NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Report to the SFH Trust Board on Annual Emergency Preparedness Resilience & Response Self-Assessment 2017

Aim

To gain approval from the Board of Directors that the 2017 EPRR Self- Assessment is a true and accurate appraisal of the Trusts current position in respect of EPRR.

Objectives

a) To outline the Core Standards
b) To identify gaps in compliance with those standards
c) To describe the actions required to achieve compliance
d) To describe the audit process used by NHS England
e) To describe the approval/rating system used by the Clinical Commissioning Groups
f) Make comparisons to the assessment in 2016

Timeline

The reports should be presented at the Board of Directors meeting on 31st August 2017..

Background

There is a legal obligation on all category 1 responders, including NHS funded organisations such as Sherwood Forest Hospitals NHS FT (SFH) to comply with the six key principles contained within the Civil Contingencies Act 2004:

1. Duty to assess risk
2. Duty to plan for emergencies
3. To have business continuity management in place
4. Duty to Cooperate
5. Information sharing
6. Warning & Informing the public.

The means by which assurance is provided back to the Secretary of State via the DoH is through the self-assessment process and resultant confirm and challenge, after which a formal rating is awarded. There are four options for rating bodies to use:

a) Full Compliance
b) Substantial Compliance
c) Partial Compliance
d) Non-Compliant

The Core Standards

The template spreadsheet used by NHSE is a difficult document to work with and received due criticism from the SFH Board at last year's submission. Therefore this year it is summarised in the following way:

1. <u>Governance</u>

Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)

Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.

Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.

The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.

Self-Assessment Rating - ***COMPLIANT***

2. Duty to Assess Risk

Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.

There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.

There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.

Self-Assessment Rating - ***COMPLIANT***

3. Duty to maintain plans

Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.

Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.

Ensure that plans are prepared in line with current guidance and good practice.

Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.

Arrangements explain how VIP and/or high profile patients will be managed.

Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content

Arrangements include a debrief process so as to identify learning and inform future arrangements.

Self-Assessment Rating – ***COMPLIANT***

4. Command and Control

Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.

Those on-call must meet identified competencies and key knowledge and skills for staff.

Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the Loggist .

Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.

Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.

Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.

Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;

Self-Assessment Rating – ***COMPLIANT***

5. Communicate with Public

Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.

Arrangements ensure the ability to communicate internally and externally during communication equipment failures

Self-Assessment Rating – ***COMPLIANT***

6. Information Sharing

Arrangements contain information sharing protocols to ensure appropriate communication with partners.
Self-Assessment Rating – ***COMPLIANT***

7. Cooperation

Organisations actively participate in or are represented at the Local Resilience Forum

Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA

Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.

Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.

Arrangements outline the procedure for responding to incidents which affect two or more regions.

Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties

Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared

Arrangements are in place to ensure the Local Health Resilience Partnership (LHRP) meets at least once every 6 months

Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level

Self-Assessment Rating – ***COMPLIANT***

8. Training & Exercising

Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents.

Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.

Demonstrate organisation wide (including on-call personnel) appropriate participation in multi-agency exercises

Preparedness ensures all incident commanders (on-call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.

Self-Assessment Rating – ***PARTIAL COMPLIANCE***

Note – assessed as partial due to absence of evidence in relation to SFH's participation in multi-agency exercises. Last one was three years ago. Next EMERGO exercise due early 2018, SFH to be fully engaged in the planning and execution of this exercise

9. HAZMAT Core Standards

There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)

Staff are able to access the organisation HAZMAT/ CBRN management plans.

HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.

Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.

Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.

There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.

The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)

There are routine checks carried out on the decontamination equipment including:

A)Suits
B)Tents
C)Pump
D)RAMGENE(monitor)
E) Other decontamination equipment

There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for:

A)Suits
B)Tents
C)Pump
D)RAMGENE(monitor)
E) Other equipment

There are effective disposal arrangements in place for PPE no longer required.

Self-Assessment Rating – ***PARTIAL COMPLIANCE***

Note – assessed as partial because Lead Nurse in ED has not had formal training on Decontamination equipment/processes, and PPM system not currently in place (though will be by the Confirm & Challenge). Trust EPO to arrange trainer training on CBRN with PHE.

10. HAZMAT Equipment Checklist

Inflatable frame	
Liner	
Air inflator pump	

Repair kit	
Tethering equipment	
OR: Rigid/ cantilever structure	
Tent shell	
OR: Built structure	
Decontamination unit or room	
AND:	
Lights (or way of illuminating decontamination area if dark)	
Shower heads	
Hose connectors and shower heads	
Flooring appropriate to tent in use (with decontamination basin if needed)	
Waste water pump and pipe	
Waste water bladder	
PPE for chemical, and biological incidents	
The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).	
Providers to ensure that they hold enough training suits in order to facilitate their local training programme	
Ancillary	
A facility to provide privacy and dignity to patients	
Buckets, sponges, cloths and blue roll	
Decontamination liquid (COSHH compliant)	
Entry control board (including clock)	
A means to prevent contamination of the water supply	
Poly boom (if required by local Fire and Rescue Service)	
Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)	
Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)	
Waste bins	
Disposable gloves	

Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe	
FFP3 masks	
Cordon tape	
Loud Hailer	
Signage	
Tabbards identifying members of the decontamination team	
Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.	
Radiation	
RAM GENE monitors (x 2 per Emergency Department and/or HART team)	
Hooded paper suits	
Goggles	
FFP3 Masks - for HART personnel only	
Overshoes & Gloves	

Self-Assessment Rating – ***NON-COMPLIANT***

Note – Non-Compliance rating given due to absence of ChEAk kits. There is some ambiguity as to whether this core standard applies to Trusts such as SFH. Trust EPO to clarify and correct.

Audit Process

It is expected that the EPRR Self - Assessment is subject to internal governance processes before submission to NHS England. This assessment was forwarded by the Trust's Resilience Assurance Committee to the Board Risk Committee, who approved it on 15th August 2017.

The Confirm and Challenge session is scheduled for 11th September when it will have been scrutinised by the Board of Directors. It is a pre-requisite of the NHS England audit that the report has the formal approval of the organisations senior Directors.

The Confirm and Challenge meeting will ask for evidence of our own ratings and may of course challenge them.

Once completed an overall rating will be issued by our CCG, as described above, and will be either:

e) Full Compliance

f) Substantial Compliance
g) Partial Compliance
h) Non-Compliant

If short of Full Compliance, we would be expected to produce an action plan addressing the gaps with timescales and responsibilities clearly identified.

The 2016 Assessment

During the submission process for 2016 the Trust did not employ its own Emergency Planning Officer, a positon vacated three years earlier, and the Trust was working via service level agreement with colleagues from Nottingham University Hospitals NHS Trust prior to an expected merger.

For the 2016 assessment we had the following areas of non-compliance:

- Business Continuity Management (a number of areas of concern)
- Lack of Procedure for Managing VIP Admissions
- Insufficient trained Log – Keepers
- Lack of Decontamination equipment (ID Tabards)
- CBRN Risk Assessment – no updated copy

Despite this the Trust received a “Substantial” rating, since when all of these areas have now been addressed.

It can be expected therefore that we have made further progress towards Full Compliance, notwithstanding the non-compliant areas listed above.

Mark Stone

Emergency Planning & Business Continuity Officer

20th October 2016