### Executive Summary

Following recommendations made by Grant Thornton as part of the Trust’s HDD phase 1 review and a review of committee structure undertaken by Deloitte’s (SaTH’s internal auditors) in 2012, the Board agreed a number of principles and changes to ensure that the formal sub-committees of the Board focus on key strategic imperatives, assurance of systems, the reduction of duplication and delivery against robust plans.

Each Committee Chair also presents a short written summary of key issues to the subsequent Board meeting, which has been identified as best practice by external audit. The draft minutes are included in Board members’ electronic information packs, with the approved version published on the Trust’s website as part of the Freedom of Information publication schedule.

It was agreed the structure would be reviewed annually and the Terms of Reference of the Tier 2 Committees reviewed by the relevant Committee and ratified by the Board.

The current structure has been reviewed a number of times and membership adjusted to maximise effective time commitments.

NED membership will be reviewed by the Chair when the current NED vacancy is filled.

### Strategic Priorities

<table>
<thead>
<tr>
<th>☑ Quality and Safety</th>
<th>☑ People and Innovation</th>
<th>☑ Financial Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Healthcare Standards</td>
<td>☐ Community and Partnership</td>
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</table>

### Operational Objectives

- Providing the best clinical outcomes, patient safety and patient experience
- Striving for excellence through people and innovation
- Building a sustainable future

### Board Assurance Framework (BAF) Risks

<p>| ☑ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience |
| ☑ Implement our falls prevention strategy to help prevent patients suffering serious injury |
| ☑ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards |
| ☐ Clear Clinical Service Vision or we may not deliver the best services to patients |
| ☑ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve |
| ☐ Appoint Board members in a timely way or may impact on the governance of the Trust |
| ☑ Achieve a Financial Risk Rating of 3 to be authorised as an FT |</p>
<table>
<thead>
<tr>
<th>Care Quality Commission (CQC) Domains</th>
<th>Safe</th>
<th>Effective</th>
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<td>Receive</td>
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The Board is asked to:

NOTE and APPROVE the Committee structure and date for Board meetings and to RATIFY the Tier 2 Committee Terms of Reference.
Committee Review
28 November 2013

1. Background
A review of Board Committee structures and reporting arrangements was undertaken by Deloitte\(^1\) in 2012 and Grant Thornton\(^2\) undertook Historic Due Diligence Phase 1 in 2010. Both of these reviews involved desk-top documentation reviews and 1:1 interviews with Board Members. There were also some actions required by the Board Governance Assurance Framework\(^3\) that were incorporated into recommendations. The key focus of all these reviews is to ensure that there is a clear reporting structure with no gaps and any duplication is minimised. It is also to ensure compliance with good practice and Monitor’s Code of Governance\(^4\) to ensure FT-readiness.

2. Committee structure
2.1 The final shape of the Committee structure and content was discussed at the Board Development Day on 22 October and approved in November 2012 with a number of decisions and principles agreed in order to ensure that the formal sub-committees of the Board focus on key strategic imperatives, assurance of systems and delivery against robust plans and to minimise duplication.

The current structure is shown at Attachment 1. The Terms of Reference for each Committee are on the trust website and in Board members’ electronic information packs.

2.2 Board meetings
- The dates and sites for Board meetings are shown below in Table 1. These are published each month and advertised in local press to encourage public attendance.

- Currently Board Development sessions are scheduled to run directly after Board meetings, but this may need to be reviewed and full days reintroduced in the future

Table 1. Board meetings 2014/15

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>May (see Note 1)</th>
<th>May</th>
<th>Jun</th>
<th>Aug (see Note 3)</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<td>27</td>
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<td>1 PRH</td>
<td>29</td>
<td>RSH</td>
<td>5 (see Note 2)</td>
<td>28</td>
<td>PRH</td>
<td>11</td>
<td>(see Note 4)</td>
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<td>RSH</td>
<td>PRH &amp; 25</td>
<td>RSH</td>
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</tr>
</tbody>
</table>

Notes
1. Easter 19-21 April
2. Special meeting to approve Annual Accounts (@ 5pm following Audit Committee)
3. To be confirmed
4. Provisional AGM

2.3 Committee membership
This is shown at Attachment 2. Allocation of NEDs to the Committees will be finalised by the Trust Chair following appointment into the NED position currently vacant

3. Recommendations
The Board is asked to

NOTE and APPROVE the Committee structure and date for board meetings and Board Development sessions in 2014 and to RATIFY the Tier 2 Committee Terms of Reference

\(^1\) Review of Board committee structure and reporting June 2012
\(^2\) Stage 1 Preliminary assessment and Financial reporting procedures Report August 2012
\(^3\) Board Governance Assurance Framework - Department of Health
\(^4\) The NHS Foundation Trust Code of Governance - Monitor
Constitution
The Shrewsbury and Telford Hospital NHS Trust was appointed as the Corporate Trustee of The Shrewsbury and Telford Hospital NHS Trust Charity (registered charity number 1107883) by virtue of Statutory Instrument SI2003/2346 under powers derived under Sch 2 Part II para 16.1c NHS and Community Care Act 1990. The Board serves as its agent in the administration of the charitable funds held by the Trust.

Membership
The Corporate Trustee consists of all non executive directors, including the Chairman, and all voting executive directors. The Chair of the Board is the Chair of the Corporate Trustee and the Vice Chair of the Board is the Vice Chair of the Corporate Trustee.

Other employees of the Trust may be invited to attend by the Chairman.

Quorum
A quorum shall be no less than six voting members.

Attendance
All members will be expected to attend at least 60% of meetings each year. In the event of a member being unable to attend, apologies must be sent to the Secretary. No alternative representation is allowed.

Frequency of Meetings
The Corporate Trustees will meet at least twice each year or as required by the annual governance schedule whichever is the greater.

Authority
The role of the Corporate Trustee is to make the most effective use of all available charitable funds, ensuring that the funds are spent appropriately as a financially sustainable organisation. The Corporate Trustee will approve:
- The Shrewsbury and Telford Hospital NHS Trust Charity objects, priorities and strategy
- Investment Strategy
- Fundraising Strategy
- Annual Budget
- Annual Accounts and Report
- Terms of Reference of the Charitable Funds Committee

Delegated Authority
The Corporate Trustee has established a Charitable Funds Committee in accordance with the Trust’s Standing Orders. The Charitable Funds Committee and has delegated responsibility for the day to day running of the Charitable Funds in accordance with the delegated limits as set out in the relevant sections of the Trust’s Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Accountability
The Corporate Trustee has ultimate responsibility for the administration of the charitable funds held by the Trust and is accountable to the Charity Commission and to the Secretary of State for Health.
Reporting from the Corporate Trustee
The Corporate Trustee reports to the Charity Commission and to the Secretary of State for Health.

Reporting to the Corporate Trustee
The Charitable Funds Committee reports to the Corporate Trustee. A report and minutes of the meetings will be presented to the Corporate Trustee by the Chair of the Charitable Funds Committee, who shall draw the attention of the Corporate Trustee to issues that require disclosure or approval.

Date Terms of reference approved
Draft version 1.1, updated following review by the Charitable Funds Committee on 9 May 2013

Date of next review
June 2013 and annually thereafter
Terms of Reference

Risk Committee

Constitution

The Risk Committee reports to the Trust Board and oversees the ongoing development, implementation and monitoring of the Trust’s Risk Management Strategy. This includes overview of the most significant risks to the achievement of the Trust’s objectives to ensure there are robust controls and mitigation actions in place.

The Committee will be required to adhere to the Standing Orders of the Trust.

Membership

<table>
<thead>
<tr>
<th>Member</th>
<th>Nominated Deputy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive (Chair)</td>
<td>Director of Safety &amp; Quality (Deputy Chair)</td>
</tr>
<tr>
<td>Director of Safety &amp; Quality</td>
<td>Deputy Chief Nurse</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Deputy Medical Director (Clinical Performance)</td>
</tr>
<tr>
<td>Director of Corporate Governance</td>
<td>Head of Assurance</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Assistant Chief Operating Officer – Scheduled Care</td>
</tr>
<tr>
<td></td>
<td>Assistant Chief Operating Officer – Unscheduled Care</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>Non-Executive Director</td>
</tr>
<tr>
<td>Head of Assurance</td>
<td>Health &amp; Safety Manager</td>
</tr>
</tbody>
</table>

Attendance when required:

<table>
<thead>
<tr>
<th>Member</th>
<th>Nominated Deputy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance Director</td>
<td>Deputy Finance Director</td>
</tr>
<tr>
<td>Workforce Director</td>
<td>Deputy Head of Human Resources</td>
</tr>
<tr>
<td>Director of Communications</td>
<td>Communications Officer</td>
</tr>
<tr>
<td>Director of Strategy</td>
<td>Head of Planning</td>
</tr>
</tbody>
</table>

Quorum

For the Committee to be quorate, the presence of at least 4 members or their nominated deputy is required.

Attendance

Members may appoint suitable deputies to represent them. Deputies must attend when required. It is expected that a member or their nominated deputy will attend for a minimum of 75% of meetings in a year. Attendance will be monitored by an attendance matrix

Frequency

The Risk Committee shall meet quarterly. Additional meetings may be held at the discretion of the Chair

Authority

Authority for all decisions relating to risk management lies with the Trust Board of the Shrewsbury and Telford Hospital NHS Trust. The Committee has delegated powers from the Trust Board to oversee the risk management arrangements within the Trust and is authorised to investigate any activity within its terms of reference
Duties

- Oversee the implementation and further development of the Trust’s Risk Management Strategy ensuring it supports the achievement of the Trust’s objectives and business plan.

- Provide a clear statement of the risk appetite for the management of risk throughout the organisation.

- Assess and review the composition and ongoing development of the Board Assurance Framework ensuring it provides a robust tool through which the Board can monitor management of the organisation’s key strategic risks, ensuring effective control and assurance mechanisms in place and that effective actions are being taken to address gaps in controls and assurance.

- Provide the Trust Board with assurance that a comprehensive Trust wide Risk Register is maintained which will enable the Board to have a shared and clear understanding of the key risks in the Trust; what mitigations are in place to manage risks and which risks are being tolerated.

- Identify and validate new strategic risks and consider whether they pose a principle risk to the Trust’s strategic objectives and should be included on the Board Assurance Framework.

- Ensuring Director risk owners and risk action owners have plans in place to control identified risks and to take necessary action to ensure remedial plans are put into place should mitigation fall behind plan.

- Identify potential threats and opportunities that may impact on the achievement of the Trust’s objectives.

- Monitor progress with the NHSLA and CNST risk management standards.

Reporting from the Committee

The Committee will be directly accountable to Trust Board.

The Chairman of the Committee will report on the proceedings of each meeting to the next meeting and will draw to the attention of the Trust Board any matters of concern in relation to the effective management of the organisation’s risks.

The Chairman of the Committee will ensure that the Trust Board receives the Trust’s Board Assurance framework.

The Risk Committee will produce an annual risk management report for the Trust Board.

Reporting to the Committee

The Operational Risk Group and Health & Safety and Security Committee will report to the Risk Committee.

Review

The Terms of Reference will be reviewed by the Board of Directors annually.

August 2013
V5
QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board resolves to establish a Committee of the Board to be known as the Quality and Safety Committee. As a committee of the Trust Board, the Standing orders of the Trust shall apply to the conduct of the working of the Quality and Safety Committee.

2. Membership

2.1 The Committee shall be appointed by the Chairman of the Trust and shall comprise the following:

- 2 Non-Executive Directors
- Medical Director
- Director of Quality and Safety/Chief Nurse
- Chief Operating Officer
- Patient Representative

2.2 The Committee will be chaired by a Non-Executive Director on the Committee nominated by the Trust Chairman. In the absence of the nominated Chairman, another NED member shall be elected chairman by the other members of the Committee.

3. Attendance

3.1 All other members of the Trust Board shall be entitled to attend and receive papers to be considered by the Committee, as agreed with the Committee Chair. If unable to attend a meeting, the Directors may be represented by a nominated deputy, but this must be agreed before the meeting with the Committee Chairman. It is expected that a member or their nominated deputy will normally attend for a minimum of 80% of meetings in a year.

3.2 Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chairman. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chair. The Directors may be represented by a nominated deputy, but this must be previously agreed with the Committee Chairman.

3.4 The Chairman of the Audit & Risk Committee shall attend at least one meeting per year.
3.5 The Chief Nurses’ Executive Assistant will ensure that an efficient secretariat service is provided to the Committee. Namely:

- that Directors are aware fully of their responsibilities in the delivery of reports in sufficient time to allow meeting papers to be circulated within the defined timescales.
- that Directors are reminded that papers not circulated in time may not be considered at the meeting.
- To manage the action summary and matters arising to ensure their timely follow through.

4. Quorum

4.1 A quorum will consist of 4 members, including 1 Non-Executive Director and 1 Executive Director.

5. Frequency of meetings

5.1 The Committee will normally meet monthly and not less than 6 times per year.

5.2 The Agenda will be circulated with papers at least 3 working days before the meeting. The Agenda will be approved by the Committee Chairman prior to circulation. Requests for non-routine agenda items are to be forwarded to the Committee Chairman normally at least 10 working days prior to the meeting.

5.4 Additional meetings may be held at the discretion of the Chairman of the Committee.

6. Authority

6.1 The Committee has responsibility for leading the Quality Governance Framework and ensuring the Committee receives quarterly updates from the Chief Nurse and prospective processes are in place for validating assurances.

6.2 The Committee is authorised by the Trust Board to investigate any Trust activity within its Terms of Reference and is expected to make recommendations to the full Trust Board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.3 With prior consent of the Chairman the Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice, and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances.

6.4 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.
7. Duties and responsibilities

7.1 The Committee will ensure that the Trust has appropriate and effective systems in place that cover all aspects of Clinical Quality and Safety to include the following:

- To ensure that the Trust fulfils its obligations with regard to the Health Act (2009) and, specifically, with regard to the Health Service Regulations (2013), in relation to the preparation of the annual Quality Account.
- To provide assurance to the Trust Board on Clinical Quality and Safety (including Clinical Effectiveness, Patient Safety and Patient Experience).
- Utilising best practice metrics to ensure that the Trust has robust clinical governance processes that deliver safe, high quality and patient centred care.
- To drive an improvement culture to promote best practice in patient care across the domains of Quality and Clinical Effectiveness, Patient Safety and Patient Experience.
- To set clear quality performance expectations and ensure the development of high quality care and continuous improvements through innovation and other quality initiatives such as CQUIN.
- To identify and advise on quality improvement priorities, for example, by commissioning in depth reviews of service areas and receiving exception reports from QIPP workstreams and external reviews of provider services.
- To receive and ensure that the Trust acts upon external reviews from regulatory and advisory organisations.
- To ensure that Risk Screening/Quality Impact Assessments are completed for all Cost Improvement Programmes and reconfigurations of service.
- To maximise organisational learning from alert systems, organisational reviews and quality related data.
- To monitor the performance of all reporting groups, approving Terms of Reference and receiving minutes, action plans and exception reports.

7.2 Key Responsibilities for Patient Safety

7.2.1 To ensure that the Trust is meeting all regulatory and mandated care standards, with robust response and tracking processes in place to meet national alert requirements, national guidelines and relevant external quality and safety standards with a focus on patient sensitive indicators.

7.2.2 To receive an agreed level of patient safety and outcomes data which provides trends and themes from care delivery, utilising clinical metrics to uniform and analyse the range of clinical services across the Trust.

7.2.3 To advise the Trust Board, through the Board Assurance Framework and Corporate Risk Register Framework, about the level of assurance or risks as regards the standards of care provided across the range of Trust services, including actions in place to drive improvements and mitigate risks.

7.2.4 To receive and review regular progress reports for achieving and maintaining compliance against all aspects of the CQC Essential Standards of Quality and Safety and develop a Quality Assurance Framework to support the governance arrangements required as would apply for a Foundation Trust.
7.3 Incident Reporting and Investigation

7.3.1 To monitor the effectiveness of the Trust's systems for reporting and investigating Never Events, Serious Incidents (SIs), Near Misses and other incidents.

7.3.2 To review the outcomes of investigations and external inspections, ensuring that the information is presented in sufficient detail to enable failings, and positive learning points in patient care to be identified and shared.

7.3.3 To receive, review and ensure implementation of action plans and progress reports proposed by management in response to SIs, Near Misses and other incidents.

7.4 Key Responsibilities for Patient Experience

7.4.1 To receive assurance regarding the delivery of the Patient Experience strategy across the Trust, overseeing the development, implementation and monitoring of the Patient Experience Strategy and Quality Strategy and associated action plans.

7.4.2 To review the findings of Patient Surveys (NHS, external organisations and local) and ensure implementation of the related action plans.

7.4.3 To ensure that policies and guidelines relating to Patient and Public involvement are developed, agreed and implemented.

7.4.4 To monitor the effectiveness of the Trust's systems for complaints handling, and review trends and themes.

7.4.5 To monitor the effectiveness of the Trust's system for patient advocacy and the encouragement of feedback from patients and relatives.

7.4.6 To receive the Complaints Annual Report.

7.4.7 To receive a patient story to be presented at the beginning of the meeting.

7.5 Key Responsibilities for Clinical Effectiveness

7.5.1 To review and monitor compliance with new and existing statutory and accreditation standards and legislative requirements in relation to quality and consider recommendations for the timely implementation of guidance.

7.5.2 To review the Quality Dashboard and consider the information contained therein to ensure that assurance is received on all quality and safety of patient care matters.

7.5.3 To review assurances received on clinical practice and be advised of the progress of any major quality initiatives in the Trust.

7.5.4 To receive updates on outcomes being improved in the Trust, eg Patient Reported Outcome Measures (PROMs).
7.5.5 To review the effectiveness of the Trust's arrangements for the systematic monitoring of mortality.

7.5.6 To receive Clinical Audit reports and the action plans related to these.

7.5.7 To review learning from external visits and ensure all necessary recommendations have been implemented to improve the safety and quality of care.

7.5.8 To receive updates on Trust participation in national confidential enquiries, ensuring consideration of relevant recommendations and appropriate implementation arising from reports.

7.5.9 To receive and comment on exception reports for the implementation and compliance with National Institute for Clinical Excellence (NICE) guidance, and other national guidance.

7.5.10 To review compliance and responses to National Patient Safety Alerts (NPSA) ensuring completion of actions.

7.6 **Key Responsibilities for the Quality Agenda**

7.6.1 To ensure that there are robust systems in place for the production of an annual Quality Account.

7.6.2 To agree the Quality priorities of the Trust following the necessary consultation with Staff, external organisations and representatives from the local population and, in due course, the FT Governors.

7.6.3 To receive a quarterly report on the Quality priority targets prior to reporting progress to the Trust Board.

7.6.4 To ensure that there are systems in place to ensure that External Audit undertake an assurance exercise of the Quality Account and that action is taken with regard to any recommendations that result from this exercise.

8. **Reporting**

8.1 The Quality and Safety Committee reports to the Trust Board. The Committee Chairman shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed or where it has significant concerns.

8.2 The Committee receives assurance from the following working groups:

- Clinical Governance Executive
- Infection Control Committee
- Patient Experience and Involvement Panel
- Clinical Audit Committee
8.3 The draft minutes of the Committee shall be circulated to Committee members within 5 working days of the subsequent meeting and presented at the Trust Board following their approval.

9. Review

9.1 The Terms of Reference of the Committee shall be reviewed by the Trust Board at least annually.

Last Reviewed: November 2013
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

Membership

1. The Committee shall comprise of at least two Non-Executive Directors and the Finance Director. The Committee can invite any member of the Trust to attend.

2. A quorum shall be two members of the Committee, including one Non-Executive Director.

3. All members of the Corporate Trustee are eligible to attend.

Frequency of meetings

4. The Committee will meet a minimum of four times a year. One of these meetings will be held to consider the Annual Accounts and Report before submitting to the Corporate Trustee for approval.

Duties

5. To be accountable to the Corporate Trustee and ensure the on-going management of Charitable Funds is consistent with the objectives and operational framework set by the Corporate Trustee.

6. To monitor compliance against Corporate Trustee policies, procedures and plans that include:

   - Terms of Reference of Charitable Funds Committee
   - Appropriate use of Charitable Funds
   - Appropriate sources of Charitable Funds
   - Investment Policy
   - Expenditure Plans

7. To advise the Corporate Trustee and monitor compliance against the requirements of the Charities Acts, Charities Commission Guidance, Equality Act and other relevant legislation and guidance.

8. To consider the Annual Accounts and Report before submitting to the Corporate Trustee for approval.

9. To monitor compliance against relevant internal audit reports and counter fraud initiatives and to report progress to the Corporate Trustee.

10. To monitor the performance of Charitable Funds investments and report to the Corporate Trustee at least quarterly.
11. To monitor the performance of the Charitable Funds Investment Manager(s) and advise the Corporate Trustee appropriately.

12. To ensure, via the Finance Director and the Finance Department, that Charitable Funds are managed in accordance with the Trust’s Standing Financial Instructions.

13. To review the financial implications on any proposal for fund raising activities that the Trust may initiate, sponsor or approve.

14. To co-ordinate and work with The League of Friends, Lingen Davies and other local charities on appropriate projects/schemes.

Last Reviewed: May 2013 (by Committee)
TBC 2013 (Trust Board)
Review: Annually
REMUNERATION COMMITTEE
TERMS OF REFERENCE

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Remuneration Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership

The membership of the Committee will vary according to the nature of the business to be discharged at a particular meeting, as follows;

2.1 Where a meeting or part-meeting of the Committee is convened for the purpose of considering any question relating to:

- the structure, size and composition of the Board of Directors; succession planning
- the appointment, remuneration and performance of Executive and Corporate Board Directors (other than the Chief Executive)
- organisational development
- the appointment of Non-Executive Directors
- local variations to national terms and conditions and locally-determined pay awards terminations
- any other ad hoc items relating to remuneration, terms and conditions of employment, incentives and reward

the Committee shall consist of the Trust Chairman and a minimum of 3 Non-Executive Directors. The Chief Executive will attend as a non-voting member of the Committee.

2.2 Where a meeting or part meeting is convened for the purpose of considering any question relating to the appointment of a Chief Executive, or the remuneration or performance of the Chief Executive the Committee shall consist of the Trust Chairman and a minimum of 3 Non-Executive Directors.

2.3 The Committee will be chaired by the Trust Chairman. In the absence of the Trust Chairman another NED member shall be elected chairman by the other members of the Committee.
3. Attendance

3.1 The Workforce Director shall normally attend meetings. If unable to attend a meeting, the Workforce Director may be represented by a nominated deputy, but this must be agreed before the meeting with the Committee Chairman. It is expected that a member or their nominated deputy will normally attend for a minimum of 80% of meetings in a year.

3.2 All Non-executive Directors of the Trust Board shall be entitled to attend and receive papers to be considered by the Committee, as agreed with the Committee Chair.

3.3 Other managers/staff may be required to attend meetings depending upon issues under discussion with prior approval of the Committee Chairman. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chairman.

3.4 The Executive Assistant to the Workforce Director will ensure that an efficient secretariat service is provided to the Committee.

- that Directors are aware fully of their responsibilities in the delivery of reports in sufficient time to allow meeting papers to be circulated within the defined timescales.
- that Directors are reminded that papers not circulated in time may not be considered at the meeting.
- To manage the action summary and matters arising to ensure their timely follow through.

4. Quorum

4.1 A quorum shall be at least three Non-executive Directors

5. Frequency of meetings

5.1 The committee will meet a minimum of three times a year. The Committee will normally meet monthly at the time of the monthly Trust Board Meeting. The Agenda will be circulated with papers at least 5 days before the meeting. The agenda will be approved by the Committee Chairman prior to circulation. Requests for non-routine agenda items are to be forwarded to the Committee Chairman normally at least 10 working days prior to the meeting.

5.2 Members will normally attend at least 80% of the meetings in the year.

5.3 Additional meetings may be held at the discretion of the Chairman of the Committee.

6. Authority

6.1 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
7. Duties

Key Responsibilities

7.1 Board structure, size and composition

- Reviewing the structure, size and composition (including the skills, knowledge and experience) required of the Board as a whole compared to its current position;
- Determining any changes and development needs.

7.2 Succession planning

- Considering succession planning for Executive Directors and other very senior managers, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

7.3 Appointment of the Chief Executive, and other Executive and Corporate Board Directors

- Where a new Chief Executive, Executive or Corporate Board Director is to be appointed, being responsible for the selection and appointment process on behalf of the Board.

7.4 Board Remuneration

- Setting the remuneration of all Executive and Corporate Directors, including salary, any performance-related elements/bonuses or allowances and provision for other benefits including cars
- Ensuring the contractual terms of the Executive and Corporate Directors are in accordance with national policy and guidance, particularly in relation to the termination of employment, notice periods and pensions benefits
- Determining whether a proportion of an Executive or Corporate Director’s remuneration should be linked to corporate and individual performance and, if so, approving an appropriate scheme of performance-related remuneration
- In developing contractual terms and remuneration packages, the Committee will have:
  a) a clear statement of the responsibilities of the individual posts and their accountabilities for meeting objectives of the organisation;
  b) a fair means of assessing the comparative job “weight”;
  c) comparative salary information from the NHS and other sector organisations and other industrial and service organisations.

7.5 Board Performance

- Reviewing the performance of the Executive and Corporate Directors, noting the assessments of the Chief Executive

7.6 Organisational Development

- Reviewing and advising on major organisational development and reconfigurations proposals.

7.7 Appointment of Non-Executive Directors

- Where a new Non-Executive Director is to be appointed, communicating views on the balance of skills, knowledge and experience required on the Board and its description of the role and capabilities required for the particular appointment.
7.8 Local Pay Awards

- Sanctioning the parameters for negotiations for all local pay and reward structures.

7.9 Terminations

- Reviewing all proposed termination payments to be made to the Chief Executive and other Board Executive and Corporate Directors, prior to submission to other bodies in accordance with the national guidelines in existence at the time.
- Reviewing all proposed termination payments to be made to other staff, in accordance with national guidelines in existence at the time.
- The Chief Executive has discretion to approve payments of up to £25,000 in cases where prompt action is required to settle an agreement. The Remuneration Committee and other bodies, as required by national guidance, will be informed in all cases where this discretion has been used.

7.10 Ad Hoc items

- Reviewing and scrutinising specific matters relating to remuneration, terms and conditions of employment incentives and reward as the Committee feels appropriate.

8. Reporting

8.1 The draft minutes shall be recorded and circulated to Committee members within 5 working days of the meeting.

8.2 The Chairman of the Committee will report to the next meeting of the Board following the Committee, summarising the main issues of the discussion and drawing the Board’s attention to any issues that require disclosure to the full Board or require executive action. The approved minutes will be submitted to the Trust Board meeting following their approval.

9. Review

9.1 The Terms of Reference of the Committee shall be reviewed at least annually by the Trust Board.

Last Reviewed: September 2013
FINANCE COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board resolves to establish a Committee of the Board to be known as the Finance Committee. As a Committee of the Trust Board, the Standing Orders of the Trust shall apply to the conduct of the working of the Finance Committee.

2. Membership

2.1 The Committee shall be appointed by the Chairman of the Trust and shall comprise the following:

2 Non-Executive Directors
Director of Finance

2.2 The Committee will be chaired by a Non-Executive Director, appointed by the chairman of the Trust Board. In the absence of the nominated Chairman another NED member shall be elected chairman by the other members of the Committee.

3. Attendance

3.1 The Chief Operating Officer, Workforce Director, Director of Business & Enterprise, Director of Estates and Facilities and the Head of IT shall also be required to attend some meetings, at the request of the Chairman. If unable to attend a meeting, the Directors/Head of Department may be represented by a nominated deputy, but this must be agreed before the meeting with the Committee Chairman. It is expected that a member or their nominated deputy will normally attend for a minimum of 80% of meetings in a year.

3.2 All other members of the Trust Board shall be entitled to attend and receive papers to be considered by the Committee, as agreed with the Committee Chair.

3.3 Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chairman. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chairman.

3.4 The Chairman of the Audit Committee will attend at least one meeting of this Committee annually.

3.5 The Finance Director’s Executive Assistant will ensure that an efficient secretariat service is provided to the Committee. Namely
• that Directors are aware fully of their responsibilities in the delivery of reports in sufficient time to allow meeting papers to be circulated within the defined timescales.
• that Directors are reminded that papers not circulated in time may not be considered at the meeting.
• To manage the action summary and matters arising to ensure their timely follow through.

4. Quorum

4.1 A quorum shall be 2 members comprising one Non-Executive Director and the Finance Director. One Executive Director (Chief Operating Officer) would attend in conjunction with the Deputy Finance Director in the event of the Finance Director being unavailable.

5. Frequency of meetings

5.1 The Committee will normally meet monthly before the monthly Trust Board Meeting and not less than 8 times per year. The Agenda will be circulated with papers at least 5 working days before the meeting.
The agenda will be approved by the Committee Chairman prior to circulation
Requests for non-routine agenda items are to be forwarded to the Committee Chairman normally at least 10 working days prior to the meeting.

5.2 Members will normally be expected to attend at least 80% of the meetings in the year.

5.3 Additional meetings may be held at the discretion of the Chairman of the Committee.

6. Authority

6.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference and is expected to make recommendations to the full Trust Board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice, and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Trust Board is required.

6.3 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

7. Duties and responsibilities

The Finance Committee shall undertake on behalf of the Trust Board objective scrutiny of the Trust's financial plans and major investment decisions. The purpose of the Committee is to provide the Board with an objective review of the financial position of the Trust and oversee the delivery of financial performance, including taking any decisions delegated to it. The Committee will operate at a strategic level as the Executive is responsible for the day to day operational
delivery and management. Additionally, the Trust Board may request that the Committee reviews specific aspects of financial performance where the Board requires additional scrutiny and assurance. The key responsibility of the Committee is to provide assurance to the Trust Board on Finance issues utilising best practice metrics that support robust governance processes, including the following:

7.1 **Strategic and Business Planning**

7.1.1 Consider processes for the preparation and the content of Strategic and Business Plans and Annual Revenue, Capital and Workforce Budgets, and test the key assumptions and risks underpinning such plans.

7.1.2 Review the Trust Annual Plan and Annual Budgets before submission to the Trust Board.

7.1.3 Monitor performance compared with the Annual Plan and Budgets and investigate variances.

7.1.4 Review and prioritise capital investment proposals within the Capital Budget.

7.1.5 Consider financial aspects of Business Cases for significant revenue or capital expenditure, as defined in the Trust’s Standing Financial Instructions and Scheme of Delegation, prior to submission to the Board of Directors.

7.1.6 Consider financial aspects of Business Cases retrospectively for return on investment/benefits realisation.

7.1.7 Identify and evaluate opportunities for increasing activity/income from market intelligence analyses.

7.1.8 Review the development of the Trust’s Marketing strategy.

7.1.9 Review the development of the Trust’s Financial Strategy and Long Term Financial Model.

7.1.10 Develop the Trust’s Investment Policy and ensure that it is consistent with best practice.

7.1.11 Monitor the implementation of the IT strategy.

7.1.12 Monitor the implementation of the Estates strategy.

7.2 **Financial Management**

7.2.1 Monitor the financial performance and workforce targets of individual Clinical Centres, as well as the complete organisation, and the proposed corrective actions where necessary.
7.2.2 Consider explanations of significant variances/deviations from Budget by Clinical Centres on a regular basis, and to consider the proposed corrective actions, their envisaged impact and the planned timescale for recovery.

7.2.3 Develop a strategic approach to managing Cost Improvement Programmes.

7.2.4 Consider the 24-month Cost Improvement Programme, monitor performance against it, and consider any proposed corrective or contingency actions and make recommendations regarding this to the Board.

7.2.5 Consider performance against external benchmark performance targets, including those set by the Care Quality Commission, Monitor, and as agreed in legally binding contracts and the proposed corrective actions where necessary.

7.2.6 Ensure the development, implementation and maintenance of an effective service line accountability framework.

7.2.7 Consider detailed expenditure, cash flow and working capital plans and forecasts.

7.2.8 Consider regular financial performance reports and forecasts, focusing particularly on risks and assumptions.

7.2.9 Commission and consider various financial reports and analyses, as appropriate.

7.2.10 Receive Schedules of losses and compensation (and the circumstances behind them)

7.2.11 Receive information on all expenditure items over £100k,

7.3 **Legally Binding Contracts with Third Parties**

7.3.1 Consider regular reports of Trust performance in respect of contracts agreed with third party organisations and to take appropriate action.

7.3.2 Ensure that Local Delivery Plans and contracts with Primary Care Trusts, Clinical Commissioning Groups and other bodies are determined, managed and delivered.

7.4 **Financial Accounting**

7.4.1 Consider the likely impact of technical changes to accounting policy or practices and agree significant changes to accounting practice in advance.

7.5 **Business Risks**

7.5.1 Consider the short to medium term impact on current performance of internal and external business risks.

7.5.2 Review Monitor’s financial risk rating and instigate appropriate action.
8. **Reporting**

8.1 The Finance Committee reports to the Trust Board.

8.2 The Finance Committee will receive and review proposals and recommendations from Capital Planning Group.

8.3 The Committee will routinely receive the following reports:
- Income/expenditure performance in the month and cumulatively, of the Trust.
- A reconciliation of actual performance against budget together with the proposed corrective actions.
- Balance sheet performance
- 12 month rolling income/expenditure forecast
- 12-month rolling cash forecast
- Performance against activity plans with proposed corrective actions and timescale for implementation
- Performance against contracts with local CCGs with proposed corrective actions and timescale for implementation

8.4 The Committee Chair will report formally to the next Trust Board meeting on all matters within its duties and responsibilities.

8.5 The Committee will make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed, or where it has significant concerns.

8.6 The draft Minutes shall be recorded and circulated to Committee members within 5 working days of the meeting and presented at the next Trust Board meeting for information.

9. **Review**

9.1 The Terms of Reference of the Committee shall be reviewed at least annually by the Trust Board.

Approved 25th July 2013
Review due July 2014
AUDIT COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board resolves to establish a Committee of the Board to be known as the Audit Committee. As a Committee of the Trust Board the Standing Orders of the Trust shall apply to the conduct of the working of the Audit Committee. The Committee is a Non Executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

2.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members.

2.2 One of the members will be appointed Chair of the Committee by the Board. The Chairman of the Trust shall not be a member of the Committee.

3. Attendance

3.1 The following members of staff and partners will normally be in attendance at every meeting:

Finance Director
Director of Corporate Governance
Internal Auditors
External Auditors

3.2 The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee, the process for assurance that supports the Annual Governance Statement. He should also attend when the Committee considers the draft Internal Audit Plan and the Annual Accounts. Other Executive Directors should be invited to attend, particularly when the Committee is discussion areas of risk or operation that are the responsibility of that director.

3.3 Other managers/staff may be invited to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary.

3.4 The Committee will exclude the Finance director and any other Trust employee from its meeting with Internal and External Auditors for a minimum of one meeting per year.

3.5 The Director of Corporate Governance will ensure that an efficient secretariat service is provided to the Committee.

4. Quorum

Audit Committee Terms of Reference - September 2013
4.1  A quorum shall be two Non Executive Directors.

5.  Frequency of Meetings

5.1  The Committee will meet at least five times per year at appropriate times in the reporting and audit cycle. The Agenda will be circulated with papers at least 5 days before the meeting. The external auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

6.  Authority

6.1  The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7.  Duties

The duties of the Committee can be categorised as follows:

7.1  Governance, Risk Management and Internal Control

7.1.1  The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non clinical), that supports the achievement of the organisation’s objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement), together with an accompanying Head of Internal Audit statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State’s Directions and as required by NHS Protect (formerly NHS CFSMS).

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
This will be evidenced through the Committee’s use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.2 **Internal Audit**

7.2.1 The Committee shall ensure that there is an effective Internal Audit function that meets mandatory **NHS Internal Audit Standards** and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the Internal Audit Strategy, Operational Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.
- Considering the major findings of Internal Audit work (and management’s response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resources and has appropriate standing within the organisation.
- An annual review of the effectiveness of Internal Audit.

7.3 **External Audit**

7.3.1 The Committee shall review the work and findings of the External Auditors and consider the implications and management’s responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management responses.

7.4 **Other Assurance Functions**

7.4.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the organisation.
7.4.2 These will include, but will not be limited to, any review by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHSLA etc) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc).

7.4.3 In addition this Committee will review the work of other Committees within the Trust whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular this will include the Clinical Quality and Safety Committee; Finance Committee, and Risk Committee.

7.4.4 The Committee shall monitor the effective implementation of agreed action arising from audit recommendations.

7.4.5 In reviewing the control processes underpinning the work of, and issues around clinical risk management, the Audit Committee will wish to satisfy itself in the narrative of the assurances that can be gained for clinical audit.

7.5 Counter Fraud

7.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

7.6 Management

7.6.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangement for governance, risk management and internal control.

7.6.2 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

7.7 Financial Reporting

7.7.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7.7.3 The Audit Committee shall review the Annual Report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
8. **Reporting**

8.1 The minutes of the Audit Committee meetings shall be formally recorded by the Director of Corporate Governance and submitted to the Board. The Chair of the Committee shall, in summarising the recent work of the Committee, draw to the attention of the Board any material issues that require disclosure to the full Board, or require executive action.

8.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts.

8.3 As well as an annual report, a self assessment of the Committee’s effectiveness will take place annually.

8.4 The Committee shall be supported by the Director of Corporate Governance whose duties in this respect will include:

- Agreement of agendas with Chair and attendees and collation of papers
- Ensuring minutes are taken at the meeting and ensuring a record is kept of matters arising and issues to be carried forward
- Advising the Committee on pertinent issues/ areas
- Enabling the development and training of Committee members

9. **Review**

The Terms of Reference will be reviewed annually.
1. Constitution

1.1 The Trust Board resolves to establish a Committee of the Board to be known as the Workforce Committee. As a Committee of the Trust Board, the Standing Orders of the Trust shall apply to the conduct of the working of the Workforce Committee.

2. Membership

2.1 The Committee shall be appointed by the Chair of the Trust and shall comprise the following:

- 2 Non Executive Directors
- Workforce Director
- Communications Director
- Chief Nurse
- Deputy Finance Director
- Chief Operating Officer

2.2 The Committee will be chaired by Workforce Director, appointed by the chair of the Trust Board.

3. Attendance

3.1 Director of Business and Enterprise, Finance Director and Medical Director shall also be required to attend some meetings, at the request of the Chair. If unable to attend a meeting, the Directors/Head of Department may be represented by a nominated deputy, but this must be agreed before the meeting with the Committee Chair. It is expected that a member or their nominated deputy will normally attend for a minimum of 80% of meetings in a year.

3.2 All other members of the Trust Board shall be entitled to attend and receive papers to be considered by the Committee, as agreed with the Committee Chair.

3.3 Other managers/staff (including Staff Side chair) may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chair. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chair.

3.4 The Workforce Director’s Executive Assistant will ensure that an efficient secretariat service is provided to the Committee. Namely:

- that Directors are aware fully of their responsibilities in the delivery of reports in sufficient time to allow meeting papers to be circulated within the defined timescales.
- that Directors are reminded that papers not circulated in time may not be considered at the meeting.
- To manage the action summary and matters arising to ensure their timely follow through.
4. Quorum

4.1 A quorum shall be 3 members comprising at least one Non-Executive Director.

5. Frequency of meetings

5.1 The Committee will normally meet bi monthly and not less than 5 times per year. The Agenda will be circulated with papers at least 5 working days before the meeting. The agenda will be approved by the Committee Chair prior to circulation. Requests for non-routine agenda items are to be forwarded to the Committee Chair normally at least 10 working days prior to the meeting.

5.2 Members will normally be expected to attend at least 80% of the meetings in the year.

5.3 Additional meetings may be held at the discretion of the Chair of the Committee.

6. Authority

6.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference and is expected to make recommendations to the full Trust Board. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

6.2 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice, and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Trust Board is required.

6.3 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

7. Duties and responsibilities

The Workforce Committee shall undertake on behalf of the Trust Board to seek assurance to the Board on the development, implementation and effectiveness of people related strategies including workforce, organisational development, staff wellbeing, staff engagement and communication in line with best practice to support the Trust's strategy.

In particular the Workforce Committee will assure the Board of the achievement of the key organisational objective relating to Workforce.

8. Reporting

8.1 The Workforce Committee reports to the Trust Board.

8.2 The Workforce Committee will receive and review proposals and recommendations from Education Committee, Clinical Centres, Trust Negotiation and Consultation Committee, Local Negotiation Committee and Clinical forums such as Nursing and Midwifery Forum.
8.3 The Committee will routinely receive the following reports:

- Progress on the Trusts Workforce Strategy
- Progress on the Trusts Organisational Development Strategy
- Regular Workforce Reports including Statutory and Mandatory training statistics
- Workforce Plans
- Staff Survey and action plans
- Staff Engagement reports
- Organisational Development updates
- Progress on the Trust’s Communication and Engagement Strategy in relation to internal / staff communication
- Progress on agreed Communication and Engagement Plans, including NHS Foundation Trust staff membership, communication and engagement

8.4 The Committee Chair will report formally to the next Trust Board meeting on all matters within its duties and responsibilities.

8.5 The Committee will make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed, or where it has significant concerns.

8.6 The draft Minutes shall be recorded and circulated to Committee members within 5 working days of the meeting and presented at the next Trust Board meeting for information.

9. Review

9.1 The Terms of Reference of the Committee shall be reviewed at least annually by the Trust Board.

Last Reviewed: 27th February 2013
Trust Board (Corporate Trustee)

Executive Directors Meeting

Tier 1
- Risk Committee
- Clinical Quality & Safety Committee
- Charitable Funds Committee
- Remuneration Committee
- Finance Committee
- Audit Committee
- Workforce Committee
- Hospital Executive Committee

Tier 2
- Health & Safety Committee
- Clinical Governance Executive
- Infection Control Committee
- Patient Engagement & Involvement Panel
- Clinical Audit Committee
- Capital Planning Group
- Financial Recovery Board
- Policy Approval Group
- Sustainable Development Meeting
- Information Governance Group
- Operational Performance Group
- IT Review Group

Tier 3
- Operational Risk Group
- Nursing & Midwifery Forum
- Medical Records Committee
- Local Safeguarding Committee
- Blood Transfusion Committee
- Resuscitation and Patient Deterioration Committee
- Drugs & Therapeutics Committee
- Research & Development Committee
- Safe Medication Practice Group
- Organ Donation Group
- Mortality Group
- Clinical Product Evaluation Committee

Care Group/Centre Governance Meetings

Tier 4

Key
- Includes NED member
**Membership – Trust Board and Committees (Tiers 1 & 2)**

**Trust Board**  (Monthly. Admin Barbara Graham)

- Mr P Latchford  Chair
- Mr H Darbhanga  Non Executive Director (NED)
- Dr R Hooper  Non Executive Director (NED)
- Mr D Jones  Non Executive Director (NED)
- Mrs D Leeding  Non Executive Director (NED)
- Dr S Walford  Non Executive Director (NED)
- Mr P Herring  Chief Executive (CEO)
- Mrs S Bloomfield  Acting Director of Nursing & Quality (ADNQ)
- Dr E Borman  Medical Director (MD)
- Mrs D Kadum  Chief Operating Officer (COO)
- Mr N Nisbet  Finance Director (FD)

*In attendance*
- Mrs J Clarke  Director of Corporate Governance/Company Secretary (DCG)
- Miss V Maher  Workforce Director (WD)
- Mr A Osborne  Communications Director (CD)
- Mrs D Vogler  Director of Business & Enterprise (DBE)

**Quoracy**  One ED (or deputy), one NED and one-third of Board

**Corporate Trustees meeting**  (At least twice per year. Admin Barbara Graham)

- Mr P Latchford  Chair
- Mr H Darbhanga  Non Executive Director (NED)
- Dr R Hooper  Non Executive Director (NED)
- Mr D Jones  Non Executive Director (NED)
- Mrs D Leeding  Non Executive Director (NED)
- Dr S Walford  Non Executive Director (NED)
- Mr P Herring  Chief Executive (CEO)
- Mrs S Bloomfield  Acting Director of Nursing & Quality (ADNQ)
- Dr E Borman  Medical Director (MD)
- Mrs D Kadum  Chief Operating Officer (COO)
- Mr N Nisbet  Finance Director (FD)

**Quoracy**  6 voting Board members or deputy, including one NED

**Risk Committee**  (Quarterly. Admin Sarah Mattey)

- Mr P Herring  Chief Executive (Chair)
- Mr H Darbhanga  Non-Executive Director (NED)
- Dr R Hooper  Non-Executive Director (NED)
- Mrs S Bloomfield  Acting Director of Nursing & Quality (ADNQ)
- Dr E Borman  Medical Director (MD)
- Mrs J Clarke  Director of Corporate Governance (DCG)
- Ms C Jowett  Head of Assurance
- Mrs D Kadum  Chief Operating Officer (COO)

**Quoracy**  4 members or deputy, including one NED

**Clinical Quality & Safety Committee**  (Monthly. Admin Bergitte McGovern)

- Dr S Walford  Non Executive Director (Chair)
- Mrs D Leeding  Non-Executive Director (NED)
- Mrs J Banks  Associate Director of Patient Safety
- Mr C Beacock  Deputy Medical Director
- Mrs S Bloomfield  Acting Director of Quality & Nursing (ADNQ)
- Dr E Borman  Medical Director (MD)
- Mr P Fewtrell  Quality Manager
- Mrs D Kadum  Chief Operating Officer (COO)

**Quoracy**  4 members or deputy including one NED
Charitable Funds Committee (Four times per year. Admin Amanda Young)

TBC
Dr R Hooper  
Non-Executive Director (NED)
Mr N Nisbet  
Finance Director (FD)
Quoracy  
One NED and FD or deputy

Remuneration Committee (Three times per year minimum. Admin Alison Kerr-Gold)

Prof P Latchford  
Chair of the Trust (Chair)
All NEDs
In attendance
Mr P Herring  
Chief Executive (CEO)
Miss V Maher  
Workforce Director (WD)
Quoracy  
4 NEDs

Finance Committee (Monthly. Admin Amanda Young)

Mr D Jones  
Non-Executive Director (Chair)
Mr H Darbhanga  
Non-Executive Director (NED)
Mr N Nisbet  
Finance Director (FD)
Quoracy  
One NED and FD or FD’s deputy plus COO

Audit Committee (Five times per year. Admin Marie Devitt)

Dr R Hooper  
Non-Executive Director (Chair)
Dr S Walford  
Non-Executive Director
TBC  
Non-Executive Director
In attendance
Mrs J Clarke  
Director of Corporate Governance (DCG)
Mr N Nisbet  
Finance Director (FD)
Mr M Owen  
Deloitte LLP
Mr A Bostock  
KPMG
Quoracy  
Two NEDs (and CEO annually)

Workforce Committee (Bi-monthly. Admin Alison Kerr-Gold)

Ms V Maher  
Workforce Director (Chair)
Mrs D Leeding  
Non-Executive Director (NED)
TBC  
Non-Executive Director
Mrs S Bloomfield  
Acting Director of Nursing & Quality (ADNQ)
Mr A Osborne  
Communications Director (CD)
Mrs J Price  
Deputy Finance Director
Quoracy  
Three members or deputy (including one NED)

Hospital Executive Committee (Monthly. Admin Barrie Reis-Seymour)

Mr P Herring  
Chief Executive (Chair)
Mrs S Biffen  
Assistant Chief Operating Officer (Scheduled Care Group)
Mrs S Bloomfield  
Acting Director Nursing & Quality (ADNQ)
Dr E Borman  
Medical Director (MD)
Mr M Cheetham  
Care Group Medical Director (Scheduled Care Group)
Mrs J Clarke  
Director of Corporate Governance (DCG)
Mr I Donnelly  
Assistant Chief Operating Officer (Unscheduled Care Group)
Dr K Eardley  
Care Group Medical Director (Unscheduled Care Group)
Dr D Hinwood  
Care Group Medical Director (Radiology)
Mrs S Kadum  
Chief Operating Officer
Mrs D Lloyd  
Care Group Director (Therapies)
Miss V Maher  
Workforce Director
Prof A Malcolm  
Care Group Medical Director (Pathology)
Mr B McElroy  
Care Group Director (Pharmacy)
Mr C Needham  
Associate Director of Estates and Facilities Management
Mr N Nisbet  
Finance Director
Mr A Osborne  
Communications Director
Cathy Smith  
Care Group Director (Women & Children Care Group)
Andrew Tapp  
Care Group Medical Director (Women & Children Care Group)
Debbie Vogler  
Director of Business & Enterprise
Quoracy  
3 Directors and 3 Care Group Directors (or deputies)
### Executive Summary

1) **Declarations of Interest** - The Code of Accountability requires Board members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any changes should be notified to the Committee Secretary. An up-to-date list of declarations is attached (Attachment 1).

2) **Common Sealing of Documents** - Update on the use of the Trust’s Common Seal since the last update to the Board in April 2013 for the period 31 March to 13 November 2013, pursuant to s9 Standing Orders “Custody of Seal and Sealing of Documents”. (Attachment 2).

### Strategic Priorities

- **Quality and Safety**
- **Healthcare Standards**
- **People and Innovation**
- **Community and Partnership**
- **Financial Strength**

### Operational Objectives

- **FS1** Deliver our milestones to achieve FT status

### Board Assurance Framework (BAF) Risks

- Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience
- Implement our falls prevention strategy to help prevent patients suffering serious injury
- Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards
- Clear Clinical Service Vision or we may not deliver the best services to patients
- Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve
- Appoint Board members in a timely way or may impact on the governance of the Trust
- Achieve a Financial Risk Rating of 3 to be authorised as an FT

### Care Quality Commission (CQC) Domains

- Safe
- Effective
- Caring
- Responsive
- Well led

### Actions

- **Receive**
- **Review**
- **Note**
- **Approve**

To CONFIRM that the Declarations listed overleaf are correct or alternatively declare any further additions or deletions and to ADVISE the Committee Secretary immediately of any changes.

Also to NOTE the Common Sealing of Documents as listed.
## DECLARATIONS OF INTEREST

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professor Peter Latchford</strong></td>
<td>• Director and shareholder in Spark UK Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Black Radley Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Black Radley Culture Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Black Radley Systems Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Black Radley Insight Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Sophie Coker Ltd</td>
</tr>
<tr>
<td></td>
<td>• Trustee of the LankellyChase Foundation</td>
</tr>
<tr>
<td></td>
<td>• Visiting Professor at Birmingham City University</td>
</tr>
<tr>
<td><strong>Mr Dennis Jones</strong></td>
<td>• None</td>
</tr>
<tr>
<td><strong>Dr Simon Walford</strong></td>
<td>• Trustee, Wolverhampton Grammar School Ltd</td>
</tr>
<tr>
<td></td>
<td>• Governor, University of Wolverhampton</td>
</tr>
<tr>
<td></td>
<td>• Director, Wolverhampton Academies Trust</td>
</tr>
<tr>
<td></td>
<td>• In receipt of an NHS Pension</td>
</tr>
<tr>
<td><strong>Dr Robin Hooper</strong></td>
<td>• Director of Verity House Limited</td>
</tr>
<tr>
<td></td>
<td>• Director of Holy Cross Limited</td>
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<tr>
<td></td>
<td>• Director of Enterprise Prospects Limited</td>
</tr>
<tr>
<td></td>
<td>• Director of Global Enterprise Solutions Limited</td>
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<tr>
<td></td>
<td>• Director of Hooper Burrowes Legal</td>
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<td></td>
<td>• Director of Sports Booker Limited</td>
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<tr>
<td></td>
<td>• Director of Acton Mill Care Farm Limited</td>
</tr>
<tr>
<td><strong>Mrs Donna Leeding</strong></td>
<td>• None</td>
</tr>
<tr>
<td><strong>Mr Harmesh Darbhanga</strong></td>
<td>• Trustee – Shropshire Community Council</td>
</tr>
<tr>
<td></td>
<td>• Director – Priory School an Academy Trust</td>
</tr>
<tr>
<td><strong>Mr Peter Herring (CEO)</strong></td>
<td>• Board Member of the Foundation Trust Network</td>
</tr>
<tr>
<td><strong>Mrs Sarah Bloomfield (ADQN)</strong></td>
<td>• None</td>
</tr>
<tr>
<td><strong>Mr Neil Nisbet (FD)</strong></td>
<td>• Trustee, Citizens Advice Bureau, Wolverhampton</td>
</tr>
<tr>
<td><strong>Mrs Debbie Kadum (COO)</strong></td>
<td>• None</td>
</tr>
<tr>
<td><strong>Dr Edwin Borman (MD)</strong></td>
<td>• Secretary General, European Union of Medical Specialists</td>
</tr>
<tr>
<td></td>
<td>• Ordinary Shareholder, F &amp; C Asset Management</td>
</tr>
</tbody>
</table>
The following sealings have taken place since the last report submitted to Trust Board in April 2013:

<table>
<thead>
<tr>
<th>Seal No.</th>
<th>Title of Document</th>
<th>Date of Sealing</th>
<th>Signed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>Grant Agreement between Lingen Davies Cancer Relief Fund (1) and SaTH NHS Trust (2) in respect of funding for provision of 3rd GI Cancer Diagnosis Room at PRH.</td>
<td>17 April 2013</td>
<td>P Herring, N Nisbet</td>
</tr>
<tr>
<td>70</td>
<td>Deed of Variation between (1) Shropshire Council (2) SaTH NHS Trust and (3) Secretary of State for health pursuant to s106 and s106A Town &amp; Country Planning Act 1990 relating to land at RSH.</td>
<td>25 June 2013</td>
<td>P Herring, N Nisbet</td>
</tr>
</tbody>
</table>
### Executive Summary

**Emergency Preparedness**

The NHS needs to be able to plan 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 outbreak or a major transport accident. Under the Civil Contingencies Act 2004, NHS organisations must show they can deal with these incidents while maintaining services to patients. This work is referred to as emergency preparedness, resilience and response (EPRR).

A revised model for EPRR was introduced in 2013, with accountability passing from statutory authorities (SHA and PCT clusters) to the NHS Commissioning Board (NHS England), Public Health England and Local Authorities.

120 new core standards for EPRR for Acute Trusts were introduced, which are the minimum standards which NHS organisations **must** meet. The accountable Emergency Planning Officer (the Director with responsibility for EPRR – at SaTH this is the Chief Operating Officer, is responsible for making sure the standards are met and that SaTH contributes to area planning through local health resilience partnerships (LHRPs) and other relevant groups.

In October 2013 a self assessment against the standards was undertaken. This showed 81 green-rated standards, 39 amber-rated standards and 0 red-rated standards.

All relevant documentation can be found in the Board member's electronic information pack and on the Trust website.

There will also be quarterly updates presented to the executive team.

The Trust is required to share the organisation's current state of compliance against the core standards with the Board for sign off.

### Strategic Priorities

- [x] Quality and Safety
- [x] Healthcare Standards
- [x] People and Innovation
- [ ] Community and Partnership
- [ ] Financial Strength

### Operational Objectives

- QS1 Reduce avoidable deaths
- HS3 Deliver all Key Performance Targets
- P14 Build Leadership and Management capability
<table>
<thead>
<tr>
<th>Board Assurance Framework (BAF) Risks</th>
<th>☑ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Implement our falls prevention strategy to help prevent patients suffering serious injury</td>
</tr>
<tr>
<td></td>
<td>☐ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards</td>
</tr>
<tr>
<td></td>
<td>☐ Clear Clinical Service Vision or we may not deliver the best services to patients</td>
</tr>
<tr>
<td></td>
<td>☐ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve</td>
</tr>
<tr>
<td></td>
<td>☐ Appoint Board members in a timely way or may impact on the governance of the Trust</td>
</tr>
<tr>
<td></td>
<td>☐ Achieve a Financial Risk Rating of 3 to be authorised as an FT</td>
</tr>
<tr>
<td>Care Quality Commission (CQC) Domains</td>
<td>☑ Safe</td>
</tr>
<tr>
<td></td>
<td>☐ Effective</td>
</tr>
<tr>
<td></td>
<td>☐ Caring</td>
</tr>
<tr>
<td></td>
<td>☐ Responsive</td>
</tr>
<tr>
<td></td>
<td>☐ Well led</td>
</tr>
</tbody>
</table>

**Recommendation**

The Board is asked to sign off the Trust’s current status of compliance against the core standards.
Emergency Preparedness Summary  
November 2013

Background

2012/13 was a year of major change to the Emergency Preparedness agenda for all NHS Trusts. The Health and Social Care Act created new commissioning structures and saw the introduction of Clinical Commissioning Groups (CCGs) and the NHS National Commissioning Board (NHS England).

The introduction of NHS Core Standards for Emergency Preparedness and Response (EPRR) requires Acute Trusts to be Compliant with 120 of the new core standards.

The changes also saw the introduction of a legally accountable Emergency Planning Officer for each NHS Trust.

The Trust is a category 1 responder under the Civil Contingency Act 2004. The Enhancement programme 2010 – 2012 also increased the responsibilities of category 1 responders, which are contained within the new plans.

Trust Current position

The Trust’s Accountable Emergency Planning Officer (the Chief Operating Officer) was required to submit a compliance statement to the Commissioning Board, using the Red, Amber, Green risk assessment process, in October 2013.

The results were 81 green rated standards, 39 amber rated standards and no red rated standards.

The key to the RAG ratings are as follows:

**RED** – Arrangements not in place or scheduled for completion;

**AMBER** – Draft or scheduled on action plan for completion;

**GREEN** – Arrangements in place now and compliant with core standards.

Of the amber risks the one to bring to the attention of the Board is the requirement to have sustainable plans that set out how the Trust will maintain business continuity. Plans exist at a high level but more work is needed at a local departmental level. This is an area for development for all NHS organisations.

In addition to the above compliance submission, an implementation plan for achievement against non-compliant standards was also required and submitted.
Next steps

A baseline assessment of all non compliant standards will be done by the end of January 2014 and an action plan put in place for the delivery for each quarter of 2014.

A quarterly position statement will be submitted to HEC for information at the end of each quarter.

Training Programme

A training programme has been written by the Emergency Planning and Resilience Manager and will be delivered in 2014 continuing into 2014/15.

Recommendation

The Board is asked to sign off the Trust’s current status of compliance against the core standards.
<table>
<thead>
<tr>
<th>CORE STANDARD NUMBER</th>
<th>ACTIONS</th>
<th>RESPONSIBILITY</th>
<th>TARGET DATE</th>
<th>REMEDIAL ACTION WHERE NECESSARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2 Be based on risk-assessed worst-case scenarios;</td>
<td>Table top exercise with Directors and Senior Managers</td>
<td>Keith Lister</td>
<td>Jan-14</td>
<td></td>
</tr>
<tr>
<td>5.19 Set out how the plan will be published – for example, on a website;</td>
<td>Updated plan to be placed on the Intranet. Non Operational version to go on Intranet</td>
<td>Keith Lister</td>
<td>Jan-14</td>
<td></td>
</tr>
<tr>
<td>5.20 Include an audit trail to record changes and updates</td>
<td>Plans reviewed annually, current placed to be validated and tested.</td>
<td>Keith Lister</td>
<td>Validation and testing to be completed as soon as possible after Board approval</td>
<td></td>
</tr>
<tr>
<td>5.21 Explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and</td>
<td>T Penny has set up codes which are awaiting approval</td>
<td>Keith Lister</td>
<td>Nov-13</td>
<td></td>
</tr>
<tr>
<td>5.22 Demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.</td>
<td>All plans Risk assessed and will be reviewed every 12 months. Urgent plans for review are: Flu Pandemic Plan and Mass Casualty Plan</td>
<td>Keith Lister</td>
<td>Rolling Programme - Flu Pandemic and Mass Casualty by end Nov 13</td>
<td></td>
</tr>
<tr>
<td>5.23 Key staff must know where to find the plan on the intranet or shared drive.</td>
<td>New plan to go on Intranet and shared drive when approved by Trust Board</td>
<td>Keith Lister</td>
<td>As soon as possible after Board approval</td>
<td></td>
</tr>
<tr>
<td>5.24 There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.</td>
<td>Plan written; needs to be implemented in 2013/2014</td>
<td>Keith Lister</td>
<td>Mar 14 with rolling programme into 2014/2015</td>
<td></td>
</tr>
<tr>
<td>5.25 Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rota must meet NHS published competencies.</td>
<td>Waiting for Local Area Team (LAT) to agree who can deliver (SLICK) training</td>
<td>Keith Lister</td>
<td>As soon as possible after Board approval</td>
<td></td>
</tr>
<tr>
<td>5.26 It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).</td>
<td>Currently delivering standard training package. E-learning to be developed over next 12 months.</td>
<td>Keith Lister</td>
<td>Quarterly Review with completion by Oct 2014</td>
<td></td>
</tr>
<tr>
<td>5.27</td>
<td>It must be clear how key staff can achieve and maintain suitable knowledge and skills.</td>
<td>Training Scheduled, Training materials and Training records</td>
<td>Keith Lister</td>
<td>Oct-14</td>
</tr>
<tr>
<td>5.36</td>
<td>Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.</td>
<td>Programme of loggist training</td>
<td>Keith Lister</td>
<td>Quarterly Reviews with completion by Oct 2014</td>
</tr>
<tr>
<td>5.44</td>
<td>Consider using help lines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.</td>
<td>Help lines agreed with Paul Corbett. Written process needs to be in place.</td>
<td>Keith Lister</td>
<td>Dec-13</td>
</tr>
<tr>
<td>5.47</td>
<td>Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.</td>
<td>Looking at previous VIP visits and developing VIP plan with WMAS in line with Royal Family protocols.</td>
<td>Keith Lister</td>
<td>Jan-14</td>
</tr>
<tr>
<td>5.54</td>
<td>Mass casualty incidents;</td>
<td>Mass casualties currently covered in MIP. Developing stand alone plan.</td>
<td>Keith Lister</td>
<td>Nov-13</td>
</tr>
<tr>
<td>6.1</td>
<td>There must be a plan setting out how the ICC will operate.</td>
<td>Interim ICC measures in the plan due to reconfiguration of Trust.</td>
<td>Keith Lister</td>
<td>As soon as possible after Board approval</td>
</tr>
<tr>
<td>6.2</td>
<td>There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).</td>
<td>Interim measures identified in MIP</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
</tr>
<tr>
<td>6.4</td>
<td>Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.</td>
<td>Interim measures identified, equipment and facilities will be commandeered from other areas as required.</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
</tr>
<tr>
<td>Paragraph</td>
<td>Implementation</td>
<td>Responsible Party</td>
<td>Review Date</td>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>7. All NHS organisations and providers of NHS-funded care must develop,</td>
<td>Trust currently running pilot in line with ISO22301 formally BS25999. This</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
<td></td>
</tr>
<tr>
<td>maintain and continually improve their business continuity management</td>
<td>will be used as model plan to improve plans across the Trust.</td>
<td></td>
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<tr>
<td>systems. This means having suitable plans which set out how each</td>
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<td>organisation will maintain continuity in its services during a</td>
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<tr>
<td>disruption from identified local risks and how they will recover</td>
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<tr>
<td>delivery of key services in line with ISO22301.</td>
<td></td>
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</tr>
<tr>
<td>7.2 set out how finances and unexpected spending will be covered, and</td>
<td>T Penny has set up codes which are awaiting approval</td>
<td>Keith Lister</td>
<td>Nov-13</td>
<td></td>
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<tr>
<td>how unique cost centres and budget codes can be made available to track</td>
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<tr>
<td>costs;</td>
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</tr>
<tr>
<td>7.3 develop business continuity strategies for continuing and recovering</td>
<td>All service area plans cover critical activities and maximum tolerable</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
<td></td>
</tr>
<tr>
<td>critical activities within agreed timescales, including the resources</td>
<td>downtime. This work is under development and need to be reviewed by the</td>
<td></td>
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<tr>
<td>required such as people, premises, ICT, information, utilities,</td>
<td>Business Continuity Group as plans are completed.</td>
<td></td>
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<tr>
<td>equipment, suppliers and stakeholders.</td>
<td></td>
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</tr>
<tr>
<td>7.4 develop, use and maintain business continuity plans to manage</td>
<td>All service area plans cover critical activities and maximum tolerable</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
<td></td>
</tr>
<tr>
<td>disruptions and significant incidents based on recovery time objectives</td>
<td>downtime. This work is under development and need to be reviewed by the</td>
<td></td>
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</tr>
<tr>
<td>and timescales identified in the business impact analysis</td>
<td>Business Continuity Group as plans are completed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.5 Each organisation’s BCMS must be based on its legal</td>
<td>Plans developing in line with civil contingencies regulations and ISO22301</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
<td></td>
</tr>
<tr>
<td>responsibilities, internal and external issues that could affect service</td>
<td></td>
<td></td>
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<tr>
<td>delivery and the needs and expectations of interested parties.</td>
<td></td>
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<tr>
<td>7.7 Organisations must make clear how their plan will be published,</td>
<td>Non operational plan will be placed on the Internet and operational internal</td>
<td>Keith Lister</td>
<td>Jan-14</td>
<td></td>
</tr>
<tr>
<td>for example on a website.</td>
<td>plan on the Intranet</td>
<td></td>
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</tr>
<tr>
<td>7.10 The planning process must take into account nationally available</td>
<td>Using ISO22301 as good practice.</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
<td></td>
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<tr>
<td>toolkits that are seen as good practice.</td>
<td></td>
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<tr>
<td>7.11 Organisations must identify and manage internal and external</td>
<td>Risk assessment continuously taking place throughout the Trust to further</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
<td></td>
</tr>
<tr>
<td>risks and opportunities relating to the continuity of their operations.</td>
<td>develop plans.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7.12 Plans must be maintained based on risk-assessed worst-case</td>
<td>Critical activity risks are assessed in all Business Continuity Plans and</td>
<td>Keith Lister</td>
<td>Quarterly Review with report to Trust Board</td>
<td></td>
</tr>
<tr>
<td>scenarios.</td>
<td>reviewed after an incident or annually. This work is under development.</td>
<td></td>
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</tbody>
</table>
## 7.13 Risk assessments must 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).

MIP Annex has links to community risk register, and uses the community risk register assessments. Internal plans 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). Business Continuity Plans are still developing with continuous reviews.

### Keith Lister
Quarterly Review with report to Trust Board

## 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.

Risk assessments are conducted in Business Continuity Plans and where possible reduction of risk takes place in the plans. Work to be developed on connection with Business Continuity risk and Corporate Risk Register.

### Keith Lister
Quarterly Review with report to Trust Board

## 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 must be published on external websites and through other information-sharing media.

Communications cascade in MIP. Warning messages will be put out through the Communications Team for both internal and external messages. Plans to go on the Intranet and Internet after Trust Board approval.

### Keith Lister
As soon as possible after Board approval

## 7.18 Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;

Alerting arrangements in plan. Work ongoing, looking at text messages and other forms of alert.

### Keith Lister
Mar-14

## 7.24 Where the incident or emergency will be managed from (the ICC);

The Trust currently has Control rooms, but more work needed to have formal ICC. Interim measures in place.

### Keith Lister
Quarterly Review with report to Trust Board

## 7.35 Details of a surge plan to maintain critical services.

MIP and Escalation Plan, more work required to connect the two plans.

### Keith Lister
Mar-14

## 7.40 Details of the training provided to staff and how the training record is maintained;

New training programme developed for delivery in 2013/2014 - rolling over into 2014/2015

### Keith Lister
2013/2014 with rolling programme into 2014/2015
<table>
<thead>
<tr>
<th>7.41 Reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);</th>
<th>Awaiting confirmation from Commissioning Board Area Team.</th>
<th>Keith Lister</th>
<th>As soon as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.42 Details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and</td>
<td>Currently delivering standard training package. E-learning to be developed over next 12 months.</td>
<td>Keith Lister</td>
<td>Quarterly Review with completion by Oct 2014</td>
</tr>
<tr>
<td>7.43 Details of how suitable knowledge and skills will be achieved and maintained.</td>
<td>Training Scheduled, Training materials and Training records</td>
<td>Keith Lister</td>
<td>Oct-14</td>
</tr>
<tr>
<td>8.1 Detailed lockdown procedures;</td>
<td>Lockdown plans for ED's. Plans under development for the remainder of the hospital</td>
<td>Keith Lister</td>
<td>Quarterly Review</td>
</tr>
<tr>
<td>8.2 Detailed evacuation procedures;</td>
<td>Fire evacuation plans in place but require rigorous testing.</td>
<td>Keith Lister</td>
<td>Every 6 months</td>
</tr>
</tbody>
</table>
## NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requirements</th>
<th>Assured</th>
<th>Nominated</th>
<th>Core</th>
<th>Interim</th>
<th>Suggested Minimum Level of Evidence to be submitted to review group</th>
<th>Self Assessment</th>
<th>Review Team Comment</th>
<th>Review Team Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>概念股 in overall integrated risk register</td>
<td>☒ ☒ ☒ ☒ ☒</td>
<td>☒ ☒ ☒ ☒ ☒</td>
<td>☒ ☒ ☒ ☒ ☒</td>
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<td>Director level representation at the LHRP; and</td>
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<td>All NHS organisations and providers of NHS funded care must ensure that the NHS Risk Register (CRR) is agreed at the local risk register level by the local planning forum.</td>
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<td>Incident/Incident Response Plan and Emergency and Business Continuity Plan</td>
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have been written in collaboration with all relevant partner organisations;  

have been written in collaboration with NHPI;  

have been written with all trusts, partners and key stakeholders and others involved in the development of the CCA.  

[5.15] It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education or training plans).  

[5.26] Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.  

[5.30] It must be clear how key staff can achieve and maintain suitable knowledge and skills.

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### NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)

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<th>Recommendation</th>
<th>Self Assessment</th>
<th>Review Team Assessment</th>
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<tr>
<td>5.30</td>
<td>Set out the responsibilities of the appropriate Sector Responsiblities Officer or nominated Executive Director</td>
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<td>5.34</td>
<td>Ensure that mutual arrangements will be activated and maintained</td>
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<td>5.35</td>
<td>Identify where the incident or emergency will be managed from (ECCs)</td>
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<td>5.36</td>
<td>Outline the role of the incident controller and create roles and responsibilities for all staff involved</td>
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<td>5.37</td>
<td>Best Practice: Use an electronic database system to record the decisions made.</td>
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<td>5.38</td>
<td>Best Practice: Use the National Resilience Extranet.</td>
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<td>5.39</td>
<td>Refer to specific action cards relating to the incident response plan</td>
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<td>5.40</td>
<td>Explain the process for completing and submitting NHS standard three-specific situation reports and how other relevant information will be shared with other organisations</td>
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<td>5.41</td>
<td>Ensure that extended working hours will apply and how they can be sustained</td>
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<td>5.42</td>
<td>Explain how to communicate with partners, the public and internal staff and on social media.</td>
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<td>5.43</td>
<td>Have agreements in place with local NHS organisations so they know how they can help with an incident</td>
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<td>5.44</td>
<td>Consider upstream advice in an emergency. Set up procedures in advance which explain the arrangements. Make sure language links are part of these arrangements</td>
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<td>5.45</td>
<td>Describe how stores and supplies will be maintained.</td>
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<td>5.46</td>
<td>Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain religions</td>
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<td>5.47</td>
<td>Explain the process of recovery and returning to normal processes.</td>
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<td>5.48</td>
<td>Explain the de-briefing process and the role and accountability of all local and national staff</td>
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<td>5.49</td>
<td>Explain how missing patients will be managed during an incident including locating and traced health services</td>
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<td>5.50</td>
<td>Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.</td>
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<td>Explain how the surge in demand will be managed.</td>
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<td>5.52</td>
<td>Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.</td>
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<td>Pandemic flu</td>
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<td>5.56</td>
<td>Patients with burns requiring critical care, and</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>5.57</td>
<td>Severe weather</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
</tbody>
</table>

**Suggested Minimum Level of Evidence to be submitted to review group:**

- Page references in IRP, answers to plans or evidence bases
- Specific Action cards

**Commentary/References to Evidence Supplied:**

- Responsibilities detailed in Major Incident Plan Action cards
- Through the normal escalation outside the Trust through the chain of command
- Local CCG response plan and LADM to be considered
- NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)

**Self Assessment:**

- Incident response plan has Action cards and the limitations of action cards are detailed
- Will submit SITREPs as required
- MAJOR ACTIONS unless organisation provides evidence
- NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)
- We have hard copy and Electronic decision Logs and messages

**Review Team Assessment:**

- Will submit SITREPs as required
- MAJOR ACTIONS unless organisation provides evidence
- NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)
- We have hard copy and Electronic decision Logs and messages

**Review Team Comment:**

- The trust has Purchased the NHE and are currently implementing to use
- Incident response plan has Actions cards, and the limitations of action cards are detailed
- Will submit SITREPs as required
- MAJOR ACTIONS unless organisation provides evidence
- NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)
- We have hard copy and Electronic decision Logs and messages

**References to Evidence Supplied:**

- NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)
- NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)
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The planning process must take into account nationally available toolkits that are seen as good practice. All areas of trust looking at and assessing Risks. Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be developed, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery. They must identify all critical activities using a business impact analysis. This must set out the effect business disruption and the actual risks of disruption. Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: severe weather (including snow, flood, prolonged periods of cold weather and flooding); IT and communications; staff absence (including industrial action); severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); and associated risks in the surrounding area (e.g. COMAH and iconic sites). Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: severe weather (including snow, flood, prolonged periods of cold weather and flooding); IT and communications; staff absence (including industrial action); severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); and associated risks in the surrounding area (e.g. COMAH and iconic sites). 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<table>
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<th>NHS Core Standards for Emergency Preparedness, Resilience &amp; Response (EPRR)</th>
<th>Action</th>
<th>Suggested Minimum Level of Evidence to be submitted to review group</th>
<th>Commentary/References to Evidence Supplied</th>
<th>Self Assessment 1</th>
<th>Review Team Comment</th>
<th>Review Team Assessment 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.24</td>
<td>Where the incident or emergency will be managed from (the ICC)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7.25</td>
<td>How the independent healthcare sector may help if required, and</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7.26</td>
<td>Reference to the National Ambulance Service Command and Control Guidance 2012 and any other relevant ambulance specific</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7.27</td>
<td>Business continuity plans must describe the effects of any disruption and how they can be managed.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7.28</td>
<td>Alternative locations for the business.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.29</td>
<td>Recovery and restoration processes and how they will be set up following an incident.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.30</td>
<td>Recovery and restoration processes and how they will be set up following an incident.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7.31</td>
<td>How the organization will respond to the media following a significant incident, in line with the formal communications strategy;</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.32</td>
<td>How staff will be accommodated overnight if necessary.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.33</td>
<td>How staff will be accommodated overnight if necessary.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.34</td>
<td>How stores and supplies will be managed and maintained;</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.35</td>
<td>Details of all plans to maintain critical services</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.36</td>
<td>Business continuity plans must specify how they will be communicated to and accessed by staff.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.37</td>
<td>Business Continuity strategies developed in response to problems identified</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>7.38</td>
<td>Business Continuity strategies developed in response to problems identified</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7.39</td>
<td>Inadequate plans or BC strategies</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>S.</td>
<td>Core Standard</td>
<td>Evidence Supplied</td>
<td>Comments</td>
<td>Self-Assessment 1</td>
<td>Review Team Assessment 1</td>
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</tr>
<tr>
<td>6.2</td>
<td>Manage up to four incidents at a time in urban areas and two in rural areas.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.3</td>
<td>Have tactical and team arrangements so that they can operate more than one control centre and manage any incident required.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.4</td>
<td>Have formal arrangements for recalling staff to duty if necessary.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.5</td>
<td>Be able to provide a forward control team if necessary.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.6</td>
<td>Have an on-call and an on-duty logbook drawn from a wide pool of staff.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.7</td>
<td>Have arrangements to communicate with and control resources from other ambulance providers.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.8</td>
<td>Have a 24-hour radiation protection supervisor in place.</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>6.9</td>
<td>Have suitable IT arrangements in place to support a significant incident or any event that requires specialisation IT.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.10</td>
<td>Establish and maintain a continuous personal development portfolio.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.11</td>
<td>Have a mobile Telemedicine Network (TMN) in place with the national remote service specification.</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>6.12</td>
<td>Have systems to manage at Emergency Operational Centres, fault back locations and across the organisation.</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>6.13</td>
<td>Have arrangements in place for routine public events, for example, demonstrations and public gatherings.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.14</td>
<td>Have arrangements in place to deal with public disorder incidents.</td>
<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6.15</td>
<td>Be able to identify the location and availability of assets across the organisation and the country.</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>6.16</td>
<td>Be able to respond to incidents in line with the decision rules and decision support tools that have been established.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.17</td>
<td>Be able to instigate and manage incident specific arrangements.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.18</td>
<td>Be able to instigate and manage incident specific arrangements.</td>
<td>X</td>
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<tr>
<td>6.19</td>
<td>Have a trigger mechanism for requesting mutual aid and a nominated person to agree to these requests, supported by a clear profile of what is required; what can be provided and how the response will be managed in the field.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.20</td>
<td>Have arrangements in place for training and exercising arrangements.</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>6.21</td>
<td>Have arrangements in place to train and manage future training for incident control team members.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.22</td>
<td>Have arrangements in place to provide radiation protection training.</td>
<td>X</td>
<td></td>
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<tr>
<td>6.23</td>
<td>Have arrangements in place to train voluntary and community first responders.</td>
<td>X</td>
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<tr>
<td>6.24</td>
<td>Have arrangements in place to provide training and exercising arrangements.</td>
<td>X</td>
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<tr>
<td>6.25</td>
<td>Have arrangements in place to provide training and exercising arrangements.</td>
<td>X</td>
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<tr>
<td>6.26</td>
<td>Have arrangements in place to train and manage future training for incident control team members.</td>
<td>X</td>
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<tr>
<td>6.28</td>
<td>Have arrangements in place to train and manage future training for incident control team members.</td>
<td>X</td>
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<tr>
<td>6.29</td>
<td>Have arrangements in place to manage up to four incidents at a time in urban areas and two in rural areas.</td>
<td>X</td>
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<tr>
<td>6.30</td>
<td>Have arrangements in place to manage up to four incidents at a time in urban areas and two in rural areas.</td>
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<td>6.31</td>
<td>Have arrangements in place to manage up to four incidents at a time in urban areas and two in rural areas.</td>
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<td>6.33</td>
<td>Have arrangements in place to manage up to four incidents at a time in urban areas and two in rural areas.</td>
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<tr>
<td>6.36</td>
<td>Have arrangements in place to manage up to four incidents at a time in urban areas and two in rural areas.</td>
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</tr>
<tr>
<td>6.37</td>
<td>Have arrangements in place to manage up to four incidents at a time in urban areas and two in rural areas.</td>
<td>X</td>
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</table>

NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)
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<th>Review Team Assessment 1</th>
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<tr>
<td>9.38</td>
<td>explain the arrangements for managing triage, treatment and transport for casualties;</td>
<td>- X - - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.39</td>
<td>state who will represent the service at LHRP, LRF and similar groups;</td>
<td>- X - - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.40</td>
<td>explain the roles of the Hospital Ambulance Liaison Officer (HALO) and Hospital Ambulance Liaison Control Officer (HALCOC) in acute trusts;</td>
<td>- X - - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
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<tr>
<td>9.41</td>
<td>refer to other relevant plans such as REAP;</td>
<td>- X - - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.42</td>
<td>explain how the Mobile Privileged Access Scheme (MTPAS) and Fixed Telecommunications Privileged Access Scheme (FTPAS) will be provided during the organisation’s day</td>
<td>X X - - - X X X</td>
<td></td>
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</tr>
<tr>
<td>9.43</td>
<td>provide evidence that arrangements for escalation within the organisation and how NHS groups will be used to communicate with the emergency services;</td>
<td>- - - - - -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>NHS England local teams;</td>
<td>- - X - - -</td>
<td>Evidence from LHRP - statement to CCG commissioners that plans of healthcare providers in LRF boundary are coordinated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.1</td>
<td>make sure that the incident response plans for all providers in an LRF are co-ordinated and compatible;</td>
<td>- X - - -</td>
<td>Distribution processes for BIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.2</td>
<td>define when the NHS will take the leading role in a significant incident or emergency;</td>
<td>- - - - -</td>
<td>Peer assessment from other area teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.3</td>
<td>mobilise primary and secondary care resources to support acute and non-acute trusts;</td>
<td>- - X - X</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.4</td>
<td>undertake the arrangements for setting up a Science and Technical Advice Cell (STAC) in consultation with local Public Health England centres;</td>
<td>- - - X - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.5</td>
<td>identify who will attend the Strategic Co-ordination Group (SCG);</td>
<td>- X X - - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
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<tr>
<td>10.6</td>
<td>transparently demonstrate the command and control of resources from all NHS organisations and providers of NHS funded care within an LRF area to respond to a significant incident or emergency; and</td>
<td>X - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.7</td>
<td>define how links will be made between the NHS England, the Department of Health and PHE;</td>
<td>- - - X - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.8</td>
<td>define how plans which demonstrate the command and control of resources from all NHS organisations and providers of NHS funded care within an LRF area to respond to a significant incident or emergency; and</td>
<td>X - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
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</tr>
<tr>
<td>10.9</td>
<td>outline how GP services will be delivered 24 hours a day – either directly or through out-of-hours services;</td>
<td>- - - - - -</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11</td>
<td>NHS England corporate and regional offices;</td>
<td>- - X - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.1</td>
<td>assign an NHS England local area to each LHRP or LRF;</td>
<td>- - X - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.2</td>
<td>define how strategic EPRR advice and support will be given to these teams;</td>
<td>- - X - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.3</td>
<td>make sure that area team incident response plans in a region are co-ordinated and compatible;</td>
<td>- - X - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.4</td>
<td>outline the procedure for responding to incidents which affect two or more LRFs or LHRPs;</td>
<td>- - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.5</td>
<td>outline the procedure for responding to incidents which affect one or more LRFs;</td>
<td>- - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.6</td>
<td>make sure that the NHS is able to respond to emergencies will be measured and controlled;</td>
<td>- - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
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<td>Evidence from LHRP - statement to CCG</td>
<td></td>
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</tr>
<tr>
<td>11.8</td>
<td>outline how the Department of Health will be supported in its incident-response role;</td>
<td>- - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.9</td>
<td>outline how information relating to national emergencies will be co-ordinated and shared; and</td>
<td>- - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.10</td>
<td>establish a link between the Regional Prevent Coordinator in the NHS England local area and those involved in Protect;</td>
<td>- - X - - -</td>
<td>Not rated in 2013, unless organisation provides evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>CCGs will in addition;</td>
<td>- - X - - -</td>
<td></td>
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</tr>
<tr>
<td>12.1</td>
<td>carry out their duties as category two responders under the CCA and provide details of how they will do this;</td>
<td>- - - - - -</td>
<td>Page revision references in BIP, annexes or standalone plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.2</td>
<td>Core Standard 12 has been TRANSFERRED to 18.8 above</td>
<td>- - X - - -</td>
<td>Details of CCA arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.3</td>
<td>make sure agreements with providers of NHS funded care include suitable EPRR provisions and category funds allocated to EPRR activities (for example, testing and exercising);</td>
<td>- - - - - -</td>
<td>Terms of National Contract passed on to providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.4</td>
<td>Core Standard 12 has been TRANSFERRED to 18.8 above</td>
<td>- - X - - -</td>
<td>Details of CCA arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.5</td>
<td>define a route for their commissioned providers to escalate issues 24 hours a day, supported by trained and competent people, in case they cannot maintain delivery of care services;</td>
<td>- - - - - -</td>
<td>Details of CCA arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.6</td>
<td>outline how the CCG will carry out its supporting role during and after an incident;</td>
<td>- - - - - -</td>
<td>Evidence from LHRP - statement to CCG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community pharmacists must also:

- explain how threat levels will be based on the broad nature of the threat but could include specific areas of business;

- outline how NHS organisations can manage risks relating to economic crime such as fraud, bribery and corruption;

- outline how NHS organisations can access Project Artemis and Project Argus Health;

- describe how their plans will be related to the national threat levels for counter terrorism security;

- outline how healthcare products and supply chain services can be provided 24 hours a day in times of crisis; and

- explain how they will support essential care in the community during a significant incident or emergency;

- make sure the needs of mental health patients involved in a significant incident or emergency are met and that they are provided with appropriate support;

- outline how they will give accurate and specific clinical advice;

- establish links with LSMS and Prevent leads in trusts.

NHS Logistics must also:

- describe how the police or other emergency services can get access to a key-holder list for any pharmacy.

- describe how NHS sites can be locked down by managing site security and the security of staff, patients and visitors;

- outline how they can assist acute trusts and ambulance services during and after an incident (with reference to specific mutual aid and cross boundary issues).

- support hospitals, GPs and ambulance services during the treatment phase of an influenza pandemic or any other public health emergency.

- outline how they will deal with the additional security risks associated with the opening and running of treatment centres.

- identify locations which patients can be transferred to if there is an incident;

- where relevant, set out detailed plans for lockdown, evacuation and managing relatives.

- co-ordinate and provide mental health support to staff, patients and relatives in collaboration with Social Services.

- outline how conflict resolution training can be used by all NHS organisations to prevent violence against staff and patients.

- co-ordinate the development of procedures for this in partnership with local mental health and learning disability trusts.

- those CCGs with ambulance Trust commissioning responsibilities must ensure, in relation to both planned and non-planned events, that specific EPRR-related services in response are detailed.

- terms of National Contract passed on to providers

- details of negotiated/funding lines

- NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)

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