (where there are more people who might be infectious) and in enclosed indoor spaces (where there is limited fresh air). Some activities, such as singing, dancing, and exercising can also increase the risk of transmission of COVID-19 as people are doing activities which generate more particles as they breathe. The risk is greatest where these factors overlap.[29] Although the Government does not want to legally restrict any of these activities, it can inform people of the risks and offer advice on how to mitigate them.

55. The best way to protect yourself and others from COVID-19 is to **get fully vaccinated**. People that are fully vaccinated should continue to follow behaviours and actions set out in the guidance on how to help limit the spread of COVID-19.

56. The behaviours encouraged to prevent the spread include:

    a. **Let fresh air in if you meet indoors**. Meeting outdoors is safer. Meeting outdoors vastly reduces the risk of airborne transmission, however, it is not always possible, particularly through the winter. If you are indoors, being in a room with fresh air (and, for example, opening your windows regularly for 10 minutes or a

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27 SARS-COV-2 Transmission Routes and Environments: Sage, 22 October 2020

28 HOCI and EMG: Masks for healthcare workers to mitigate airborne transmission of SARS-CoV-2, 25 March 2021

29 SARS-COV-2 Transmission Routes and Environments: Sage, 22 October 2020

small amount continuously) can still reduce the airborne risk from COVID-19 substantially compared to spaces with no fresh air.[30] Some evidence suggests that under specific conditions high levels of ventilation could reduce airborne transmission risk by up to 70%.[31]

b. **Wear a face covering** in crowded and enclosed settings where you come into contact with people you do not normally meet.

c. **Get tested, and self-isolate if required**. Anyone with symptoms of COVID-19 should self-isolate and take a free PCR test as soon as possible. Anyone who tests positive must self-isolate. Anyone who is notified they are a close contact of someone who has tested positive should also take a free PCR test as soon as possible and self-isolate if required. The data on symptoms associated with COVID-19 is continuously being gathered and kept under review.

d. **Try to stay at home if you are feeling unwell**.

e. **Wash your hands** with soap and water or use hand sanitiser regularly throughout the day.

f. **Download and use the NHS COVID-19 app to know if you've been exposed to the virus**.

Figure 2: Safer Behaviours and Actions

[30] Role of Ventilation in Controlling SARS-CoV-2 Transmission SAGE-EMG
[31] Press release: New film shows importance of ventilation to reduce spread of COVID-19

Businesses

57. To support businesses through the autumn and winter period, the Government will continue to provide up-to-date Working Safely guidance on how employers can reduce the risks in their workplace. Businesses should consider this guidance in preparing their health and safety risk assessments, and put in place suitable mitigations.

58. In line with government guidance at step 4, an increasing number of workers have gradually returned, or are preparing to return, to offices and workplaces. As workers return to the workplace, employers should follow the Working Safely guidance.

59. By law, businesses must not ask or allow employees to come to work if they are required to self-isolate.

60. In addition, businesses are encouraged to:

    a. Ask employees to stay at home if they are feeling unwell.
    b. Ensure there is an adequate supply of fresh air to indoor spaces. Businesses should identify any poorly ventilated spaces, for example by using a CO_2 monitor, and take steps to improve fresh air flow in these areas.
    c. Provide hand sanitiser to enable staff and customers to clean their hands more frequently, and clean surfaces which people touch regularly.
    d. Display an NHS QR code poster for customers to check in using the NHS COVID-19 app, so they are alerted if there's an outbreak and can take action to protect others.
    e. Consider using the NHS COVID Pass.

Using the NHS COVID Pass

The Government has been working with organisations to encourage the voluntary use of certification and the NHS COVID Pass.

Over 200 events and venues have already used certification and the NHS COVID Pass as a condition of entry, including matches in the Premier League, festivals such as the Reading and Leeds Festivals and All Points East, some nightclubs, and the BBC Proms.

ONS data shows that 11% of people have already been asked to show proof of vaccination or a recent negative test to enter an event or venue.[32] At present, the NHS COVID Pass certifies individuals based on vaccination, testing or natural immunity status.[33] Settings using voluntary certification can also ask individuals, including those 11 and over, to demonstrate their testing status through messages or emails from Test and Trace. Organisations can easily and securely check someone's NHS COVID Pass using the NHS Verifier App, which can be downloaded from the Apple App Store or Google Play, or carry out visual checks using the shimmering effect on the NHS COVID Pass screen which demonstrates that it is an active app and not a screenshot.

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[32] ONS Opinions and Lifestyle Survey (COVID module), 25 August to 5 September 2021
[33] NHSX Guidance: Using the NHS COVID Pass

Ventilation

61. Due to the importance of fresh air in limiting the spread of COVID-19, the Government will set out in guidance the practical steps everyone can take to maximise fresh air in order to reduce the risk of airborne transmission, taking into account the colder months when more activities take place indoors.

62. The Government will support improved ventilation in key settings by:

    a. Providing further advice and support to businesses to help them check their ventilation levels and introduce Carbon Dioxide (CO_2) monitoring where appropriate.

    b. Conducting further scientific research to assess ventilation levels in a range of business settings.

    c. Investing £25 million in c.300,000 CO_2 monitors for schools.

    d. Improving the management of ventilation across the public sector estate alongside bespoke guidance to maximise the effectiveness of existing mechanical and natural ventilation. This has included deploying CO_2 monitors in courts as well as targeted rollouts and trials of these monitors in other settings.

    e. Continuing to support and promote pilots of how to limit transmission through ventilation or air purification, such as the trials of high-efficiency particulate absorbing filters and ultraviolet-C air cleaners in 30 Bradford schools, as well as working with stakeholders such as the Rail Delivery Group and Rail Safety and Standards Board to trial the use of upgraded air filtration devices on passenger rail stock.

6. PURSUING AN INTERNATIONAL APPROACH: HELPING VACCINATE THE WORLD AND MANAGING RISKS AT THE BORDER

Managing risks at the border

63. Since the start of the pandemic, the Government has put in place measures at the border to address the risk of importing the virus. The strength of these measures has varied according to the latest assessment of the risks of importation. Since May this year, the framework established under the second Global Travel Taskforce has set the path for a progressive and sustained return to international travel. The number of daily international and domestic flights has increased by 59% since step 4 compared to step 3 levels. However, this still only represents 53% of 2019 average levels.[34]

64. The Traffic Light System has sought to balance a greater degree of travel with limiting the risk to the UK from Variants of Concern. More recently the rules have been relaxed for many fully vaccinated travellers, reflecting the progress of vaccination campaigns at home and abroad.

65. The Government continues to work with the travel industry and private testing providers to further reduce testing costs and improve the speed and quality of testing performance, while ensuring travel is as safe as possible. More than 80 companies have had misleading prices corrected on the Government's website and, in addition, over 50 firms have been removed. From 21 September private providers will be liable for criminal offences and penalties if they do not meet standards set out in legislation. This action will help ensure consumers can trust the testing providers listed on GOV.UK and only the most reliable companies are available.

66. The Government will shortly set out a revised framework for international travel, in advance of the next formal checkpoint review, with a deadline of 1 October.

Helping vaccinate the world

67. Alongside G7 partners, the UK remains committed to accelerating equitable access to COVID-19 vaccinations, therapeutics, and diagnostics to save lives across the world. Increased access to vaccines globally will also help to protect the UK by reducing the risk of Variants of Concern emerging. The UK remains one of the biggest donors to the Access to COVID-19 Tools Accelerator (ACT-A) and to date the UK has donated $1.135 billion.[35] ACT-A's COVID-19 Vaccines Global Access (COVAX) facility has so far shipped over 243 million doses to 139 participants.[36] In addition the UK has so far donated 10.3 million vaccination doses, either bilaterally or through COVAX, and aims

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[34] ONS, Daily UK flights from Economic activity and social change in the UK, real-time indicators: 2 September 2021

[35] WHO, ACT funding commitment tracker, 3 September

[36] https://www.gavi.org/covax-facility. Figures accurate as of w/c Monday 13 September.

to share a total of 30 million by the end of this year, and 100 million by June 2022. The Government is also supporting efforts to develop more resilient global supply chains for vaccines, including by supporting the continued efforts of the COVAX Supply Chain & Manufacturing Task Force to tackle supply challenges and promote not-for-profit global production.

68. The UK continues to engage bilaterally with key international partners and to take a leading role in multilateral discussions on the global response to the pandemic. The UK has led the G7 Presidency during a challenging year, engaging with key international partners across a wide range of COVID-19 international issues. The UK will continue to lead, through and beyond 2021, on delivering on the commitments and ambitions set out by G7 leaders at the Summit in Carbis Bay in June for supporting global recovery, including by reopening international travel.[37]

69. The UK will continue to push for greater scientific leadership and innovation, working closely with others including the World Health Organization, to develop the Global Pandemic Radar and increase international pathogen genomic sequencing capability through the new Centre for Pandemic Preparedness. These are global public goods which will keep citizens everywhere safe.

[37] Carbis Bay G7 Summit Communiqué

7. CONTINGENCY PLANNING

70. The Government's objective is to avoid a rise in COVID-19 hospitalisations that would put unsustainable pressure on the NHS. The Government will monitor all the relevant data on a regular basis to ensure it can act if there is a substantial likelihood of this happening.

71. It is possible that Plan A is not sufficient to prevent unsustainable pressure on the NHS and that further measures are required. This is not the Government's preferred outcome but it is a plausible outcome and one that must be prepared for. The high levels of protection in the population against COVID-19 should mean that very stringent restrictions are not needed over autumn and winter to reduce the rate of transmission of COVID-19, reduce growth in hospitalisations and prevent unsustainable pressure on the NHS. However, there remains significant uncertainty.

72. The Government has taken the best scientific advice from the Scientific Advisory Group for Emergencies (SAGE). The Scientific Pandemic Influenza group on Modelling (SPI-M) has reflected on their modelling of step 4 of the roadmap. Despite unexpected falls in cases in mid-July 2021, these scenarios can still be used to consider the future autumn and winter trajectory, likely with a delay in timing of peaks until later in the year, and possibly with broader, longer peaks than those originally estimated.[38] As made clear in the Government's roadmap, further hospitalisations and deaths are expected because neither coverage nor effectiveness of the vaccine can ever be 100%.

73. SAGE and SPI-M modellers now deem the most pessimistic scenarios in the step 4 modelling to be unlikely, except in the case of a new dangerous Variant of Concern or significant waning immunity. However, there remains considerable uncertainty and scenarios which place the NHS under extreme and unsustainable pressure remain plausible. As a result, the Government must continue to monitor the data and prepare contingencies.

74. The Government monitors and considers a wide range of COVID-19 health data including cases, immunity, the ratio of cases to hospitalisations, the proportion of admissions due to infections, the rate of growth in cases and hospital admissions in over 65s, vaccine efficacy, and the global distribution and characteristics of Variants of Concern. In assessing the risk to the NHS, the key metrics include hospital occupancy for COVID-19 and non-COVID-19 patients, intensive care unit capacity, admissions in vaccinated individuals, and the rate of growth of admissions. The Government also tracks the economic and societal impacts of the virus, to ensure that any response takes into account those wider effects.

Plan B

75. If the data suggests the NHS is likely to come under unsustainable pressure, the Government has prepared a Plan B for England. The Government hopes not to have to implement Plan B, but given the uncertainty, it is setting out details now so that the public and businesses know what to expect if further measures become necessary.

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[38] S1360 SAGE 95 minutes, S1376 SPI-M-O Consensus statement, 8th Sept 2021

76. Given the high levels of protection in the adult population against COVID-19 by vaccination, relatively small changes in policy and behaviour could have a big impact on reducing (or increasing) transmission, bending the epidemic curve and relieving pressure on the NHS. Thanks to the success of the vaccination programme, it should be possible to handle a further resurgence with less damaging measures than the lockdowns and economic and social restrictions deployed in the past. The Government would provide prior notice as far as possible to the public and Parliament ahead of implementing any necessary changes in a Plan B scenario.

77. The Government's Plan B prioritises measures which can help control transmission of the virus while seeking to minimise economic and social impacts. This includes:

    a. Communicating clearly and urgently to the public that the level of risk has increased, and with it the need to behave more cautiously.

    b. Introducing mandatory vaccine-only COVID-status certification in certain settings.

    c. Legally mandating face coverings in certain settings.

78. The Government would also consider asking people once again to work from home if they can, for a limited period. The Government recognises this causes more disruption and has greater immediate costs to the economy and some businesses than the other Plan B interventions, so a final decision would be made based on the data at the time.

Communications

79. Communications have been effective at highlighting key messages and supporting the public to follow safer behaviours. In a Plan B scenario, the Government would issue clear guidance and communications to the public and businesses, setting out the steps that they should take to manage the increased risks of the virus.

Communications – supporting evidence

At step 4, the Government shifted its approach from one of legal requirements and restrictions towards one focused around personal responsibility and voluntarily following safer behaviours. Though there has been a slight decline in the observance of key protective behaviours post step 4, the majority still continue to adhere to the guidance. Of those surveyed, 89% still self-report to wearing face coverings outside the house, and 84% claim to engage in regular handwashing.[39] Adult, mean daily contacts have not increased rapidly since step 4, and remain much lower than pre-pandemic levels (3.0 in late August 2021 vs 10.8 pre-pandemic).[40] [41] Children's social contact decreased over the summer holidays[42] but is likely to increase rapidly in September. The public's continued engagement with these protective measures has helped reduce transmission.

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[39] ONS Opinions and Lifestyle Survey (COVID module), 25 August to 5 September 2021
[40] Comix Social Contact Survey, Week 75
[41] Quantifying the impact of physical distance measures on the transmission of COVID-19 in the UK
[42] Comix Social Contact Survey, Week 75

Mandatory Vaccine-only COVID-status Certification

80. On 19 July, the Prime Minister served notice that, by the end of September, the Government was planning to make full vaccination a condition of entry to nightclubs and other venues where large crowds gather.

81. The gap between the announcement and intended implementation has given people sufficient time to receive two doses of a vaccination. Since 19 July, over 1 million first doses, and over 6.1 million second doses, have been administered. This means that over 7.2 million doses have been administered to adults aged 18 and older in England,[43] considerably bolstering the level of immunity in the population. Of the 1 million new doses administered, over 600,000 were aged between 18 and 29.[44] At the same time, more than 200 events and venues have made voluntary use of certification and the NHS COVID Pass as a condition of entry. The impact of the use of the NHS COVID Pass is being further assessed through the findings of Phase II and Phase III of the Events Research Programme.

82. Taking into account the latest data on the state of the epidemic, mandatory vaccine-only certification will not be implemented from the end of September. It would, however, be part of the Government's Plan B if the data suggests action is required to prevent unsustainable pressure on the NHS. Mandating vaccine-only certification would be preferable to closing venues entirely or reimposing social distancing.

83. At present, the Government continues to encourage the voluntary use of the NHS COVID Pass, particularly in the types of settings listed below, as a tool to help manage risk and to help to prepare for mandatory introduction, if it is required. For now, the NHS COVID Pass will continue to certify individuals based on vaccination, testing or natural immunity status. If Plan B is implemented, at that point the NHS COVID Pass will change to display full vaccination only. Exemptions will continue to apply for those who cannot be vaccinated for medical reasons, for those on COVID vaccine clinical trials, and for under 18s.

84. Under Plan B, the Government expects to introduce mandatory vaccine certification in a limited number of settings, with specific characteristics. The Government hopes that it would not be necessary to mandate vaccine certification more widely than these settings, though this cannot be entirely ruled out.

85. If Plan B is implemented, it could be at short notice in response to concerning data. Therefore, in order to help businesses prepare their own contingency plans, the Government will shortly publish more detail about the proposed certification regime that would be introduced as part of Plan B. The Government would seek to give businesses at least one week's notice before mandatory vaccine certification came into force.

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[43] NHS daily vaccine publications 9 September

[44] NHS daily vaccine publications 9 September

Mandatory Vaccine-only COVID-status Certification

Settings

Under Plan B, the Government expects that mandatory vaccine-only certification would be introduced for visitors to the following venues:

- All nightclubs;
- Indoor, crowded settings with 500 or more attendees where those attendees are likely to be in close proximity to people from other households, such as music venues or large receptions;
- Outdoor, crowded settings with 4,000 or more attendees where those attendees are likely to be in close proximity to people from other households, such as outdoor festivals; and
- Any settings with 10,000 or more attendees, such as large sports and music stadia.

There are some settings that will be exempt from requirements to use the NHS COVID Pass, including communal worship, wedding ceremonies, funerals and other commemorative events, protests and mass participation sporting events.

Supporting evidence

The COVID-Status Certification Review concluded that there would be a public health benefit from certification. Certification of immunity for certain uses has the potential to enable access to a wide range of activities in ways that could reduce transmission of the virus.

There is good evidence to suggest certification will have a beneficial impact on infection rates. Vaccines reduce the likelihood of someone becoming infected, and, therefore, vaccine certification reduces the risk of onward transmission if an infected person does enter a venue. Vaccination also reduces the chances of someone who is infected being hospitalised or dying.

PHE analysis of the Events Research Programme found that, while proof of full vaccination or a negative LFD test would not completely eliminate the possibility of an infectious individual attending an event, it should reduce the likelihood of someone transmitting highly infectious amounts of virus to a large number of individuals attending the event. The study concluded that promoting attendance by fully-vaccinated individuals at events will be important to mitigate risks.[45]

For venues, certification could allow settings that have experienced long periods of closure to remain open, compared to more stringent measures which may severely reduce capacity or cause them to close entirely.

[45] Smith et. al (2021) Public health impact of mass sporting and cultural events in a rising COVID-19 prevalence in England

Legally mandating face coverings in additional settings

86. Though there is no current legal requirement, the Government recommends that people continue to wear face coverings in crowded and enclosed spaces where you come into contact with people you don't normally meet, for example on public transport. This recommendation is in line with the findings from the Social Distancing report and has a low economic cost.[46] If Plan B is implemented, the Government will bring back the legal requirement to wear face coverings in some settings. The precise settings will be decided at the time.

Face coverings – supporting evidence

Face coverings have low economic costs and can be effective in reducing transmission in public and community settings, by reducing the emission of virus-carrying particles when worn by an infected person, and may also provide a small amount of protection to an uninfected wearer.[47] Currently 91% of public transport users report to having worn a face covering the last time they used public transport.[48] Use remains high but has gradually fallen since the start of step 4.[49]

SAGE estimates that widespread application of face coverings is likely to have a small but significant impact on transmission, as face coverings mitigate most transmission routes.[50] SAGE evidence also states that face coverings (if worn correctly and of suitable quality) are likely to be most effective (at least in the short to medium term)[51] in reducing transmission indoors where other measures, such as social distancing and ventilation, are not feasible or are inadequate.

Advice to work from home

87. SPI-M and SAGE have advised that high levels of homeworking have played a very important role in preventing sustained epidemic growth in recent months.[52] If the Government were to re-introduce this measure it would be seeking to reduce the transmission risk inside and outside of the workplace, including by reducing the number of people taking public transport and the number of face to face meetings and social activities, and thereby reducing community and household transmission.

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46 Social Distancing Review: Report, July 2021
47 SAGE EMG paper (January 2021) on material face coverings
48 ONS Opinions and Lifestyle Survey (COVID module), 25 August to 5 September 2021
49 ONS Opinions and Lifestyle Survey (COVID module), 25 August to 5 September 2021
50 SAGE (April 2021) – Considerations in implementing long-term 'baseline' Non-Pharmaceutical Interventions (NPIs)
51 SAGE EMG paper (January 2021) – EMG paper on material face coverings
52 S1376 SPI-M-O Consensus statement

Working from home – supporting evidence

SAGE has advised that working from home is one of the most effective measures available at reducing contacts, including associated transport and social interactions, which has a strong impact on transmission and R. The REACT survey[53] from Imperial College London showed that working from home reduced the chance of catching COVID-19. Those who were working from home were less likely to test positive for COVID-19 than those who left their homes to work in February. Analyses of risk by occupation consistently show a lower risk for those occupations with higher levels of working from home.[54]

However, the overall socio-economic effects of the Government's working from home guidance are complex and unevenly distributed. For example, working from home has reduced the frequency of commuting for many workers resulting in reduced consumption in direct office-related spending, indirect social consumption (such as in retail and hospitality) and transport use in city centres. However, some of this reduced consumption is displaced to surrounding areas where homeworkers live and therefore partly replaced by increased consumption of other goods and services closer to home.[55]

Overall impacts on productivity are uncertain and vary by sectors and workers. While there are positive impacts for some individuals, in terms of spending less time and money commuting, others will suffer owing to inadequate working conditions at home, particularly younger workers, and those living alone or with poorer mental health due to reduced interactions with colleagues. Some businesses have reported that productivity has either remained the same or increased, owing to benefits such as a happier workforce and reduced overheads (for example, in spending on office space). However, other businesses report that prescriptive working from home guidance poses challenges, such as hampering the exchange of ideas, stifling creativity and hindering collaboration. Working from home could make it harder for some businesses to carry out client engagement, and to train and onboard new and existing staff. These businesses argue that over time a reduction in these activities will likely pose challenges to the productivity of their workforces.

88. While the Government expects that, with strong engagement from the public and businesses, these contingency measures should be sufficient to reverse a resurgence in autumn or winter, the nature of the virus means it is not possible to give guarantees. The Government remains committed to taking whatever action is necessary to protect the NHS from being overwhelmed but more harmful economic and social restrictions would only be considered as a last resort.

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[53] REACT-1 (March 2021) – REACT-1 round 9 final report: Continued but slowing decline of prevalence of SARS-CoV-2 during national lockdown in England in February 2021. Data collected 4-12 February 2021

[54] ONS (February 2021) – COVID-19 Infection Survey

[55] Fraja et al (January 2021) – Zoomshock: The geography and local labour market consequences of working from home

Variants of Concern

89. New variants of the virus will continue to emerge both at home and abroad in the coming months and years. As was clear with the spread of the Alpha variant, and this summer with Delta, a variant has the potential to radically change the course of the epidemic. Over time, there may be variants which evade immune responses and weaken the protection given by vaccines, have increased transmissibility (as with Alpha and Delta), or alter the severity or the symptom profile of the virus.

90. To confront this risk, the Government has developed a range of tools to reduce the risk of variants emerging, stop and slow importation of the most dangerous variants, identify new variants and outbreaks, and ensure the Government is ready to respond if outbreaks occur.

91. Domestic sequencing capacity has been enhanced in 2021 and will continue to increase over the coming months, enabling a higher number of PCR positive cases to undergo whole genome sequencing, improving the detection of variants. In addition, wastewater testing and the use of new technology, such as genotype assay testing, have been expanded as an additional surveillance function to detect variants and outbreaks.

92. The Government's work to support and develop international surveillance capabilities and support for the rollout of vaccines globally will also protect the UK by helping to identify and reduce the risk of Variants of Concern.

Local management of the virus

93. Local authorities have always played a critical role in public health protection, emergency response and infectious disease control. COVID-19 has been no different, with local authorities leading the response in their communities. The Government will continue to support and work with local authorities and local areas directly to reduce the spread and minimise the impact of COVID-19.

94. This includes support for areas with enduring transmission. These are those parts of the country where the case rate has remained above the national or regional average for a prolonged period. Support includes targeted testing and programme support for public health activities such as vaccination.

95. The Government will also continue to provide access to:

    a. **The COVID-19 Contain Framework** which clarifies the national support and infrastructure available to local authorities.

    b. **National support for an enhanced response** in areas with particularly challenging disease situations. This support includes targeted surge testing, vaccination logistical support, logistics support, and national funding to enhance local communications efforts.

c. **The Education Contingency Framework**, which provides guidance on the principles for managing local outbreaks of COVID-19 in all education and childcare settings. This framework sets clear thresholds for managing COVID-19 cases, when settings should consider seeking public health advice, and provides advice on all types of measures that settings should prepare for in the event they are needed.

96. The COVID-19 Contain Framework will be updated at the beginning of October. This will provide an overview of the support local authorities can expect from regional and national teams, and will continue to refer to the responsibilities of Directors of Public Health, regional health protection teams, and the Government's Local Action Committee command structure.

8. LEGISLATION AND REVIEWS

97. At step 4 of the roadmap, the vast majority of COVID-19 regulations were removed.

98. The Government has reviewed the remaining regulations and decided, subject to agreement from Parliament, that it is necessary to extend the following regulations until 24 March 2022, at which point they will be reviewed:

    a. The Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020, which impose legal requirements to self-isolate on positive cases and unvaccinated close contacts. Self-isolation will remain crucial in breaking chains of transmission throughout autumn and winter.

    b. The Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations 2020, which enable local authorities to respond to serious and imminent public health threats.

99. The Health Protection (Coronavirus, International Travel and Operator Liability) (England) Regulations 2021, which impose testing and quarantine requirements on arrivals in England, will remain.

100. The Government formally reviews the Coronavirus Act 2020 every six months to ensure that Parliament has an opportunity to expire any temporary non-devolved provisions that are no longer necessary to manage COVID-19. As part of the third six-month review of the Act due in September 2021, the Government is committed to removing those legal provisions that are no longer necessary or proportionate. The Government intends to recommend to Parliament that the following temporary non-devolved provisions are expired:

    a. Section 23 (UK wide), which enables changes to the timings of urgent warrants under the Investigatory Powers Act 2016.

    b. Section 37 (Schedule 16) (for England), which gives Ministers the power to direct the temporary closure of educational institutions and providers.

    c. Section 51 (Schedule 21) (for England), which allows restrictions to be imposed upon potentially infectious persons including detention, and screening for COVID-19.

    d. Section 52 (Schedule 22) (for England), which enables Ministers to restrict or prohibit gatherings or events and to close and restrict access to premises during a public health response period.

    e. Section 56 (Schedule 26) (England and Wales), which provides that appeals imposed under powers set out in Schedule 21 of the Coronavirus Act can be heard by telephone or video in civil proceedings in the Magistrates Court.

    f. Section 77 (UK wide), which increases the rate of the basic element of Working Tax Credit.

g. Section 78 (for England), which is a power for local authorities to change how they meet in meetings held before 7 May 2021.

101. The Government also intends to expire parts of Section 38/Schedule 17 of the Act. Schedule 17 allows the Secretary of State to disapply or modify existing requirements in education and childcare legislation. Expiring parts of schedule 17 includes removing the ability to modify the duty on local authorities to secure the special educational needs provision in a child or young person's Education and Health Care plan.

102. The Government will consult with the Devolved Administrations in the normal way ahead of publishing the ninth edition of the Coronavirus Act report and subsequent parliamentary debate.

103. The Coronavirus Act is a critical part of the Government's response to the pandemic, as it continues to support the NHS in retaining emergency staff, enables Statutory Sick Pay to support self-isolation, as well as enabling remote participation in court proceedings among other necessary provisions.

104. The remaining temporary powers in the Coronavirus Act are due to expire at midnight on 24 March 2022. In the spring, the Government will review this legislation and the other remaining regulations and measures and decide whether any need to remain in place.

105. The Public Health (Control of Disease) Act 1984 gives emergency powers to be used in pandemics if they present significant harm to human health. This was used as the legal basis for national restrictions in England. No changes to the Public Health Act are planned.

This publication is available at www.gov.uk/official-documents

Any enquiries regarding this publication should be sent to us at publiccorrespondence@cabinetoffice.gov.uk.

Our Reference: BNSSG/NOV22

To: Lisa Manson, Director of Performance and Delivery (Accountable Emergency Officer) NHS BNSSG ICB

Copy: Janette Midda, EPRR Manager

Leigh Clarke
NHS England and NHS Improvement
Head of EPRR

Tel: 07736484395
Email: leigh.clarke2@nhs.net

Sent by email

16 November 2022

Dear Lisa,

NHS BNSSG Integrated Care Board (ICB) and System Emergency Preparedness, Resilience and Response core standard assurance confirm and challenge outcome.

Many thanks for preparing and submitting your self-assessment, supporting evidence and your engagement at the EPRR Core Standards assurance review meeting held on 11 November 2022. This letter summarises the outcome from the meeting, capturing agreed actions and points from our discussions.

ICB outcome from the 2022 EPRR Core Standards review
This year following a tri-annual review of the Core Standards a full assurance process took place. The table below summarises the outcomes of the assurance review and provides the overall compliance rating.

Organisation	2020	2021	2022
NHS BNSSG ICB	Substantial	Full	Substantial

ICB Compliance level (see annex 1 for descriptors)**: Substantial Compliance**
Through the submission of a self-assessment, evidence and additional commentary provided prior to and during the confirm and challenge session, you were able to address the queries raised by NHSE. We support your self-assessed level of compliance and recognise EPRR systems, structures, processes and procedures within BNSSG ICB will continually improve and evolve as you continue your ICB transformation journey from a Clinical Commissioning Group.

ICB areas of partial compliance:

1. Core Standard 14: Countermeasures – BNSSG LHRP BMG planned activity to ensure a systemwide response capability by the end of Quarter 4.

NHS England ICB Observations:
Several areas were identified as requiring further explanation prior to the confirm and challenge session. These areas and responses were captured on FuturesNHS and are not cited here as clarification was provided.

During the meeting the following areas were discussed in more detail:

1. Core Standard 10: Incident Response – It was acknowledged that the process of overseeing readiness for ICB transition through an enhanced EPRR assurance process caused some issues as it felt discrete and separate from the wider

transition process. Part of the process called for an Incident Response Plan (IRP) to be validated. It was confirmed that BNSSG ICB would be participating in Exercise Artic Willow in which the plan in part of full would be validated. NHSE attended two days of Artic Willow (15 and 16 November) and are assured your IRP is effective.

2. Core Standard 12: Infectious disease – It was noted that the ICB does not have any direct responsibility for patient care and any system-based response would utilise current response and coordination systems and processes.

3. Core Standard 13: New and Emerging Pandemics – It was suggested that where several capabilities have been developed in response to COVID-19 and are likely to replace the need for a specific pandemic flu plan that it would be helpful to capture this in a visual in order to provide reassurance that current capabilities will meet requirements.

4. Core Standard 23: EPRR Exercising and Testing Programme – It was suggested that some additional columns on the exercise programme including e.g. the type of exercise (e.g. comms, live, table top etc) and/or rational for an exercise being cancelled, would help to demonstrate compliance.

5. Core Standard 24: Responder Training – It was noted that strategic training had in recent years been modified (duration/content etc) but retained the same name of SLC. It was suggested that the training plan reflect this nuance.

ICB Outcome from the 2022 EPRR Core Standards Deep Dive review
The focus of the deep dive for 2022 was on Evacuation and Shelter and the ICB were assessed as **Fully Compliant**.

System outcomes from the 2022 EPRR Core Standards review

Organisation	Compliance 2020/21	Compliance 21/22
NBT	Substantial – 91%	Substantial – 94%
Sirona	Substantial – 92%	Partial – 80%
AWP	Fully – 100%	Fully – 100%
Severnside	Fully – 100%	Fully – 100%
UHBW	Substantial – 96%	Partial – 86%

You provided a full and concise overview of the approach you have used to undertake the EPRR Core Standards confirm and challenge process for 2022. You advised that two of your providers had several challenges which you were now monitoring and supporting. You identified that UHBW were outlier in the number of incidents they were reporting especially relating to infrastructure-based incidents which you were actively following up.

You cited several areas of good practice that you would look to highlight and share to support collective improvement.

NHSE South West did not have any observations or advisories to raise in relation to the confirm and challenge process adopted to assess your providers.

Good Practice and Innovation

1. ICB encouraging and supporting the development of system-based capabilities. Examples include countermeasures, Training and Evacuation and Shelter.
2. Ex Carnage (mass casualty)
3. Severnside adaption to Advanced Adastra Incident (prolonged cyber incident)
4. AWP system of Governance and control.
5. AWP utilising 'peer review' to assess BCM arrangements
6. AWP and Sirona partnership working – training and exercising
7. The utilisation of FuturesNHS for evidence collection and time saving in future rounds of assurance.

ICB areas identified as requiring further consideration by NHS England

NHS England confirmed that the following items will be further considered to support planning interfaces between the Region and Systems:

1. Infectious Diseases: Explore the architecture between Health and Public at Regional (NHSE and UKHSA) and System (ICB and Public Health) Level to ensure robust partnership working in the response and resolution of outbreaks.

2. Evacuation: Explore a Regional exercise looking at the issues, risks and response options to the evacuation of a large hospital setting.

Next Steps

The outcome of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England South West Senior Leadership Team before being submitted to the NHSE National Team.

Following further scrutiny and challenge by the BNSSG Local Health Resilience Partnership (LHRP) a summary will be requested at the inaugural Regional Health Resilience Partnership (RHRP) in December 2022.

If you would like to discuss any elements of the confirm and challenge process and/or the contents of this letter, please do not hesitate to contact me directly.

Finally, thank you again for the hard work put into this year's assurance process while contending with significant system pressures, issues and incidents.

Yours Sincerely,

Leigh Clarke
Head of EPRR
NHS England South West

Annex 1: Compliance Levels

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

Deputy Director Emergency Preparedness,
Resilience and Response,
NHS England and NHS Improvement (South West)

Email: ian.phillips1@nhs.net

Tel: 07730 391526

Our Reference: SW/EPRR/CT001/03/LHRP

8 August 2022

Dear LHRP Members,

FUTURE LOCAL HEALTH RESILIENCE PARTNERSHIP ARRANGEMENTS WITHIN THE AVON AND SOMERSET LOCAL RESILIENCE FORUM AREA

The Health and Care Act 2022 and national EPRR Guidance 2022 afforded Integrated Care Boards (ICBs) the opportunity to review previous Local Health Resilience Partnership (LHRP) boundaries and elect to either remain bound to the relevant Local Resilience Forum area or choose to establish a new LHRP, based on their ICB locality.

The Regional EPRR team met with the Accountable Emergency Officers (AEO) and EPRR leads for the designate ICBs that supported the Avon & Somerset LHRP on 6 June 2022, where future options for the Avon & Somerset LHRP were discussed. Following a short period of consultation with the 3 designate ICBs, the 3 AEOs[1] concluded that they would all support the establishment of 3 new LHRPs, reflecting their respective ICB areas.

Therefore, from 1 July 2022 the Avon & Somerset LHRP has been dis-established and 2 new LHRPs have been established (BNSSG LHRP and Somerset LHRP) and the BaNES element of the previous Avon & Somerset LHRP will now be wholly managed by the existing BSW LHRP.

Additionally, noting that under that Health and Care Act 2022, as a Category One responder, ICBs have primacy for local emergency health response planning within their System (LHRP), the ICB AEO will now to co-chair the LHRP, with a nominated local DPH co-chair and they are to lead LHRP activity and maintain the involvement and support of LHRP partners at both a strategic and tactical level[2].

The national EPRR Framework 2022 notes that the role and responsibilities of the LHRP include:

- LHRPs coordinating NHS EPRR across their area and providing health input into LRFs and multi-agency planning for Incidents

[1] BNSSG, BSW and Somerset designate ICBs
[2] The Regional NHSE attendance at LHRP Executive Meetings reverts from co-chair, to member of the LHRP.

- LHRPs ensuring coordinated strategic planning for incidents impacting on health or continuity of patient services and effective engagement across the LHRP and local ICBs

- the DPH co-chair having specific responsibility to provide public health expertise and coordinate public health input

- the ICB co-chair providing local leadership on EPRR matters to all NHS funded organisations and maintaining engagement across the local health and social care system to ensure resilience is commissioned effectively, reflecting local risks

- the LHRP should consider, and contribute to, the Community Risk Register (CRR) developed by the LRF. These assessments should inform the planning and strategy set by the LHRP. The LHRP will co-ordinate health input to NHS England, UK HSA and local government in ensuring that member organisations develop and maintain effective health planning arrangements for incidents. Specifically, they must ensure that:

    - the arrangements reflect strategic leadership roles, ensuring robust service and local ICS response at the tactical level to incidents

    - coordination and leadership across health organisations within local ICSs are in place

    - there is opportunity for co-ordinated training and exercising and the sharing of lessons identified

    - the health sector is integrated into appropriate wider EPRR plans and structures of civil resilience partner organisations within the LRF area covered by the LHRP

    - there is a mechanism for the peer review of EPRR assurance against the Core Standards.

In practical terms the 3 ICB LHRPs (BNSSG, BSW and Somerset) will now establish their own Business Management Group (BMG) and Executive Forums to manage their respective responsibilities and Partners should expect to be contacted directly by the ICBs to future LHRP events.

Additionally, the 3 ICB AEOs and their EPRR leads plan to inaugurate a mechanism to establish the 'Joint forum', whereby the 3 ICBs will deliver cohesion and mutual aid support to their LHRPs and the wider Avon and Somerset LRF and more on this will follow from the ICBs.

These changes were presented to the Avon & Somerset LRF Executive Board on 16 July 2022 and while 3 LHRPs will represent the wider Health and Care agenda at the LRF, this will allow for more localised planning and response to your patients, the wider population and staff.

Finally, the Regional NHS England team remains an active Partner in the delivery of local and regional emergency health response planning and response in the Avon and

Somerset LRF area and indeed, the wider SW Region. The Regional NHSE organization remains a Category One responder and therefore, will maintain our statutory functions to the LRF and its Partners, including leading all future NHS Level 3 or Level 4 Incidents, within the Region. Further, the Regional NHSE team will support and assist LHRP activities as a member of the LHRP and retaining the Assurance process of ICB annual EPRR Core Standards.

Should you have any questions on these changes, then please raise them with your ICB EPRR lead or myself.

Yours Sincerely,

I M PHILLIPS
Deputy Director Emergency Preparedness, Resilience and Response,
NHS England and NHS Improvement (South West)

Distribution:

Previous A&S LHRP Executive and BMG Members
Avon & Somerset LRF
ICB AEOs
ICB EPRR Leads
Director of Performance and Improvement
Director of Performance
Locality Directors
Heads of EPRR
Senior Manager EPRR

ASW Assurance
Sharing excellence in governance

NHS

University Hospitals Bristol and Weston NHS Foundation Trust
Final Internal Audit Report: Emergency Preparedness, Resilience and Response

Report Reference: UHBW06/22
January 2022

Distribution List (for action):

- John Wintle – Resilience Manager
- Lucy Parsons – Deputy Chief Operating Officer
- Philip Kiely – Deputy Chief Operating Officer

Additional Copies (final report, for information):

- Mark Smith – Deputy Chief Executive and Chief Operating Officer
- David Armstrong – Chair of the Audit Committee
- Natashia Judge – Head of Corporate Governance
- KPMG – External Auditor

Assurance Opinion	
Significant	
Satisfactory	
Limited	✓
No	

Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the 2021/2022 Audit and Assurance Plan, as approved by the Audit Committee, we have undertaken a review of the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements.

The Trust is defined as a Category 1 Responder under Schedule 1 of the Civil Contingencies Act 2004, which imposes a series of duties in relation to contingency planning. These are to assess the risk of an emergency occurring, to maintain plans to respond to an emergency, to publish the assessments and plans in so far as this is necessary or desirable to deal with an emergency and to maintain arrangements to warn, inform and advise members of the public in the event of an emergency. The NHS England EPRR Core Standards are the minimum standards the Trust must meet.

The Trust is also required to comply with CQC Regulation 12: Safe Care and Treatment to ensure that people who use the services are safe and any risks to their care and treatment are minimised, and providers are able to respond to and manage major incidents and emergency situations.

In 2019 and 2020, the Trust responded to a number of business continuity incidents in addition to the COVID-19 pandemic, as well as aligning processes following the University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust merger.

The Trust is subject to an EPRR annual assurance process and is required to complete a self-assessment, which is submitted to NHSE/I in conjunction with the BNSSG CCG. The Trust concluded that it was substantially compliant with NHS Core Standards in 2019 and 2020.

Objectives and Scope of the Audit

The overall objective of the review was to provide assurance that the Trust had implemented a sound system of business continuity and emergency planning. The review focused on the following areas:

- Assess whether the Trust's Emergency Preparedness, Resilience and Response Policy and Business Continuity Management Policy are fit for purpose and in line with national guidance.

- Assess whether the Trust has appropriate incident and business continuity plans in place at Trust, divisional and departmental/service levels to deal with major and significant events.
- Ascertain whether plans are adequately tested on a regular basis and any learning from such tests or real events is appropriately disseminated.
- Assess whether policies and plans are readily accessible and key staff are aware of their responsibilities and adequately trained.
- Assess whether the Civil Contingencies Steering Group, Business Continuity Planning Group and Incident Response Planning Group are operating effectively and fulfilling their Terms of Reference.
- Determine whether there is adequate reporting and escalation of matters through the Trust's governance structure, where necessary.

We have also considered the impact of COVID-19 and/or recovery/restoration and transformation on any changes to the systems/processes or procedures in place for this area.

COVID-19 AND/OR RECOVERY/RESTORATION AND TRANSFORMATION

The COVID-19 pandemic caused delays in the Emergency Preparedness, Resilience and Response work plan and training requirements for 2020/2021, and the Civil Contingencies Steering Group and Business Continuity Planning Group were stood down for a year. However, the pandemic also presented opportunities for improvement. In March 2021, the Trust held a facilitated debrief session led by the Resilience Manager to assess the Trust's response to the pandemic. This was a comprehensive exercise and the session was preceded by a questionnaire to allow time for feedback from operational staff. There was representation from all divisions and other key stakeholders with a Trust-wide role to ensure consistency within divisions and communicate feedback, positive or negative, across the Trust. A separate report was provided to the BNSSG CCG to reflect on the system and national response.

OVERALL CONCLUSION

The Trust's Emergency Preparedness, Resilience and Response policies and plans are fit for purpose and in the main, in line with national guidance. The Trust does not currently have a Business Continuity Management Policy, as required by NHS England, an up to date Training Needs Analysis to ensure on-call staff training needs are known and captured to support an effective response to incidents and emergencies, or up to date business continuity plans at divisional and service area level to deal with major and significant events. We recognise the Resilience Manager is working to improve Emergency Preparedness, Resilience and Response and business continuity arrangements across the Trust, however, the COVID-19 pandemic and the Trust's near continuous internal critical incident during most of 2021/2022 has hampered progress.

Our overall conclusion is supported by the conclusion for each area reviewed, as set out below:

Area reviewed	Rating	Conclusion
1. Emergency Preparedness, Resilience and Response Policy and Business Continuity Management Policy		The Trust's Emergency Preparedness, Resilience and Response (EPRR) Policy and Incident Response Plan are fit for purpose and in line with national guidance, as per the Civil Contingencies Act 2004, NHS England EPRR Framework and NHS England EPRR Core Standards, and the Trust's Business Continuity Management Toolkit is in line with national guidance as per the NHS England Business Continuity Management Toolkit. Without a Business Continuity Management Policy there are no procedures in place to exercise and test business continuity plans and incident response plans, or an audit programme to monitor compliance. The Trust acknowledges this is a gap in its EPRR arrangements.
2. Incident Response Plans and Business Continuity Plans		Incident Response Plans and Business Continuity Plans The Trust's Overarching Business Continuity Plan which is currently under review is detailed, developed in line with the NHS England Business Continuity Management Toolkit and outlines the wider framework to manage and coordinate a response across the Trust. However, only one of the Trust's seven divisions and three of its ten hospitals and clinics has a current business continuity plan, and there is no oversight of service area plans. The Incident Response Plan is detailed and thorough in the main. The Trust has a number of plans in place to respond to and manage major incidents and emergency situations. The Trust's EPRR Policy, business continuity plans and incident response plans are available to all staff on the Document Management System, including some that have expired. Staff Awareness The Trust is working to improve staff awareness of the Trust's business continuity arrangements. The Resilience Manager's recent exercise to assess preparedness of the clinical divisions, highlighted gaps in service level awareness at divisional level. Business Continuity Plan Testing The Trust has tested its business continuity arrangements through response to incidents during the COVID-19 pandemic. Proactive testing of business continuity plans would confirm their adequacy and promote continual improvement. Lessons Learned The lessons learned from exercises and incidents are not always fully documented. A new Business Continuity Plan template, introduced in April 2021, should help improve consistency and accountability. The review of the combined lessons learned tracker by the Business Continuity Planning Group or Incident Response Planning Group, as appropriate, should improve the quality of completion and the dissemination of outcomes from exercises and incidents.

Area reviewed	Rating	Conclusion
		Training Due to the absence of an up to date Training Needs Analysis and 'gaps' in training records, we could not confirm whether on-call staff were up to date with training. To be fully compliant with CQC Regulation 12, the overview of business continuity and incident response delivered as part of the Trust's induction and the Trust's training plans for the safe operation of premises and equipment need to be up to date. The Resilience Manager is currently developing training material to be included in the local induction workbooks and on ESR (as specific to role training), which has been agreed with the Education Team.
3. Civil Contingencies Steering Group, Business Continuity Planning Group, Incident Response Planning Group and the reporting and escalation of EPRR matters through the Trust's governance structure	✓	There is appropriate reporting of EPRR matters through local working groups and the 2020-2021 EPRR Annual Report was received by the Trust Board in August 2021. The EPRR Work Programme, which includes the Trust's ongoing self-assessment against NHS England EPRR Core Standards, is presented to the Senior Leadership Delivery Group (SLTDG) on a quarterly basis for assurance and will be available on the SLTDG workspace to improve oversight of EPRR arrangements. The EPRR Risk Register will be received at the Trust's Risk Management Group on a quarterly basis.

Overall Assurance Opinion

It is our view that the overall assurance opinion on the design and operation of controls is Limited as recorded in the table on the face of this report and in accordance with the opinion definitions under the *ASW Assurance - About Us* section of this report.

We would like to acknowledge the help and assistance given by the Resilience Manager during the course of this review.

Rating of Recommendations

Recommendations raised in this report have been rated in accordance with the organisation's risk matrix.

J C McCall

Jenny McCall, Director of Audit and Assurance Services

Report Data

Date of Work Undertaken	May – November 2021
Date of Issue of Draft Report	26th November 2021
Date of Return of Draft Report	14th January 2022
Date of Approval of Final Report	14th January 2022
Lead Auditor	Samantha Drobig – Senior Audit and Assurance Specialist Sonia Athanatou – Audit and Assurance Specialist
Client Lead Manager(s)	John Wintle – Resilience Manager
Client Lead Director	Mark Smith – Deputy Chief Executive and Chief Operating Officer
Governance/Regulatory Links	Civil Contingencies Act 2004 NHS England EPRR Core Standards CQC Regulation 12: Safe Care and Treatment

Action Plan

Rec no.	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1	The Trust's EPRR Policy should include the following requirements as part of a programme to safely test major incident, critical incident and business continuity response arrangements: • Communications exercise every six months. • Table top exercise every 12 months. • Live play exercise every three years. • Command post exercise every three years. • Lessons identified.	Low (3)	Agree	Include as part of the EPRR work plan to review the EPRR Policy earlier than the existing review date of October 2022.	Approved EPRR Policy	John Wintle, Resilience Manager	30th June 2022
2	The Trust should have a Business Continuity Management Policy in place in line with NHS England requirements.	High (9)	Agree	Produce a BCM Policy and robust BCMS that includes exercise schedule and Trust training commitments.	Approved BCM Policy	John Wintle, Resilience Manager	30th June 2022

Rec no.	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
3	The Trust should expand on the exercise to assess divisional preparedness and establish an audit programme based on the full scope of business continuity arrangements with a three-year audit cycle, in line with NHS England requirements. Gaps in business continuity plans identified through the audit programme should be addressed through the Business Continuity Planning Group and communicated to divisions.	Moderate (6)	Agree	This is already underway through Business Continuity Planning Group (BCPG) work and the EPRR work plan. It will be a rolling activity and not a one-off exercise. The EPRR Officer is producing a schedule of mini simulations to be held at ward / service level to inform targeted training of areas of weakness. The addition of the ESR BC awareness is a tool that will be used to understand awareness across the Trust to again feed on to the overall picture of where targeted training will be required.	Returned divisional declarations and schedule of mini simulations. ESR reports on the uptake of BC awareness training and trend of improvement.	John Wintle, Resilience Manager	31st August 2022
4	The dedicated EPRR intranet page should be updated and contain a link to the Document Management System (DMS) pages where EPRR documents are held. The version of the Business Continuity Plan template that has expired should be removed from DMS.	Low (3)	Agree	The EPRR Officer has this as an action to update as part of the EPRR work plan.	Screenshots of the EPRR intranet page.	Sebastien Denault, EPRR Officer / John Wintle, Resilience Manager	30th September 2022

Rec no.	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
5	Working with the Business Continuity Management Group the Resilience Manager should: • Create a master list of all service areas required to have a business continuity plan. • Consider the EPRR Risk Register and guidance available from NHSE/I to decide which 'specific risk' business continuity plans are necessary for potentially Trust-wide disruptive events. • Ensure that each service area and Trust-wide specific risk area identified has a business continuity plan in place as required, in line with the Business Continuity Plan template.	High (12)	Agree	This is under way through the BCPG asking for divisional level tactical plans.	Divisional level plans and the collated master list.	John Wintle, Resilience Manager	30th June 2022
6	Once business continuity plans are in place for all required service areas these should be tested within set timeframes according to how critical the services are to the Trust.	High (9)	Agree	Embed this within the BCM Policy once plans are in place – testing will be undertaken as plans are in place rather than waiting for all plans to be in place and aimed at the divisional level plans. Dependant on leading work stream from Recommendation 5 of this report to produce the information required – hence target date of September 2022.	BCM Policy and plan validation exercise documents.	John Wintle, Resilience Manager	30th September 2022

Rec no.	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
7	The Business Continuity Plan (BCP) template and Incident Response Plan template should include: • 'Test Cycle' and 'Last Test Date' information. • 'Review Frequency' information. • A 'Document Change Control' section similar to the Trust's Overarching BCP, to record whether amendments were made following a review of a plan, and a brief summary of the amendments made. • For ad hoc reviews following an incident, the Datix identification code of the incident should also be captured.	Moderate (6)	Agree	Include as part of the annual review of plan template.	BCP template and examples of updated plans in new format.	Sebastien Denault, EPRR Officer / John Wintle, Resilience Manager	30th April 2022
8	To ensure on-call staff are appropriately trained to fulfil their role the Resilience Manager should: • Update the Training Needs Analysis and communicate training requirements to on-call Strategic Directors (formerly on-call Executive Directors) and Managers. • Keep the training matrix up to date. • Where identified ensure the required training is provided to staff that are yet to receive it. • Record the dates of when training was provided to staff.	High (10)	Agree	This is related to regional work being undertaken by the Resilience Manager as part of the training exercise and events (TEE) group of NHSE/I. Once the regional TNA is in place this will inform local organisational needs analysis.	Training Needs Analysis and training matrix/ records.	John Wintle, Resilience Manager	30th June 2022

Detailed Findings

1. Emergency Preparedness, Resilience and Response Policy and Business Continuity Management Policy

What We Checked

We established whether the Trust has an Emergency Preparedness, Resilience Response (EPRR) Policy and a Business Continuity Management (BCM) Policy and compared them the Civil Contingencies Act 2004, NHS England EPRR Framework and NHS England EPRR Core Standards, and we compared the Trust's BCM Toolkit with the NHS England BCM Toolkit.

What We Found

The EPRR Policy is fit for purpose and in line with national guidance. To fully comply with the NHS England EPRR Framework and NHS England EPRR Core Standards the EPRR Policy should include the following:

- Communications exercise every six months.
- Table top exercise every 12 months.
- Live play exercise every three years.
- Command post exercise every three years.
- Lessons identified.

These are described within the section on training and exercising in the 2020-2021 EPRR Annual Report.

The Trust does not have a Business Continuity Management Policy and recognises this is a gap in its EPRR arrangements.

We confirmed that the Trust's Incident Response Plan is fit for purpose and in line with national guidance, with appropriate definitions and information on incident levels and engagement with the Local Resilience Forum (LRF) and Local Health Relationship Partnership (LHRP).

The Trust's BCM Toolkit is overall fit for purpose although the Trust does not have an internal audit programme to monitor compliance with its business continuity arrangements and ensure they are effectively implemented and maintained. Good practice suggests a three-year audit cycle. The NHS England BCM Toolkit states that hot debriefs should take place immediately after an incident and cold debriefs should take place within 14 days of an incident. The Trust's BCM Toolkit only includes guidance on hot and cold debriefs after an exercise. The Trust's Incident Response Plan states that an initial local debriefing session should be held as soon as practical after the incident and a cold debrief should ideally be held within 2-4 weeks of the incident, which is to allow time for those involved in the response to produce a brief account of their involvement and ensure a structured debrief takes place to inform the post incident report and organisational learning.

Recommendations

Risk	Risk Rating	Recommendation
The Trust does not fully comply with all national EPRR guidance.	Rare (1) X Moderate (3) = 3 – Low Risk	See Recommendation 1 in the Action Plan.
The Trust's business continuity arrangements do not comply with NHS England requirements.	Possible (3) X Moderate (3) = 9 – High Risk	See Recommendation 2 in the Action Plan.
The Trust does not meet the requirements of the NHS England Business Continuity Management Toolkit.	Unlikely (2) X Moderate (3) = 6 – Moderate Risk	See Recommendation 3 in the Action Plan.

2. Incident Response Plans and Business Continuity Plans

What We Checked

We assessed whether:

- There are appropriate incident response plans (IRPs) and business continuity plans (BCPs) in place at Trust, divisional and departmental/service levels.
- The EPRR Policy, EPRR information and IRPs and BCPs are readily accessible on Connect.
- Staff are aware of IRPs and BCPs relevant for their role.
- Plans are tested on a regular basis.
- Lessons learned and opportunities for improvement are captured and circulated, as appropriate.
- Staff are up to date with training, as per the training record maintained by the Resilience Manager for on-call Executive Directors and Managers.

What We Found

IRPs and BCPs

We reviewed the Trust's Overarching BCP and noted that:

- Although it was last updated in July 2020 to incorporate Weston, it is still listed on the DMS as the UHB Overarching BCP. We understand that the plan is currently under review.
- It refers to a BCM Strategy (i.e. BCM Policy), although the Trust does not have one in place.
- It has links to several plans addressing Trust-wide disruptive issues e.g. loss of power. However, some links are obsolete and some BCPs that are listed relating to disruptive events e.g. loss of digital systems do not have a link to where they are available on the DMS. The Resilience Manager should consider whether a link to the BCP page on the DMS, rather than links to individual plans, would be more appropriate and easier to maintain.

We reviewed the BCPs available on DMS in August 2021 and we found that:

- There were 105 BCPs, of which 57 were up to date. 33 were obsolete and a further 15 had passed their review date, but not their expiration date. The Resilience Manager should consider the usefulness of keeping obsolete documents on the DMS that can be opened and downloaded and whether this might confuse staff.

- The DMS folder is structured alphabetically, which does not allow grouping into Trust divisions/hospitals etc.
- The six risk-specific plans that the Trust is required to have, as described in the EPRR Policy, were available. However, the Mass Countermeasure Distribution Plan has been obsolete since January 2021. There were also some risk-specific plans (such as the Flood Emergency Plan and Heatwave Plan), available on the DMS, that are not mentioned in the EPRR Policy, but are referenced within the Overarching BCP.

The total number of BCPs needed to ensure the Trust can respond to business continuity incidents is currently not known. The exercise to assess divisional preparedness should help to determine the number required and develop a comprehensive list.

We intended to review all divisional BCPs, all hospital/clinic BCPs and a sample of service area BCPs to ensure they had been prepared in line with the Trust's BCP template. However, only one of the Trust's seven divisions and three of its ten hospitals and clinics has a current BCP in place, and there is no oversight of service area plans. We reviewed the Division of Medicine BCP, the three hospital/clinic BCPs that were up to date (Bristol Heart Institute (BHI), Bristol Haematology and Oncology Centre (BHOC) and South Bristol Community Hospital (SBCH)) and two service level BCPs (Clinical Neurophysiology and A312 Orthopaedic and Fracture Clinic). Although the Resilience Manager reviews the completion of information in line with the BCP template before BCPs are uploaded to DMS, we noted that:

- There is no consistency regarding the 'Change Control' section. This was present in two out of the six BCPs, and it was not at the same point within the document.
- The Division of Medicine BCP did not state the next review date.
- Although the current BCP template has a 'Requirements for Service Recovery' section, the Division of Medicine BCP refers to departmental BCPs without providing specific details regarding which ones.
- Although the current BCP template does not require documentation regarding COVID-19 related impact, the Clinical Neurophysiology BCP had an appendix with relevant information.

We reviewed the Incident Response Plans (formerly the Major Incident Plans) and we noted that:

- The 'Mass Casualty' section does not provide any detail for Bristol sites, which are major trauma units. There is a dedicated Weston area IRP for mass casualties.
- The Incident Coordination Centre SOP and the Incident Response Plan (Part 2 – Action Cards) are overdue for review.
- The Incident Response Plan is presented in four concise parts and the format is convenient to update individual sites.
- They all contain a 'Document Control' and 'Change Control' table to capture information regarding review date, review cycle, approval and ratification body.
- They do not state their testing frequency requirements and the last test date.

The Trust has a number of plans in place to respond to business continuity and major incidents to support partial compliance with the EPRR requirement as per CQC Regulation 12: Safe Care and Treatment to be able to respond to and manage major incidents and emergency situations.

NHS England EPRR Core Standards

The Trust completed the annual self-assessment against NHS England EPRR Core Standards in October 2021, which is currently awaiting review by NHS England and the BNSSG CCG. The requirements for 2020-2021 have changed and 16 out of the 69 core standards have been removed, including the requirement to have a specific infectious disease plan. The Trust was assigned a 'Substantial' level of EPRR assurance for 2019-2020.

BCP Accessibility

All BCP plans are available on the DMS via Connect.

We reviewed the dedicated EPRR intranet page and noted that:

- It is a work in progress, as there are sections not yet populated and key staff details are not provided.
- There is a link to the Civil Contingencies Steering Group, Business Continuity Planning Group and Incident Response Planning Group workspaces. There are also links to the workspace for on-call Executive Directors and Managers and the 'Patient Flow' workspace, but the former does not work and the latter has restricted access.
- There are various NHS England and BNSSG CCG plans and documents, however, none are Trust-specific (e.g. BCP template and lessons learned template).
- There is no mention that all plans are available on DMS.

Staff Awareness

Following an exercise initiated by the Resilience Manager to gauge BCP awareness at divisional level, we reviewed responses from the three clinical divisions (Diagnostics & Therapies, Surgery and Women's & Children's Services) that had been received at the time of this review and noted that:

- This was a useful exercise, as a lot of areas were proposing to circulate the BCPs and a sign-off sheet to support awareness in the areas requested by the Resilience Manager.
- The Division of Surgery followed a format that is less useful for promoting EPRR awareness, because it does not identify the areas where further actions are needed.
- The exercise identified gaps in staff training, as there were elements of EPRR planning, such as the 'Medway downtime packs', that many staff were not familiar with.

The Division of Specialised Services has subsequently submitted their assessment. The Division of Weston had not responded at the time of our review and we understand there is a lack of resource within the division to enable timely completion of their EPRR requirements.

BCP Testing and Audit

Although previously identified as an Internal Audit recommendation in 2018 and reported as completed by the Trust, the Resilience Manager advised that the Trust does not have individual service area BCP testing schedules. We understand that this is a recognised gap and will be added to the agenda for the Business Continuity Planning Group. There has not been proactive BCP testing within the Trust during the last year. The Trust does not have a BCP testing schedule in place, or an audit programme to monitor compliance with BCP testing.

Lessons Learned

The lessons learned template, as part of a new BCP template (introduced in April 2021), is complete and fit for purpose. The requirement to document the action owner and timeframe for completion in the incorporated 'immediate action plan' should improve accountability. The template used to capture information regarding critical incidents contains a Lessons Learned page, however, this is not always thoroughly completed. The review of the combined lessons learned tracker by the Business Continuity Planning Group or Incident Response Planning Group, as appropriate, should improve the quality of completion and the dissemination of outcomes from exercises and incidents.

Training

The Trust's Training Needs Assessment (TNA) was last reviewed in September 2017. The Resilience Manager is currently undertaking a regional piece of work for the NHSE/I South West Training Exercise and Events Group (TEE) to create a regional TNA to establish what training should be mandatory and the frequency. The outcome of this piece of work will help to update the Trust's TNA.

According to the July 2021 version of the training record maintained by the Resilience Manager for on-call Executive Directors and Managers:

- The training matrix shows the minimum level of training required for each staff group as per the outdated TNA, which does not correspond to all current training available to staff, as appears on the EPRR work plan.
- All staff appear to be due some of their required EPRR training. However, we cannot draw conclusions from the training matrix, as staff training needs are not properly defined.
- The last recorded training was the 'Strategic/Tactical Leadership in a Crisis' on 08/03/2021 (SLC Lite). Out of the 96 staff that are on the log and still working at the Trust, this was attended by nine on-call staff from five divisions, while a further 38 staff appear to require this training. All eligible staff were notified through the on-call manager email distribution list. There are similar events organised as part of the 2022 EPRR work plan.
- The on-call Executive Directors and Managers, who are due to complete training, do not currently receive any reminders for unmet EPRR training needs.

Using ESR for the EPRR training is a positive development that will allow compliance to be measured, with a target of 80% compliance, similar to other mandatory training.

Recommendations

Risk	Risk Rating	Recommendation
Staff may not be aware of the EPRR process where the dedicated EPRR intranet page is not thoroughly completed.	Rare (1) X Moderate (3) = 3 – Low Risk	See Recommendation 4 in the Action Plan.
Critical services may be disrupted where the Trust does not have appropriate business continuity plans in place and/or because staff are unaware of the business continuity plans in place. Trust services may be disrupted where the Trust does not have business continuity plans in place for Trust-wide 'specific risk' areas.	Possible (3) X Major (4) = 12 – High Risk	See Recommendation 5 in the Action Plan.
In the absence of a business continuity plan testing schedule, gaps and weaknesses in business continuity plans and in competencies and training of relevant staff may not be identified or addressed where plans are not tested/rehearsed on a regular basis.	Possible (3) X Moderate (3) = 9 – High Risk	See Recommendation 6 in the Action Plan.
Individual business continuity plans and incident response plans may not be reviewed on a regular basis or provide the information required to respond to business continuity incidents.	Unlikely (2) X Moderate (3) = 6 – Moderate Risk	See Recommendation 7 in the Action Plan.
The Trust may not react to emergency situations in the most advantageous way, with potentially serious consequences for individuals and the Trust itself, where the leadership team has not been adequately trained to best deal with critical events.	Unlikely (2) X Catastrophic (5) = 10 – High Risk	See Recommendation 8 in the Action Plan.

3. Civil Contingencies Steering Group, Business Continuity Planning Group, Incident Response Planning Group and the reporting and escalation of EPRR matters through the Trust's governance structure

What We Checked

We assessed whether the following groups set up to manage EPRR matters: Civil Contingencies Steering Group, Business Continuity Planning Group and the Incident Response Planning Group were operating effectively and fulfilling their Terms of Reference.

We reviewed agendas, meeting minutes, action logs and reports for the above groups to determine whether there was adequate reporting and escalation through the Trust's governance structure, where necessary.

What We Found

Civil Contingencies Steering Group (CCSG)

The CCSG was stood down in July 2021, due to EPRR workload, as the group is not a statutory requirement. The purpose of the group was to develop and drive forward civil contingency planning and govern EPRR within the Trust. Agenda items included the EPRR Work Programme, Incident Response Planning Group and Business Continuity Planning Group progress reports and the EPRR Risk Register. We noted work was required to align Bristol and Weston business continuity planning in October 2021, training was delayed due to COVID-19 in February 2021, and some training and exercising had restarted in April 2021. There were no items for escalation regarding EPRR.

The CCSG previously reported to the Senior Leadership Team Delivery Group (SLTDG) on a quarterly basis, which included a summary of progress against and oversight of the EPRR Work Programme and the EPRR Risk Register. The group provided the 2020-2021 EPRR Annual Report to the Trust Board, which included:

- Risk assessments to inform contingency planning activities.
- Activities to develop and maintain arrangements for responding to a major incident.
- Activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.
- EPRR training and exercising that took place over the past year.
- Recent emergency incidents and disruptive events.

Business Continuity Planning Group (BCPG)

The BCPG Terms of Reference had been approved and was last updated in November 2020. The purpose of the group is to ensure that robust arrangements are in place across all divisions to enable the Trust to maintain critical business function during emergency or otherwise unusual circumstances, and meetings are chaired by the Resilience Manager. The BCPG is an action-focused group at operational level. The group maintains an action log, but does not have administrative support to take minutes during meetings, and the action log does not record meeting attendance. The meetings took place on a quarterly basis in line with the Terms of Reference, and the agendas included updates on business continuity planning by division and recent business continuity incidents. The group was operating effectively and there were no matters for escalation regarding EPRR.

The BCPG was previously accountable to the CCSG and provided verbal progress reports at CCSG meetings. The BCPG is required to submit quarterly progress reports to the SLTDG through the EPRR Work Plan as of November 2021.

Incident Response Planning Group (IRPG)

The IRPG Terms of Reference had been approved and was last updated in August 2021. The group was re-established to ensure delivery of the Trust's EPRR strategic agenda, with the primary role to ensure robust arrangements are in place across all clinical and non-clinical divisions to meet the Trust's civil protection duties. The IRPG is also an action-focused group at operational level. The meetings took place on a quarterly basis in line with the Terms of Reference and were chaired by the Resilience Manager. The agendas included updates on the NHSE/I Assurance and Action Plan, the Trust's Training and Exercises Programme and learning from incidents and exercises. The group was operating effectively and there were no matters for escalation regarding EPRR.

The IRPG was previously accountable to the CCSG, and is required to submit quarterly progress reports to the SLTDG through the EPRR Work Plan as of November 2021.

The EPRR Work Programme, which includes the Trust's ongoing self-assessment against NHS England EPRR Core Standards, will continue to be presented to the SLTDG on a quarterly basis for assurance and will be available on the SLTDG workspace to provide a complete overview of the arrangements in place and where there are weaknesses. The EPRR Risk Register will be received on a quarterly basis at the Trust's Risk Management Group as of October 2021.

Recommendations

Risk	Risk Rating	Recommendation
No recommendations have been made		

ASW Assurance – About Us

ASW Assurance is the largest provider of internal audit, counter fraud and consultancy services in the South West. We maintain a local presence and close engagement within each health community, with audit teams based in Bristol, Exeter, North Devon, Plymouth, Torquay and Cornwall, linked by shared networks and systems. More information about us, including the services we offer, our client base, our office locations and key people can be found on our website at www.aswassurance.co.uk.

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All audit and assurance assignments are conducted in conformance with the International Standards for the Professional Practice of Internal Auditing.

Confidentiality

This report is issued under strict confidentiality and, whilst it is accepted that issues raised may need to be discussed with officers not shown on the distribution list, the report itself must not be copied/circulated/disclosed to anyone outside of the organisation without prior approval from the Director of Audit and Assurance Services.

Inherent Limitations of the Audit

There are inherent limitations as to what can be achieved by systems of internal control and consequently limitations to the conclusions that can be drawn from this review. These limitations include the possibility of faulty judgment in decision-making, of breakdowns because of human error, of control activities being circumvented by the collusion of two or more people and of management overriding controls. Also there is no certainty that controls will continue to operate effectively in future periods or that the controls will mitigate all significant risks which may arise in future. Accordingly, unless specifically stated, we express no opinion about the adequacy of the systems of internal control to mitigate unidentified future risk.

Rating of Audit Recommendations

The recommendations in this report are rated according to the organisation's risk-scoring matrix and have been arrived at by assessing the risk in relation to the organisation as a whole.

Overall Assurance Opinion Definition

The overall assurance opinion on the front page of this report is based on the following definitions:

Significant	Controls are well designed and are applied consistently. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Controls are generally sound and operating effectively. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Rating of Individual Findings

The following ratings have been used to summarise our evaluation of each area reviewed and helps form our overall assurance opinion:

	Processes are appropriately designed and appear to be operating well. Any areas for improvement that were identified are not significant and are unlikely to reoccur.
	Controls and arrangements are generally appropriately designed working well but we have identified areas where these arrangements should be further strengthened. We do not have significant concerns regarding this area and any issues that were identified are unlikely to reoccur if properly managed.
	Urgent action is needed to address weaknesses in the processes which are in place to manage the task or function. We have significant concerns regarding this area and consider that issues may arise or reoccur.

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NHS England

Summary of Published Key Guidance for Health Emergency Preparedness, Resilience and Response (EPRR)

Preparing for Emergencies in the NHS in England

Summary of Published Key Guidance for Health, Emergency Preparedness, Resilience and Response (EPRR)

Version number: v 3.0

First published: March 2015

Updated: March 2019

Prepared by: NHS England EPRR

Classification: OFFICIAL

This material should be read in conjunction with the NHS England Emergency Preparedness Framework. All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the Guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency planning in the NHS in England.

The web version of the guidance is available at http://www.england.nhs.uk/ourwork/eprr/

Introduction

- For the attention of all NHS emergency preparedness, resilience and response (EPRR) personnel.
- The following charts give an overview of the key EPRR guidance documents currently published. These lists are not exhaustive.
- For published documents, web-site links are imbedded in the charts. ‘Mouse over’ the boxes to see the links and click on the boxes to open the hyperlink (whilst viewed as a slideshow).
- For general queries, to request information about inaccessible documents, or to suggest amendments please contact NHS England (National) EPRR Team at England.eprr@nhs.net

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

NHS England

Business Continuity

- NHS England Business Continuity Management Framework (2013)
- NHS England Business Continuity Management Toolkit
- Cabinet Office: Business Continuity (web-page)
- ISO 22301 Business Continuity Management Systems (BCMS) - Requirements
- ISO 22313 Business Continuity Management Systems - Guidance

Guidance and Framework

- NHS England Emergency Preparedness Framework
- NHS England Core Standards for Emergency Preparedness, Resilience and Response
- Mutual Aid Guidance

Exercising

- Off the Shelf Exercises
- Cabinet Office: Exercises and training

Incident Response

- Incident Response Plan - National

Evacuation and Sheltering

- Planning for the evacuation and sheltering of people in health sector settings
- Hospital Evacuation Plan
- Community Evacuation Plan

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

NHS England

HAZMAT & CBRN

- Chemical Incidents – Planning for the management of self-presenters in healthcare settings
- Guidance for the initial management of self presenters from incidents involving hazardous materials
- UK Reserve National Stock for Major Incidents – How to access stock in England
- PGDs for Hazmat and CBRN incidents
- CBRN Incidents: A Guide to Clinical Management and Health Protection
- Ambulance service guidance on dealing with radiological incidents and emergencies (Mar 2010)
- Radiation Monitoring Units
- NHS Guidance - Incidents Involving Radioactivity (1998)
- NARU: Initial Operational Response

Mass Casualty & Major Incidents

- Concept of Operations for the Management of Mass Casualties
- Clinical Guidance for Major Incidents
- Planning for the psychological and mental health care of people affected by major incidents and disasters
- NARU: Clinical Guidance Medical Support Minimum Requirements for a Mass Casualty Incident (Oct 2014)

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

NHS England

Pandemic Influenza

- Operating Framework – Response to Pandemic Influenza
- Roles and Responsibilities of CCGs in Pandemic Influenza
- Pandemic Influenza – NHS guidance on the current and future preparedness in support of an outbreak (January 2017)
- The UK Influenza Preparedness Strategy
- PHE Pandemic influenza response plan
- Health and Social Care Influenza Pandemic Preparedness and Response (Apr 2012)
- Responding to Pandemic Influenza: The Ethical Framework for Policy and Planning (Nov 2007)
- Pandemic Flu: Managing Demand and Capacity in Health Care Organisations (Surge) (May 2009)
- Pandemic Influenza: Guidance on the Management of Death Certification and Cremation Certification (Aug 2008)

Surge and Escalation

- Management of Surge and Escalation in Critical Care Services
  SOPs for Critical Care, Burns Services and ECMO

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

NHS England

Reference Materials

- Information on FFP3 Respirators
- Information for LHRPs
- A Plan for NHS Blood and Transplant and Hospitals to address Red Cell Shortages August 2016
- A Plan for NHS Blood and Transplant and Hospitals to address Platelet Shortages August 2016
- NHS Guidance on Planning for Disruption to Road Fuel Supply: Strategic National Guidance NHS Organisations (Nov 2008)
- PHE: Cold Weather Plan for England (October 2017)
- PHE: Heatwave Plan for England (May 2017)
- PHE: Flooding Advice
- National Risk Register (2017)
- The Central Government's Concept of Operations (April 2013)
- Lexicon of UK Civil Protection Terminology (February 2013)
- Emergency Response and Recovery (October 2013)
- Emergency Preparedness: Guidance on Part 1 of the Civil Contingencies Act 2004, its associated Regulations and non-statutory arrangements (March 2012)
- Expectations and Indicators of Good Practice Set for Category 1 and 2 Responders (October 2013)
- Recovery Guidance Common Issues and Recovery Plan Template (November 2008)
- The role of Local Resilience Forums (July 2013)
- Enhanced SAGE Guidance: A strategic Framework for the Scientific Advisory Group for Emergencies (SAGE) (October 2012)
- Provision of Scientific and Technical Advice in the Strategic Co-Ordination Centre (STAC) - Guidance to Local Responders (April 2007)
- Strategic Framework and Policy Statement on Improving the Resilience of Critical Infrastructure to Disruption from Natural Hazards (March 2010)
- Home Office: Guidance on Dealing with Fatalities in Emergencies (2004)
- National Recovery Guidance - Humanitarian Aspects - Mass Fatalities

Updates since previous version

Amendment	Date	Made by:
Management of surge and escalation in critical care services: standard operating procedure for Adult and Paediatric Burn Care Services in England and Wales	August 2015	NHS England EPRR
Updated list of documents included, based on Framework and Guidance Review Process. Updated links.	November 2015	NHS England EPRR
Updated all links and document titles	December 2017	NHS England EPRR
Links updated PGD's summarised Exercising Added	March 2019	NHS England EPRR

NHS Commissioning Board

NHS Commissioning Board Business Continuity Management Framework (service resilience)

THE NHS CONSTITUTION
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NHS Commissioning Board Business Continuity Management Framework

Date	7 January 2013
Audience	• NHS Commissioning Board directors of operations and delivery • NHS Commissioning Board regional directors • NHS Commissioning Board area team directors • NHS Trust and NHS Foundation Trust chief executives • Ambulance Service chief executives • Clinical commissioning groups • Accountable emergency officers.
Copy to	• Members of local health resilience partnerships (LHRPs) • NHS Commissioning Board emergency planning leads • Strategic Health Authority emergency planning leads.
Description	Please read this document in the context of: • NHS standard contracts • the NHS Planning Framework • the NHS Commissioning Board Emergency Planning Framework (2013).
Cross reference and links	http://www.commissioningboard.nhs.uk/eprr/ Further links are listed in section 7.
Action required	NHS organisations and providers of NHS funded care must be able to maintain continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action. All NHS organisations and providers of NHS funded care must contribute to co-ordinated plans for emergency preparation and service resilience through their local health resilience partnerships.
Timing	As new health EPRR arrangements are introduced (by April 2013).
Contact details	NHSCB.EPRR@nhs.net NHS Operations, Quarry House, Leeds LS2 7UE.

Contents

1. Introduction

1.1. The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

1.2. Under the Health and Social Care Act 2012, the NHS Commissioning Board must be 'properly prepared for dealing with an emergency' and must monitor and control all service providers to make sure they too are prepared.

1.3. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health community as 'emergency preparedness resilience and response' (EPRR).

1.4. NHS organisations and providers of NHS funded care must therefore be able to maintain continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action.

1.5. Business continuity management (BCM) gives organisations a framework for identifying and managing risks that could disrupt normal service.

1.6. An organisation's business continuity management system (BCMS) helps it to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect.

1.7. Disruptions can be caused by periods of severe pressure (for example, in winter), a long-term increase in demand for services, external emergencies and disasters, and internal system failures. Planning to tackle these effects goes way beyond the initial emergency response.

1.8. Business continuity management is an essential tool in establishing an organisation's resilience.

2. What is this document for?

2.1. This document highlights the need for business continuity management in NHS organisations. It lists the relevant standards and indicates the guidance organisations need to follow.

2.2. It also promotes joint working arrangements between NHS organisations when planning for and responding to disruptions. This partnership approach must focus on the best needs of patients, not the performance targets of each organisation.

2.3. All NHS organisations must use this framework and the associated core standards in order to align themselves with ISO 22301 and fulfil all assurance processes.

3. What are the business continuity requirements for providers of NHS funded care?

3.1. Some NHS organisations are identified under the Civil Contingencies Act (CCA) 2004 as 'category one' responders. This means they have a legal duty to develop robust business continuity management arrangements which will help them to maintain their critical functions if there is a major emergency or disruption. This could include, for example, an infectious disease outbreak, severe weather, fuel shortages, industrial action, loss of accommodation, loss of critical information, loss of communication technology (ICT) or supply chain failure.

3.2. Not all providers of NHS funded care are covered by the requirements of the CCA. But it is good practice for all of them to act as if they were.

3.3. Each NHS organisation is responsible for making sure it meets the legal requirements and core standards for business continuity set out in this document. This responsibility extends to services provided through partnerships or other forms of contractual arrangement.

3.4. The core standards in appendix 1 are the minimum standards which NHS organisations and sub-contractors **must** meet.

3.5. The accountable emergency officer in each NHS organisation is responsible for making sure these standards are met.

3.6. We will seek evidence that these standards are being met.

4. International and national standards

4.1. The main guidance for business continuity management is contained in:

a. **ISO 22301** Societal Security - Business Continuity Management Systems – Requirements[1]

b. **ISO 22313** Societal Security - Business Continuity Management Systems – Guidance

c. **PAS 2015** - Framework for Health Services Resilience[2].

4.2. In the past, organisations in the UK developed their business continuity management systems in line with BS25999. However, this standard has been replaced by ISO 22301.

4.3. ISO 22313 provides good practice, guidelines and recommendations based on the requirements of ISO 22301.

4.4. The aim of PAS 2015 is to provide a resilience framework for NHS organisations and all providers of NHS funded care

4.5. Other useful guidance includes:

a. ISO 27000 series – a set of standards relating to security management systems[3]

b. ISO 31000 series – a set of standards relating to risk management family of standards[4]

c. PD 25222 – guidance on supply chain continuity[5]

d. PD 25888 – guidance on recovery following a disruption[6]

e. PD25111 – guidance on the human aspects of business continuity[7]

f. NHS Commissioning Board Emergency Planning Guidance 2013

g. NHS Sustainable Development Unit Adaptation Guidance August 2012[8].

4.6 We will also publish a Business Continuity Management Toolkit in 2013 to help all NHS organisations develop their business continuity management system.

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[1] http://www.iso.org/iso/catalogue_detail?csnumber=50038

[2] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030201297

[3] http://www.27000.org/index.htm

[4] http://www.iso.org/iso/catalogue_detail?csnumber=43170

[5] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030239218

[6] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030194308

[7] http://shop.bsigroup.com/ProductDetail/?pid=000000000030229830

[8] http://www.sdu.nhs.uk/documents/publications/Adaptation_Guidance_Final.pdf#search="adaptation"

5. The patient care pathway

5.1. The NHS is used by 62 million people in the UK. Its services cover everything from pre-birth screening to end-of-life care.

5.2. The NHS is a 'people-rich' organisation, employing 1.7 million staff across the UK.

5.3. Three million people are treated by the NHS every week. Each one of these people takes a specific care pathway through services delivered by a variety of NHS organisations and providers of NHS funded care.

5.4. NHS organisations and providers of NHS funded care must shift the focus of their business continuity management systems to that of a whole-system approach to the patient care pathway. Each organisation will play a part, but realistic resilience and continuity arrangements will only be achieved if we consider and understand the patient's whole journey.

5.5. NHS organisations and providers of NHS funded care will therefore need to recognise how their critical activities depend on each other and to align their plans with all partner organisations.

5.6. Some elements of ISO 22301 **must** be done in partnership with other health organisations, recognising the patient care pathway and the patient's needs throughout each stage. These are set out below.

Understanding the organisations and their context

5.7. NHS organisations and providers of NHS funded care should understand the functions, needs and issues of the partners who play connecting parts in the patient care pathway.

Understanding the needs and expectations of interested parties

5.8. 'Interested parties' will include patients, the wider community, other NHS organisations, the emergency services, local authorities and suppliers.

5.9. NHS organisations and providers of NHS funded care must identify all those who have an interest in their services and establish their needs and expectations.

5.10. They must then build these needs and expectations into their response and recovery arrangements.

Scope

5.11. NHS organisations and providers of NHS funded care must establish the scope of their business continuity management system, taking into account any internal and external dependencies, for example staffing, ICT, food, fuel and other supplies.

5.12. They should share the scope of their system with partner organisations and interested parties so that it is clear which services are and are not included.

Communications

5.13. NHS organisations and providers of NHS funded care should establish and maintain procedures for regular communications with partner organisations and other interested parties. This is particularly important during the planning stage for known disruptions such as winter weather.

5.14. Formal reporting and situation updates may also be required in the lead up to and during a disruption to create a local, regional and national overview of effects across the NHS. These arrangements should be tested to make sure each organisation can maintain the flow of information.

5.15. Plans should be developed and shared between organisations through Local Health Resilience Partnerships and Local Resilience Forums.

Warnings

5.16. NHS organisations and providers of NHS funded care should establish and maintain robust internal and external communication procedures for before, during and after a disruption. These procedures should include a system for alerting partner organisations and interested parties of any current or potential disruption to services.

Business impact analysis

5.17. NHS organisations and providers of NHS funded care should identify dependencies and supporting resources that help them deliver their critical activities effectively. This analysis should be a broad review using established organisational risk, capability and capacity processes. It should also include suppliers, partner organisations and other relevant interested parties. Any critical activities highlighted should form part of the organisational risk matrix.

Business continuity strategy

5.18. NHS organisations and providers of NHS funded care should identify what they require of partners and suppliers in order to implement their business continuity management strategy effectively.

Response

5.19. NHS organisations and providers of NHS funded care should develop their response plans in collaboration with partners and other directly-linked NHS organisations. In this way they can make sure the actions in their response arrangements do not have a negative effect on other organisations.

Business continuity plans

5.20. Business continuity plans should contain details of all internal and external dependencies and interactions, as well as details on how and under what circumstances key interested parties will be communicated with.

Recovery

5.21. NHS organisations and providers of NHS funded care should make sure the actions in their recovery arrangements do not have a negative effect on partner organisations.

5.22. They should develop recovery plans, including prioritised recovery timeframes, in collaboration with other directly-linked NHS organisations.

Exercising and testing

5.23. NHS organisations should aim to exercise and test their business continuity arrangements alongside partner NHS organisations. They should then share lessons learned and post-exercise reports with all interested parties.

6. Equality and diversity

6.1. Investing in a diverse NHS workforce enables us to deliver a better service and improve patient care in the NHS. Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense.

6.2. When putting arrangements in place to reflect this suite of documents, organisations should be mindful of their obligations under the Equality Act 2010. The Equality Duty ensures that public bodies consider the needs of all individuals in shaping policy, delivering services, and in relation to their own employees. It encourages public bodies to understand how different people will be affected by their activities on different people so that policies and services are appropriate and accessible to all and meet different people's needs.

7. References and information sources

This document should be read in the context of the following sources of information.

7.1. The Civil Contingencies Act 2004[9]

7.2. The Cabinet Office website[10]

7.3. The Health and Social Care Act 2012[11]

7.4. NHS Commissioning Board EPRR documents and supporting materials[12], including:

a. NHS CB Emergency Planning Framework (2013);

b. NHS Commissioning Board Command and Control Framework for the NHS during significant incidents and emergencies (2013); and

c. NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

7.5. National Occupational Standards (NOS) for Civil Contingencies – Skills for Justice[13].

7.6. ISO 22301 Societal Security - Business Continuity Management Systems – Requirements[14]

7.7. BSI PAS 2015 - Framework for Health Services Resilience[15]

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[9] http://www.legislation.gov.uk/ukpga/2004/36/contents

[10] http://www.cabinetoffice.gov.uk/ukresilience

[11] http://www.legislation.gov.uk/ukpga/2012/7/enacted

[12] www.commissioningboard.nhs.uk/eprr/

[13] http://www.skillsforjustice-nosfinder.com/epc/aboutnos.php

[14] http://www.iso.org/iso/catalogue_detail?csnumber=50038

[15] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030201297

8. Freedom of information

This document is available to the public.

9. Glossary

BCM	Business continuity management
BCMS	Business continuity management system
BS	British Standard
BSI	British Standard Institution
EPRR	Emergency preparation, resilience and response
CCA	Civil Contingencies Act (2004)
ISO	International Standards Organisation
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NHS CB	NHS Commissioning Board
PAS	Publicly Available Specification
PD	Published document

APPENDIX 1 – CORE STANDARDS FOR BUSINESS CONTINUITY MANAGEMENT

These standards will be updated from time to time. The following extract is correct at the time of publication. To view the latest list of core standards, please see the NHS Commissioning Board Core Standards for Emergency Preparation, Resilience and Response Framework at www.commissioningboard.nhs.uk/eprr/

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Cat 1 responders				Cat 2	Not categorised			
		Acute trusts	Ambulance trusts	NHS CB area teams	NHS CB regional &	CCGs	Primary care	Other NHS organisatio	Community providers	Mental health
1	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	X	X	X	X	X	X	X	X	X
3	**3. All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	X	X	X	-	X	X	X	X	X
3 . 1	director-level representation at the LHRP; and	X	X	X	-	X	-	X	X	X
4	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS CB report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	X	X	X	X	X	X	X	X	X
4 . 1	Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme should link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	X	X
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	X	X
5	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	X	X	X	X	Note[1]	Note 1	Note 1	Note 1	Note 1
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X	X	-	X	-	-	-	X	X
5 . 28	Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X	X	X	X	X	X	X	X	X

Note: 1. All NHS Organisations and providers of NHS funded care must maintain suitable incident response plans. However, the details in these plans will depend on the organisation's size and role. Providers of NHS funded care include:

- independent hospitals under contract to deliver NHS care;
- urgent care centres;
- nursing homes;
- residential and elderly mentally-impaired (EMI) homes; and
- patient care transport providers.

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS CB area teams	NHS CB regional &	CCGs	Primary care	Other NHS organisatio	Community providers	Mental health
5 . 31	Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X	X	X	X	X	X	X	X	X
5 . 40	Explain the process for completing, authorising and submitting NHS CB standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X	X	X	X	X	X	X	X	X
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X	X	X	X	X	X	X	X	X
5 . 48	Explain the process of recovery and returning to normal processes.	X	X	X	X	X	X	X	X	X
5 . 51	Explain who will be responsible for managing escalation and surges.	X	X	X	X	X	X	X	X	X
5 . 52	Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X	X	X	X	X	X	X	X	X
6	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This should include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	X	X	X	X	Note[2]	Note 2	Note 2	Note 2	Note 2
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	X	X	X	X	X	X	X	X	X
7 . 1	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	X	X	X	X	X	X	X	X
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X	X	X	X	X	X	X	X	X
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X	X	X	X	X	X	X	X	X
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X	X	X	X	X	X	X	X	X
	Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.	X	X	X	X	X	X	X	X	X
7 . 5	Each organisation's BCMS should be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X	X	X	X	X	X	X	X	X
7 . 6	Organisations should establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X	X	X	X	X	X	X	X	X
7 . 7	Organisations must make clear how their plan will be published, for example on a website.	X	X	X	X	X	X	X	X	X
7 . 8	The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the Chief Executive.	X	X	X	X	X	X	X	X	X
7 . 9	There must be an audit trail to record changes and updates such as changes to policy and staffing.	X	X	X	X	X	X	X	X	X
7 . 10	The planning process must take into account nationally available toolkits that are seen as good practice.	X	X	X	X	X	X	X	X	X

Note: 2. Each NHS organisation is responsible for providing a suitable environment for managing a significant incident or emergency (an ICC). However, the exact specification of the ICC will depend on the organisation's size and role.

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS CB area teams	NHS CB regional &	CCGs	Primary care	Other NHS organisatio	Community providers	Mental health
	Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.	X	X	X	X	X	X	X	X	X
7 . 11	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X	X	X	X	X	X	X	X	X
7 . 12	Plans must be maintained based on risk-assessed worst-case scenarios.	X	X	X	X	X	X	X	X	X
7 . 13	Risk assessments should take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	X	X	X	X	X	X	X	X	X
7 . 14	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	X	X	X	X	X	X	X	X
7 . 15	They must identify all critical activities using a business impact analysis. This should set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	X	X	X	X	X	X	X	X	X
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	X	X	X	X	X	X	X	X
	Business continuity plans should set out how the plans will be called into use, escalated and operated.	X	X	X	X	X	X	X	X	X
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans should be published on external websites and through other information-sharing media.	X	X	X	X	X	X	X	X	X
7 . 18	Plans should set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X	X	X	X	X	X	X	X	X
7 . 19	the procedures for escalating emergencies to CCGs and the NHS CB area, regional and national teams;	X	X	X	X	X	X	X	X	X
7 . 20	24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X	X	X	X	X	X	X	X	X
7 . 21	the responsibilities of key staff and departments;	X	X	X	X	X	X	X	X	X
7 . 22	the responsibilities of the Chief Executive or Executive Director;	X	X	X	X	X	X	X	X	X
7 . 23	how mutual aid arrangements will be called into use and maintained;	X	X	X	X	X	-	X	X	X
7 . 24	where the incident or emergency will be managed from (the ICC);	X	X	X	X	X	-	X	X	X
7 . 25	how the independent healthcare sector may help if required; and	X	X	X	X	X	X	X	X	X
7 . 26	the insurance arrangement that are in place and how they may apply.	X	X	X	X	X	X	X	X	X