

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
-----	--------	---------------	-----------------	---	--	--------------------	------	-----------	----------

Domain 1 - Governance

1	Governance	Senior Leadership	Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	<u>Evidence</u> <ul style="list-style-type: none"> Name and role of appointed individual AEO responsibilities included in role/job description 	Fully compliant				
2	Governance	EPRR Policy Statement	<p>The organisation has an overarching EPRR policy or statement of intent.</p> <p>This should take into account the organisation's:</p> <ul style="list-style-type: none"> Business objectives and processes Key suppliers and contractual arrangements Risk assessment(s) Functions and / or organisation, structural and staff changes. 	<p>The policy should:</p> <ul style="list-style-type: none"> Have a review schedule and version control Use unambiguous terminology Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised Include references to other sources of information and supporting documentation. <p><u>Evidence</u></p> <p>Up to date EPRR policy or statement of intent that includes:</p> <ul style="list-style-type: none"> Resourcing commitment Access to funds Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. 					
3	Governance	EPRR board reports	<p>The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.</p> <p>The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements</p>	<p>These reports should be taken to a public board, and as a minimum, include an overview on:</p> <ul style="list-style-type: none"> training and exercises undertaken by the organisation summary of any business continuity, critical incidents and major incidents experienced by the organisation lessons identified and learning undertaken from incidents and exercises the organisation's compliance position in relation to the latest NHS England EPRR assurance process. <p><u>Evidence</u></p> <ul style="list-style-type: none"> Public Board meeting minutes Evidence of presenting the results of the annual EPRR assurance process to the Public Board For those organisations that do not have a public board, a public statement of readiness and preparedness activities. 					
4	Governance	EPRR work programme	<p>The organisation has an annual EPRR work programme, informed by:</p> <ul style="list-style-type: none"> current guidance and good practice lessons identified from incidents and exercises identified risks outcomes of any assurance and audit processes <p>The work programme should be regularly reported upon and shared with partners where appropriate.</p>	<p><u>Evidence</u></p> <ul style="list-style-type: none"> Reporting process explicitly described within the EPRR policy statement Annual work plan 					
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	<p><u>Evidence</u></p> <ul style="list-style-type: none"> EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board Assessment of role / resources Role description of EPRR Staff/ staff who undertake the EPRR responsibilities Organisation structure chart Internal Governance process chart including EPRR group 					

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	<u>Evidence</u> <ul style="list-style-type: none"> Process explicitly described within the EPRR policy statement Reporting those lessons to the Board/ governing body and where the improvements to plans were made participation within a regional process for sharing lessons with partner organisations 	Fully compliant				
Domain 2 - Duty to risk assess									
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	<ul style="list-style-type: none"> Evidence that EPRR risks are regularly considered and recorded Evidence that EPRR risks are represented and recorded on the organisations corporate risk register Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather 	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	<u>Evidence</u> <ul style="list-style-type: none"> EPRR risks are considered in the organisation's risk management policy Reference to EPRR risk management in the organisation's EPRR policy document 	Fully compliant				
Domain 3 - Duty to maintain Plans									
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements <u>Evidence</u> <ul style="list-style-type: none"> Consultation process in place for plans and arrangements Changes to arrangements as a result of consultation are recorded 	Partially compliant	MS to create sheet for recording all collaboration undertaken, and affix to updated plans	M Stone	End Dec 2023	
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: <ul style="list-style-type: none"> current (reviewed in the last 12 months) in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Partially compliant	MS to update plan and remove references to out of date legislation and guidance	M Stone	End Dec 2023	
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: <ul style="list-style-type: none"> current in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required reflective of climate change risk assessments cognisant of extreme events e.g. drought, storms (including dust storms), wildfire. 	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required <p>Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/</p>	Partially compliant	IPC lead to create protocol for managing HCID and append to Infectious Disease Outbreak Policy	Sally Palmer	End November 2023	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 	Fully compliant				
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required <p>Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination.</p> <p>There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements.</p> <p>Commissioners may be required to commission new services to support mass countermeasure distribution locally; this will be</p>	Partially compliant	MS to update plan and incorporate updated guidance .	M Stone	End Dec 2023	

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required <p>Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.</p>	Partially compliant	Protocol for freeing up 124 surgical beds to be agreed with system partners and added to the IRP	M Stone	End Dec 2023	
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 	Fully compliant				
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 	Fully compliant				
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 	Fully compliant				
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	<p>Arrangements should be:</p> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	<ul style="list-style-type: none"> Process explicitly described within the EPRR policy statement On call Standards and expectations are set out Add on call processes/handbook available to staff on call Include 24 hour arrangements for alerting managers and other key staff. CSUs where they are delivering OOHs business critical services for providers and commissioners 	Fully compliant				
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	<ul style="list-style-type: none"> Process explicitly described within the EPRR policy or statement of intent <p>The identified individual:</p> <ul style="list-style-type: none"> Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) Has a specific process to adopt during the decision making Is aware who should be consulted and informed during decision making Should ensure appropriate records are maintained throughout. Trained in accordance with the TNA identified frequency 					
Domain 5 - Training and exercising									
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	<ul style="list-style-type: none"> Process explicitly described within the EPRR policy or statement of intent Evidence of a training needs analysis Training records for all staff on call and those performing a role within the ICC Training materials Evidence of personal training and exercising portfolios for key staff 	Fully compliant				
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	<p>Organisations should meet the following exercising and testing requirements:</p> <ul style="list-style-type: none"> a six-monthly communications test annual table top exercise live exercise at least once every three years command post exercise every three years. <p>The exercising programme must:</p> <ul style="list-style-type: none"> identify exercises relevant to local risks meet the needs of the organisation type and stakeholders ensure warning and informing arrangements are effective. <p>Lessons identified must be captured, recorded and acted upon as part of continuous improvement.</p> <p><u>Evidence</u></p> <ul style="list-style-type: none"> Exercising Schedule which includes as a minimum one Business Continuity exercise Post exercise reports and embedding learning 					
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	<p><u>Evidence</u></p> <ul style="list-style-type: none"> Training records Evidence of personal training and exercising portfolios for key staff 					

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Fully compliant				
Domain 6 - Response									
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	<ul style="list-style-type: none"> Documented processes for identifying the location and establishing an ICC Maps and diagrams A testing schedule A training schedule Pre identified roles and responsibilities, with action cards Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions. 	Fully compliant				
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Fully compliant				
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	<ul style="list-style-type: none"> Business Continuity Response plans Arrangements in place that mitigate escalation to business continuity incident Escalation processes 	Fully compliant				
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	<ul style="list-style-type: none"> Documented processes for accessing and utilising loggists Training records 	Fully compliant				
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	<ul style="list-style-type: none"> Documented processes for completing, quality assuring, signing off and submitting SitReps Evidence of testing and exercising The organisation has access to the standard SitRep Template 	Partially compliant	Updated templates to be added to IRP	M Stone	End Dec 2023	
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
-----	--------	---------------	-----------------	---	--	--------------------	------	-----------	----------

Domain 7 - Warning and informing

33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	<ul style="list-style-type: none"> Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry. 	Fully compliant				
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	<ul style="list-style-type: none"> An incident communications plan has been developed and is available to on call communications staff The incident communications plan has been tested both in and out of hours Action cards have been developed for communications roles A requirement for briefing NHS England regional communications team has been established The plan has been tested, both in and out of hours as part of an exercise. Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate). 	Fully compliant				
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	<ul style="list-style-type: none"> Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident Appropriate channels for communicating with members of the public that can be used 24/7 if required Identified sites within the organisation for displaying of important public information (such as main points of access) Have in place a means of communicating with patients who have appointments booked or are receiving treatment. Have in place a plan to communicate with inpatients and their families or care givers. The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements 	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	<ul style="list-style-type: none"> Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media Develop a pool of media spokespeople able to represent the organisation to the media at all times. Social Media policy and monitoring in place to identify and track information on social media relating to incidents. Setting up protocols for using social media to warn and inform Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response 	Fully compliant				
Domain 8 - Cooperation									
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	<ul style="list-style-type: none"> Minutes of meetings Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities. 	Fully compliant				
38	Cooperation	LRP / BRP Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	<ul style="list-style-type: none"> Minutes of meetings A governance agreement is in place if the organisation is represented and feeds back across the system 	Fully compliant				
39	Cooperation	Mutual aid arrangements	<p>The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies.</p> <p>In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.</p>	<ul style="list-style-type: none"> Detailed documentation on the process for requesting, receiving and managing mutual aid requests Templates and other required documentation is available in ICC or as appendices to IRP Signed mutual aid agreements where appropriate 	Fully compliant				
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	<ul style="list-style-type: none"> Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs Where an organisation sits across boundaries the reporting route should be clearly identified and known to all 	Not applicable				
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	<ul style="list-style-type: none"> Detailed documentation on the process for managing the national health aspects of an emergency 	Not applicable				
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	<ul style="list-style-type: none"> LHRP terms of reference Meeting minutes Meeting agendas 	Not applicable				
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	<ul style="list-style-type: none"> Documented and signed information sharing protocol Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004 	Partially compliant	Information Sharing Protocol to be updated	J Widdowson	End Dec 2023	
Domain 9 - Business Continuity									

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the <u>ISO standard 22301</u> .	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: <ul style="list-style-type: none"> • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning 	Fully compliant				
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: <ul style="list-style-type: none"> • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation 	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	<p>The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme.</p> <p>Documented process on how BIA will be conducted, including:</p> <ul style="list-style-type: none"> • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. <p>The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA:</p> <ul style="list-style-type: none"> • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially. 	Partially compliant	MS to continue to deve,op new BCMS system in line with the NHSE BC Toolkit	M Stone	End June 2024	
47	Business Continuity	Business Continuity Plans (BCP)	<p>The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:</p> <ul style="list-style-type: none"> • people • information and data • premises • suppliers and contractors • IT and infrastructure 	<p>Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation.</p> <p>Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following:</p> <ul style="list-style-type: none"> • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices 	Partially compliant	MS to continue to deve,op new BCMS system in line with the NHSE BC Toolkit	M Stone	End June 2024	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	<p>Confirm the type of exercise the organisation has undertaken to meet this sub standard:</p> <ul style="list-style-type: none"> • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <p><u>Evidence</u> Post exercise/ testing reports and action plans</p>	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Fully compliant				
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Partially compliant	MS to continue to deve,op new BCMS system in line with the NHSE BC Toolkit	M Stone	End June 2024	
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Partially compliant	MS to continue to deve,op new BCMS system in line with the NHSE BC Toolkit	M Stone	End June 2024	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing • Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Fully compliant				
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers.	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	<ul style="list-style-type: none"> Exercising Schedule Evidence of post exercise reports and embedding learning 	Fully compliant				
Domain 10 - CBRN									
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Fully compliant				
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Fully compliant				
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Fully compliant				
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	<p>Documented plans include evidence of the following:</p> <ul style="list-style-type: none"> Command and control structures Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability Procedures to manage and coordinate communications with other key stakeholders and other responders Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control Distinction between dry and wet decontamination and the decision making process for the appropriate deployment Identification of lockdown/isolation procedures for patients waiting for decontamination Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance Arrangements for staff decontamination and access to staff welfare Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability through designated clean entry routes 	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
59	Hazmat/CBRN	Decontamination capability availability 24/7	<p>The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities</p> <p>There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s)</p> <p>The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.</p>	<p>Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board</p> <p>Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans</p> <p>Assessment of local area needs and resource</p>	Fully compliant				
60	Hazmat/CBRN	Equipment and supplies	<p>The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.</p> <p>Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients</p> <p>• Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/epr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/epr-chemical-incidents.pdf</p>	<p>This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).</p> <p>There are appropriate risk assessments and SOPs for any specialist equipment</p> <p>Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required.</p> <p>Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.</p>	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	<p>There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident.</p> <p>Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations</p> <p>The PPM should include where applicable:</p> <ul style="list-style-type: none"> - PRPS Suits - Decontamination structures - Disrobe and robe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes 	<p>Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment</p> <ul style="list-style-type: none"> • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment <p>Organisations using PPE and specialist equipment should document the method for it's disposal when required</p> <p>Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR</p> <p>Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment</p> <p>Records of maintenance and annual servicing</p> <p>Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53</p>	Fully compliant				
62	Hazmat/CBRN	Waste disposal arrangements	<p>The organisation has clearly defined waste management processes within their Hazmat/CBRN plans</p>	<p>Documented arrangements for the safe storage (and potential secure holding) of waste</p> <p>Documented arrangements - in consultaion with other emergency services for the eventual disposal of:</p> <ul style="list-style-type: none"> - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners <p>Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53</p>	Fully compliant				
63	Hazmat/CBRN	Hazmat/CBRN training resource	<p>The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments</p>	<p>Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy)</p> <p>Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination</p> <p>Documented evidence of training records for Hazmat/CBRN training - including for:</p> <ul style="list-style-type: none"> - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken <p>Developed training programme to deliver capability against the risk assessment</p>	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG					
					Action to be taken	Lead	Timescale	Comments		
					<p>Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.</p> <p>Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.</p>					
64	Hazmat/CBRN	Staff training - recognition and decontamination	<p>The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination.</p> <p>Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres)</p> <p>Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented</p>	<p>Evidence of trust training slides/programme and designated audience</p> <p>Evidence that the trust training includes reference to the relevant current guidance (where necessary)</p> <p>Staff competency records</p>						
65	Hazmat/CBRN	PPE Access	<p>Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE.</p> <p>This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7</p>	<p>Completed equipment inventories; including completion date</p> <p>Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination</p> <p>Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS</p>						
66	Hazmat/CBRN	Exercising	<p>Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme</p> <p>NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities:</p> <ul style="list-style-type: none"> • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access 	<p><u>Evidence</u></p> <ul style="list-style-type: none"> • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning 						
67	CBRN Support to acute Trusts	Capability		<p>Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail" column are expressed in documentation. This will help determine:</p> <ul style="list-style-type: none"> -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. <p>Specific plans, technical drawings, risk assessments, etc. that outline:</p> <ul style="list-style-type: none"> -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., "what radiation monitoring equipment do you have, and where is it?") <p>Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible.</p> <p>Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).</p>						

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.	Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.	Not applicable				