NHS
Nottingham and Nottinghamshire
Integrated Care Board

Emergency Preparedness, Resilience and Response (EPRR) Policy

June 2025 – June 2028

CONTROL RECORD	
Title	Emergency Preparedness, Resilience and Response (EPRR) Policy
Reference Number	EPRR-001
Version	3.0
Status	Final
Author	Emergency Preparedness, Resilience and Response (EPRR) Manager
Sponsor	Deputy Chief Delivery Officer
Team	System Coordination Centre (SCC) and Emergency Preparedness, Resilience and Response (EPRR)
Amendments	Reflect the new SCC & EPRR Team and its roles and responsibilities. Removal of Business Continuity (to be incorporated in the new ICB Business Continuity Policy)
Purpose	To state the ICB's approach to Emergency Preparedness, Resilience and Response (EPRR), including the preparation for, testing and response to any incident and emergency.
Superseded Documents	Emergency Preparedness, Resilience and Response Policy v2.0
Audience	All employees and appointees of the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) and individuals working within the organisation in a temporary capacity.
Consulted with	NHS England
Equality Impact Assessment	Complete (See Appendix A)
Approving Body	Audit and Risk Committee
Date approved	18 June 2025
Date of Issue	June 2025
Review Date	June 2028

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NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)'s policies can be made available on request in a range of languages, large print, Braille, audio, electronic and other accessible formats from the Engagement and Communications Team at nnicb-nn.comms@nhs.net.

Contents

1. Introduction

1.1. This policy applies to the NHS Nottingham and Nottinghamshire Integrated Care Board, hereafter referred to as 'the ICB'.

1.2. The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could cause large numbers of casualties and affect the health of the community or the delivery of patient care. The Civil Contingencies Act (2004) (CCA) and the NHS Emergency Preparedness, Resilience and Response (EPRR) Framework requires NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to such incidents while maintaining services to patients.

1.3. Under the Health and Care Act 2021, the ICB is designated as a Category 1 responder and, therefore, subject to the full set of civil protection duties under the CCA.

1.4. In addition to meeting legislative duties, the ICB is required to comply with guidance and framework documents, including but not limited to:

- NHS England Emergency Preparedness, Response and Resilience Framework;
- NHS England Core Standards for Emergency Preparedness, Response and Resilience;

1.5. This document outlines how the ICB complies with its Category 1 statutory responsibilities and Emergency Preparedness, Resilience and Response (EPRR) obligations.

2. Policy Statement

2.1. The ICB is aligned to the strategic direction which is set nationally through the core standards. This then derives the EPRR annual work programme which is endorsed and supported by the Audit and Risk Committee and ICB Board.

2.2. The ICB accepts its statutory duties as a Category 1 Responder under the Civil Contingencies Act 2004 (CCA) and detailed within Section 46 of the Health & Social Care Act 2021 (H&SCA) and as such will:

- Assess the risk of emergencies occurring and use this to inform the ICB and wider system contingency planning;
- Have in place a single incident response plan that sets out how the ICB will respond to a business continuity, critical or major incident.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination; and
- Cooperate with other local responders to enhance co-ordination and efficiency.

2.3. In addition, the ICB recognises its EPRR responsibilities as detailed within Section 9.3 of NHS England EPRR Emergency Preparedness, Resilience and Response Framework 2022 to:

- Support NHS England (Midlands) in monitoring compliance and gaining assurance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable Core Standards;
- Support NHS England (Midlands) in discharging its EPRR functions and duties locally
- ICB will operate a 24-hours a day, 7 days a week, on-call function. The Incident response plan defines command and control.
- Have the ability to support commissioned providers in escalating issues and represent health within the LRF and wider multi agency partners
- Provide sufficient resources and funding to ensure the ICB complies with its EPRR obligations.
- Have a risk-based, coherent and accessible incident response plan in place, which recognise the ICB's statutory responsibilities as a commissioning organisation and is, therefore, proportionate to the level of risk.
- Specific roles and accountabilities in relation to EPRR and incident response are assigned within the organisation and that all staff have a clear understanding of their own responsibilities;
- To ensure that the ICB has access to up-to-date guidance relating to EPRR and this is disseminated accordingly within the ICB and system providers;
- To ensure that staff receive training aligned to their role and responsibility. The ICB SCC & EPRR team are responsible for monitoring compliance.
- Learnings from exercises and incidents are captured and actioned through debriefing processes to drive continuous improvement
- As the ICB coordinates the health system there will be two levels of health meetings;
    - The ICB Co- Chairs and provides secretariat support to the Local Health Resilience Partnerships (LHRP) alongside the Director of Public Health
    - The ICB Chairs the Health Emergency Planning Operational Group (HEPOG) which provides a route of escalation through the LHRP in respect of commissioned provider EPRR preparedness.

2.4. In order to deliver this, the ICB Board is committed to maintaining a dedicated EPRR asset within the organisation, which it will review on a regular basis, and for which it will provide adequate funding and resources to ensure it is able to discharge its responsibilities and to ensure it has both the required competencies and capacity.

3. Scope

3.1. This policy relates to all ICB EPRR activities/functions, all employees and appointees of the ICB and others working within the organisation in a temporary capacity. It also applies to ICB employed staff who carry out work within another organisation's premises. These are collectively referred to as 'individuals' hereafter.

3.2. Activities relating to Business Continuity are included in the ICBs BCMS Policy

4. Roles and Responsibilities

4.1. The EPRR function is supported by the following roles:

Role	Responsibilities
Accountable Emergency Officer (AEO)	The role of the Accountable Emergency Officer (AEO) will be undertaken by an ICB Board Member. The Accountable Emergency Officer will: • Ensure that the ICB and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022, the NHS Standard Contract, NHS EPRR Framework and the NHS Core Standards for EPRR. • Review EPRR resource and funding on a regular basis. • Properly prepare and resource to deal with an incident. • Have robust business continuity planning arrangements in place that align to ISO 22301 or subsequent guidance that may supersede this. • Robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served. • Complies with any requirements of NHS England, in respect of monitoring compliance with regards to EPRR. • Provides NHS England with such information as it may require for the purpose of discharging its EPRR functions. • Is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate.

Role	Responsibilities
	• Ensures organisations are represented at the LHRP by the AEO or a suitable director alternative. • Reports (as a minimum) annually to the ICB Board on the ICBs EPRR activities, including lessons from incidents and exercise, and the assurance position of the organisation. • Is appropriately represented on the Midlands Health Resilience Partnership Board, ensuring that risks identified by the LHRP are brought to the attention of the Midlands Health Resilience Partnership Board. • Has an appropriate deputy in place to cover periods when the AEO is away from work and not in a position to perform their role.
Deputy AEO	The Deputy AEO will cover periods when the AEO is away from work and not in a position to perform their role. This role will be split to cover executive elements at ICB Board Member level and non-executive at Director level.
Head of SCC & EPRR	The Head of SCC & EPRR is the ICB's senior management lead for EPRR and is responsible for driving forward the strategic approach and horizon scanning as well as overall operational management. The Head of EPRR will ensure that relevant networks and partnerships are built on in relation to planning and response. The role is responsible for ensuring that an effective on-call, training and exercising, incident response and business continuity management system is in place. The Head of EPRR is responsible for ensuring the AEO is assured and that the EPRR duties are being fulfilled.
Deputy Head of SCC & EPRR	• The Deputy Head of SCC & EPPR will support the Head of SCC & EPRR in performing their duties. • Supporting all teams across the ICB to understand and hold relevant responsibility in relation to both the SCC and EPRR function. • Support the senior leadership of the ICB in the identification, mitigation, and management of EPRR risk including preparedness to respond to major and critical incidents and business continuity risks affecting the ICB.

Role	Responsibilities
	• Support the development of the EPRR and SCC function, building a collaborative working environment and an innovative culture across a 7 day service. • Work closely with system partners and across teams to ensure plans, policies and action cards are current and relevant to the responsibilities across the system. • Lead on the implementation and provision of training to meet the needs of the ICB whilst also ensuring that the system has relevant training.
EPRR Manager	The ICB's EPRR Manager is responsible for all aspects of operational implementation of the aims contained within this policy, including ensuring plans and arrangements are regularly reviewed; the delivery of on-call and EPRR training and exercising the ICB's incident response. The SCC & EPRR Officers co-ordinates the work programme and the management of plans The EPRR Manager will ensure that the ICB will collaborate with partners.
EPRR & SCC Officers	The SCC & EPRR Officers undertake a number of roles is support of the Head of SCC & EPRR; and the EPRR Manager. Functions include co-ordination of on-call, ensuring that this operates as efficiently as possible across both strategic and tactical. The SCC & EPRR Officers also supports the training and exercising requirements and works with the EPRR Manager to ensure that the ICB meets its EPRR obligations.
Tactical (Silver) On-call	The ICB Silver (Tactical) Commander is responsible for directly managing the ICB's response to an incident. They will interpret strategic direction and develop the tactical plan to achieve the objectives set by strategic command. • Work in co-operation with and communicate effectively with other health and multiagency partners at the tactical level. • Gather and share information and intelligence to inform effective decision-making. • Make effective decisions (e.g. through use of the Joint Decision Model).

Role	Responsibilities
	• Undertake an ongoing assessment of the risks to the health of the community and to the delivery of healthcare to the community. • Develop tactical plans, aligned to the strategic plan, based upon available information, incident and emergency plans and the assessed risks. • Implement and brief tactical plans, reviewing them on an ongoing basis, in consultation with key staff and partners. • Determine and prioritise the resources required for the response in both the short and longer term. • Provide accurate and timely information to inform and protect the community, working with the media where relevant, and within the agreed organisational communication strategy. • Coordinate responses from the operational level. • Identify where circumstances warrant a strategic level of management and ensure fully briefed as required. • Ensure effective and timely handover of command. • Maintain the health, safety and welfare of individuals during the response. • Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation. The ICB Silver (Tactical) Commander must know and understand: • The legal basis of their authority and the powers that derive from this (e.g. statute, contract, policy etc). • The principles of 'Emergency Response and Recovery' and the 'NHS Emergency Preparedness Resilience and Response Framework'. • The command and control structures for health and multi-agency emergency response. • How to undertake an ongoing risk assessment. The roles and responsibilities of key emergency response partners (i.e. emergency services, local authorities and other health partners) 6. the key elements of organisational and multi-agency emergency plans (i.e. aim & objectives, activation process and roles and responsibilities of responding agencies).

Role	Responsibilities
	• The range of tactical options available and how they should be communicated. • How to assess the short- and long-term human impact of the incident or emergency and identify the most vulnerable groups. • The information needs of the various organisations involved in the response. • The Joint Services Interoperability Principles (JESIP) joint doctrine.
Strategic (Gold) On-call	The ICB Gold (Strategic) Commander has overall command of the organisation's resources. They are responsible for liaising with partners to develop the strategy, policies and objectives and to allocate the funding which will be required to manage the incident. They will also ensure arrangements are in place to support the recovery from an incident. • Develop and review response and communications strategies for your organisation with appropriate stakeholders and multi-agency partners. • Co-ordinate and communicate effectively at tactical and strategic level, across health and with multi-agency partners. • Gather and share information and intelligence to inform effective decision-making. • Make effective decisions based on the best available information (e.g. through use of the Joint Decision Model). • Brief the strategic plan, appropriately delegate to tactical level and regularly review. • Ensure sufficient, appropriate resources are available to support the response. • Identify the long-term and medium-term recovery priorities. • Ensure effective and timely handover of command. • Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation.

Role	Responsibilities
	The NHS Strategic Commander must know and understand: • The legal basis of their authority and the powers that derive from this (e.g. statute, contract, policy etc). • The principles of 'Emergency Response and Recovery' and the 'NHS Emergency Preparedness Resilience and Response Framework'. • The command and control structures for health and multi-agency emergency response. • The roles and responsibilities of key emergency response partners (i.e. emergency services, local authorities and other health partners). • The key elements of organisational and multi-agency incident and emergency plans. • The factors relevant to setting and reviewing the response strategy, identified in point 1 of the Performance Criteria (e.g. risk assessment, community impact, environmental impact and the longer-term recovery process). • The financial arrangements that are needed to enable an emergency response. • How to assess the short- and long-term human impact of the incident or emergency and identify the most vulnerable groups.
Loggist	The Loggist is responsible for ensuring that appropriate decision logs are recorded for a specified Decision Maker during a declared Business Continuity, Critical or Major Incident: • Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation as specified by nominated Decision-Maker. • Ensure effective and timely handover of Logging. The Loggist must know and understand: • Current legislation, policy and procedures relevant to the role of the Loggist. Log keeping requirements including ways of working with the decision maker and the purpose of decision logs.

5. Definitions

5.1. The ICB has adopted the following definitions from NHS England EPRR Framework 2015 and CCA 2004:

Term	Definition
Critical Incident	Any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical service.
Emergency	Means: a) An event or situation which threatens serious damage to human welfare in a place in the United Kingdom. b) An event or situation which threatens serious damage to the environment of a place in the United Kingdom. c) War, or terrorism, which threatens serious damage to the security of the United Kingdom.
Incident Response Plan	Outlines how an organisation will respond to a critical or major incident.
Major Incident	Is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special measures to be implemented.

6. Command and Control (including on-call)

6.1. As a Category 1 responder under the Civil Contingencies Act 2004, it is essential that the organisation maintains the ability to provide senior level leadership and effect a response to an incident or emergency as required, both in and out of hours.

6.2. The ICB on-call will respond (but are not limited to) 2 key strands of enquiry, these include:

- **Declared Incidents (Business Continuity, Critical or Major)**

  It is a requirement under associated legislation and guidance that on-call arrangements are in place to ensure a 24/7 response to incidents.

  Nottingham and Nottinghamshire ICB will coordinate the local NHS response within Nottingham and Nottinghamshire in the event of any standby or declared Business Continuity, Critical or Major incident. It does this by provision of senior leadership to coordinate the Nottingham or Nottinghamshire healthcare system both in and out of hours (refer to the ICB's Incident Management Plan for full details).

- **System Management and Oversight**

  As commissioners of patient services, the ICB is required to have robust processes where providers commissioned by the ICB can access ICB senior management advice and decision making 24/7 for issues requiring support to ensure the effective delivery of healthcare services within Nottingham and Nottinghamshire, this would include spot purchasing of beds, ambulance performance and oversight, surge and escalation management and oversight (refer to the Operational Pressures Handbook for full details).

7. On Call Rota and Staff Wellbeing

7.1. The ICB have adopted a two tier on-call system consisting of a Silver and Gold on-call, this ensures appropriate access to decision makers at both Tactical and Strategic levels. The Silver (tactical) on-call is performed by staff at the Band 8c and 8d grades. The Gold (strategic) on-call is performed by staff at the Band 9 and VSM grades.

7.2. Colleagues required for on-call responsibilities are identified by the ICB SCC & EPRR team, aligned with Silver (Tactical) and Gold (Strategic) roles. A waitlist exists for resilience purposes, where participants maintain training readiness without remuneration. Employees may volunteer to join the on-call rota, subject to assessment by HR and SCC & EPRR teams. Those seeking removal from on-call duties must consult Occupational Health, with recommendations reviewed by HR and SCC & EPRR teams.

7.3. On-call duty runs 24 hours a day, 7 days a week The On Call week is split so that one person will cover 09:00 Sunday to 08:59 Wednesday and a second person will cover 09:00 Wednesday to 08:59 Sunday.

7.4. The On Call rota is managed by the ICB's SCC & EPRR Team, including the production of the rota which is published in advance (12 months ahead).

7.5. The ICB complies with the European Working Time Directive to prevent overwork, setting limits such as an average 48-hour workweek over 17 weeks, 11 consecutive hours of rest in 24 hours, a 20-minute break after six hours of work, and 24 hours of continuous rest in 7 days (or 48 hours in 14 days). The ICB encourages staff to take 1 day of TOIL after On Call duty, with any exceptions requiring consultation with a line manager.

7.6. Compensatory rest arrangements should align with the nature of on-call workloads, whether high or low. Rest is agreed upon by the line manager and employee after the on-call duty, as advance planning may not be feasible. For example, if a staff member is called during the night, their next day start time may be delayed (e.g., by two hours). On-call staff must ensure a proper handover before taking compensatory rest.

7.7. On-call staff must proactively arrange a handover of duties during changeover by contacting the incoming on-call manager or director. They should report any incidents from the previous period requiring further action and complete any other necessary handover processes. It is the outgoing on-call staff member's responsibility to ensure an appropriate handover is completed before taking compensatory rest.

8. Record Keeping (including Incident Loggist)

8.1. Those on call must keep a log of each time they are contacted or make contact in relation to their on call activities. A new log must be started for each staff member on call so that it is clear who is writing the log and what on call position they hold.

8.2. Decisions must be recorded in a way that makes them auditable. Individual decision makers must be identified and accountable for the decisions they make. Wherever possible the rationale supporting the decision should be recorded along with the decision itself. All decisions should be proportionate, necessary and legal.

8.3. The purpose of completing a log/record of on call events is:

- To support staff in keeping a record of actions taken, conversations and decisions so that they can refer back during an ongoing incident.
- To provide evidence of decisions and actions that can be used in an inquest or public inquiry.
- To provide a learning tool for all on call staff, so that others can learn from the situations faced and the decisions taken in response to them.

8.4. NHS funded organisations must have appropriately trained and competent loggists to support the management of an incident. Loggists are an integral part in any incident management team. It is essential that all those tasked with logging do so to best practice standards and understand the importance of logs in the decision making process, in evaluation and identifying lessons and as evidence for any subsequent inquiries.

8.5. Following an incident a number of internal investigations or legal challenges may be made. These may include Coroner's inquests, public inquiries, criminal investigations and civil action. When planning for and responding to an incident it is essential that any decisions made, or actions taken are recorded and stored in a way that can be retrieved at a later date to provide evidence. It may be necessary to provide all documentation, therefore robust and auditable systems for documentation and decision making must be maintained. The organisation's Document Retention policies and procedures should cover the requirements of EPRR.

9. Work Programme

9.1. EPRR activities are managed through the annual EPRR work programme. This programme is informed by the outcomes of the audit and assurance process, identified risks, lessons learned from incidents and exercises and horizon scanning.

9.2. The work programme will be overseen by the Audit and Risk Committee ahead of the ICB Board and progress review will be regularly reported to the AEO.

10. Governance and Reporting

10.1. The ICB's Audit and Risk Committee Chair will support the AEO in providing assurance to the ICB that the ICB complies with all applicable EPRR requirements.

10.2. The ICB's AEO will ensure that the ICB Board receives an annual report detailing compliance with the EPRR Core Standards. The report with cover:

- Compliance with the EPRR Core Standards.
- Progress against the EPRR work programme.
- Incidents that have occurred since the previous report and any lessons identified.
- Exercises undertaken and any lessons identified.
- Training undertaken.
- Risks.

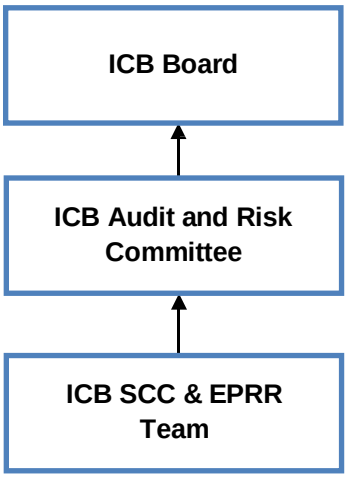
10.3. The ICB Board report will be available to the public however the report will be redacted to exclude incidents. The Audit and Risk Committee will receive the annual report prior to the ICB Board.

10.4. The Head of SCC & EPRR will ensure that the ICB's Audit and Risk Committee receives a biannual report following the ICB Board meeting. The report will cover progress against actions from the EPRR Core Standards and the EPRR Work Programme.

10.5. All relevant EPRR documentation including plans and policies will go to the Audit and Risk Committee and ICB Board for approval and oversight. This includes:

- ICB Incident Response Plan
- ICB Business Continuity Plan
- EPRR Policy
- BCMS Policy
- EPRR Annual report.

10.6. The ICB's EPRR Governance Reporting Structure is as follows:



11. Risk Management Strategy

11.1. The ICB SCC & EPRR team have processes allowing risk identification, assessment, mitigation.

11.2. The Audit and Risk Committee have oversight of the risks through the ICB EPRR Annual Board report. The ICB AEO also attends the Midlands Health Resilience Partnership Board

11.3. The National Risk Register (NNR) and Community Risk Register (CR) for EPRR are intended to capture a range of civil emergencies which may affect the ICB and wider health systems ability to deliver its duty under the CCA (2004)

11.4. Risks for Nottingham and Nottinghamshire are reviewed periodically by the LRF Advisory Group, the EPRR Manager from the ICB is a member of this group. The LRF has also produced a Community Risk Register which has been incorporated into the ICB and LHRP Work Programme

11.5. The health system risks are reported and reviewed through the LHRP. The LHRP takes place quarterly.

11.6. The ICB will chair the LHRP Risk Management Group. This group will ensure that health system preparedness arrangements reflect current and emerging threats, including those cascaded down from a national level. The Nottinghamshire LHRP Risk Management Group takes place quarterly. The LHRP Risk Management Group feeds into the LHRP.

11.7. The SCC & EPRR Team will hold regular meetings with the ICB Operational Risk Manager to consider EPRR risks for inclusion on the ICB's Operational Risk Register.

11.8. Risks will be sent to the ICB Board on an annual basis for horizon scanning and awareness.

11.9. The ICB Internal Risk Group works with teams to review departmental risks to determine those requiring escalation to the corporate risk register and ICB Business Continuity. The ICB Manager is a member of this group.

12. Maintenance of Plans and Policies

12.1. All EPRR plans are reviewed on an annual basis to ensure that legislation and guidance are up to date and that plans are fit for purpose. In the event of incidents and exercises that provide lessons learned, or changes to contacts, the plans will be updated immediately and will not wait until the annual review

12.2. In addition to the annual review, a full review of each plan will be undertaken on a 3-year basis

12.3. All review dates are tracked through the ICB Work Programme

12.4. All EPRR plans are signed off by the Head of SCC & EPRR and the AEO following consultation with the relevant audience.

12.5. All EPRR plans must undergo consultation with the relevant audience. Comments and actions, along with their assigned owners must be tracked and made visible on each plan.

12.6. The policy will be audited throughout the year, both internally and externally. The EPRR Manager will also ensure that any appropriate external audits tools and assurance processes are conducted on a regular basis. An example of an external audit tool includes the EPRR Core Standards assurance to NHS England.

13. Training

13.1. Those individuals undertaking roles and responsibilities within this policy must undertake appropriate training aligned with the Training Needs Analysis and National Occupational Standards.

13.2. The ICB SCC & EPRR team will outline all training available internally, externally and through multi agency partners in the annual training programme.

13.3. All training is recorded on the training tracker which includes automated reminders for expiration dates to ensure all on call colleagues remain current. The ICB SCC& EPRR team maintains the training record during the transition to the online platform.

13.4. Staff undertaking EPRR roles will maintain their own Personal Development Portfolio (PDP) to log training and exercises.

14. Exercising

14.1. All EPRR plans must be tested regularly using recognised and agreed processes such as table-top or live exercises.

14.2. The annual exercise schedule will be determined by the SCC & EPRR team on an annual basis and will be based on horizon scanning, risks and discussion with partners. Exercise arrangements for the ICB are in line with the NHS England requirements and entail:

- Communications exercise every six months;
- Table-top exercise every year;
- Command post exercise every three years; and a
- Live exercise every three years.

14.3. Any learnings from lessons or incidents will be recorded as part of the continuous improvement work.

14.4. In testing the incident response plan, all reasonable adjustments must be made to ensure all staff, regardless of any protected characteristics, can fully participate in exercises and training.

15. Staff Welfare

15.1. The response to any incident must consider implications for staff welfare, agreeing all necessary actions / adjustments to support ICB staff.

16. Continuous Learning and Lessons Identified

16.1. The ICB has a structured approach to ensure that EPRR activities are comprehensive, proactive and continuously improved.

16.2. Lessons from incidents and exercises are logged and reviewed by the SCC & EPRR team. The team will assign an owner and a timeframe for completion. Lessons that do not require an action will be accompanied by a justification.

16.3. The ICB Board and Audit and Risk Committee have oversight of learnings.

16.4. All incidents and exercises will be followed by an immediate hot debrief to capture any learnings and to provide an opportunity for staff to de-escalate after an incident.

16.5. Within 28 days of an incident, EPRR will conduct a cold debrief with the staff concerned. The outcomes and results of the debrief will form a post incident or post exercise report which will include an action plan for implementation of lessons identified.

17. Equality and Diversity Statement

17.1. NHS Nottingham and Nottinghamshire ICB pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation as a commissioner and provider of services, as well as an employer.

17.2. The ICB is committed to ensure that the way we provide services to the public and the experiences of our staff does not discriminate against any individuals or groups on the basis of their age, disability, gender identity (trans, non-binary), marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

17.3. The ICB is committed to ensuring that its activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, Roma and travellers.

17.4. As an employer, the ICB is committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

17.5. To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed for, and is attached to, this policy.

18. Communication, Monitoring and Review

18.1. The ICB will establish effective arrangements for communicating the requirements of this policy through the internal communication methods. This will primarily be by ensuring continual awareness and accessibility of this policy through the staff intranet.

18.2. Communications and assurances will also be undertaken with any external suppliers and contractors affected by or who have an influence on the effective implementation of this policy.

18.3. New starters (including temporary and agency staff) will be informed of this policy as part of the ICB's induction programme.

18.4. Any public communications must take account of the need to reach all members of the public, reflecting protected characteristics such as disability.

18.5. This policy will be reviewed and approved by the Audit and Risk Committee every three years with an annual assurance report for the plan update and test.

18.6. As part of a rolling programme to assess the impact of the ICB's policies, frameworks and procedures on its equality performance, a triennial review of this policy will be undertaken to provide an assurance that its implementation is not having a negative impact on the ICB's equality performance, and to also identify any positive effects.

19. Interaction with other Policies

19.1. This policy should be read in conjunction with the following:

- BCMS Policy
- Risk Management Policy
- Health, Safety and Security Policy
- Incident Reporting and Management Policy
- Information Governance Management Framework.

20. References

20.1. For further, more detailed information regarding the contents of this policy please refer to the following documents:

- Civil Contingencies Act 2004
- The NHS England Emergency Preparedness Framework
- NHS England Core Standards for EPRR
- NHS England Business Continuity Management Framework.

Appendix A: Equality Impact Assessment

Name of Policy	Emergency Preparedness, Resilience and Response (EPRR) Policy
Date of Completion	June 2025
EIA Responsible Person Include name, job role and contact details.	Kevin Robotham, EPRR Manager Email: kevinrobotham@nhs.net

For the policy, please answer the following questions against each of the protected characteristics, human rights and health groups:	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?
Age	There are no actual or expected positive impacts on the characteristic of Age.	There are no actual or expected negative impacts on the characteristic of Age.	None.
Disability[1] (Including: mental, physical, learning, intellectual and neurodivergent)	There are no actual or expected positive impacts on the characteristic of Disability.	There are no actual or expected negative impacts on the characteristic of Disability.	Mechanisms are in place via the Communications and Engagement Team to receive the policy in a range of large print, Braille, audio, electronic and other accessible formats.

Gender[2] (Including: trans, non-binary and gender reassignment)	There are no actual or expected positive impacts on the characteristic of Gender.	There are no actual or expected negative impacts on the characteristic of Gender.	None.
Marriage and Civil Partnership	There are no actual or expected positive impacts on the characteristic of Marriage and Civil Partnership.	There are no actual or expected negative impacts on the characteristic of Marriage and Civil Partnership.	None.
Pregnancy and Maternity	There are no actual or expected positive impacts on the characteristic of Pregnancy and Maternity Status.	There are no actual or expected negative impacts on the characteristic of Pregnancy and Maternity Status.	None.
Race[3]	There are no actual or expected positive impacts on the characteristic of Race.	There are no actual or expected negative impacts on the characteristic of Race.	Mechanisms are in place via the Communications and Engagement Team to receive the policy in a range of languages.
Religion and Belief[4]	There are no actual or expected positive impacts on the characteristic of Religion or Belief.	There are no actual or expected negative impacts on the characteristic of Religion or Belief.	None.
Sex[5]	There are no actual or expected positive impacts on the characteristic of Sex.	There are no actual or expected negative impacts on the characteristic of Sex.	None.
Sexual Orientation[6]	There are no actual or expected positive impacts on the characteristic of Sexual Orientation.	There are no actual or expected negative impacts on the characteristic of Sexual Orientation.	None.

Human Rights[7]	There are no actual or expected positive impacts on the characteristic of Human Rights.	There are no actual or expected negative impacts on the characteristic of Human Rights.	None.
Community Cohesion and Social Inclusion[8]	There are no actual or expected positive impacts on the characteristic of Community Cohesion and Social Inclusion.	There are no actual or expected negative impacts on the characteristic of Community Cohesion and Social Inclusion.	None.
Safeguarding[9]	There are no actual or expected positive impacts on the characteristic of Safeguarding.	There are no actual or expected negative impacts on the characteristic of Safeguarding.	None.
Socioeconomic and other 'at risk' groups[10] (Including carers, homeless, Looked After Children, living in poverty, asylum seekers, rural communities, victims of abuse, ex-offenders)	There are no actual or expected positive impacts on the characteristic of Other Groups at Risk.	There are no actual or expected negative impacts on the characteristic of Other Groups at Risk.	None.

[1]**Disability** refers to anyone who has: "…a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities…" (Equality Act 2010 definition). This includes, but is not limited to: mental health conditions, learning disabilities, intellectual disabilities, neurodivergent conditions (such as dyslexia, dyspraxia and dyscalculia), autism, many physical conditions (including HIV, AIDS and cancer), and communication difficulties (including d/Deaf and blind people).

[2]**Gender**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: "A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."

[3]**Race**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A person's colour, nationality, or ethnic or national origins. This also includes people whose first spoken language is not English, and/or those who have a limited understanding of written and spoken English due to English not being their first language.

[4]**Religion and Belief**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.

[5]**Sex**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A reference to a person who has a particular protected characteristic and is a reference to a man or to a woman.

[6]**Sexual Orientation**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Sexual orientation means a person's sexual orientation towards persons of the same sex, persons of the opposite sex or persons of either sex.

[7]The **Human Rights Act 1998** sets out the fundamental areas that everyone and every organisation must adhere to. In relation to health and care, the most commonly applicable of the Articles within the Human Rights Act 1998 include: Article 2 Right to Life, Article 5 Right to Liberty and Security, Article 8 Right to Respect of Private and Family Life, and Article 9 Freedom of Thought, Conscience and Religion.

[8]**Community Cohesion** is having a shared sense of belonging for all groups in society. It relies on criteria such as: the presence of a shared vision, inclusion of those with diverse backgrounds, equal opportunity, and supportive relationships between individuals. **Social Inclusion** is defined as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights (United Nations definition). For the EQIA process, we should note any positive or negative impacts on certain groups being excluded or not included within a community or societal area. For example, people who are homeless, those from different socioeconomic groups, people of colour or those from certain age groups.

[9]**Safeguarding** means: "…protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility" (NHS England definition). Those most in need of protection are children, looked after children, and adults at risk (such as those receiving care, those under a DoLS or LPS Order, and those with a mental, intellectual or physical disability). In addition to the ten types of abuse set out in the Health and Care Act 2022, this section of the EQIA should also consider PREVENT, radicalisation and counterterrorism.

[10]**Other Groups** refers to anyone else that could be positively or negatively impacted by the policy, process, strategy or service change. This could include, but is not limited to: carers, refugees and asylum seekers, people who are homeless, gypsy, Roma and traveller communities, people living with an addiction (e.g., alcohol, drugs or gambling), people experiencing social or economic deprivation, and people in stigmatised occupations (e.g., sex workers).