The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 October 2023

Agenda item		128/23		
Report Title		Emergency Planning, Resilience and Response Annual Report 2022-23		
Executive Lead		Sara Biffen, Acting Chief Operating Officer		
Report Author		Emma-Jane Beattie, Emergency Planning Manager		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	-
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	-
Well Led	√	Our partners	√	
Consultation Communication		2023.09.07: Health, Safety, Security & Fire Committee 2023.09.15: Emergency Planning and Business Continuity Group 2023.10.04: Audit and Risk Assurance Committee		
Executive summary:		This paper provides assurance on the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements. In summary, there continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing risk and hazard landscape.		
Report Recommendations:		The Board of Directors is asked to approve the annual report and note the following: • Current compliance against the NHS England Core Standards for EPRR. • Training and exercising programme for 2023/2024. • Lessons learnt and recommendations from live incidents/disruptive challenges that the Trust has managed and learning from a range of exercises that the trust has facilitated during 2022/2023.		
Appendices:		Appendix 1: EPRR Core Standards Self-Assessment Appendix 2: EPRR Annual Work Programme		

1.0 Introduction

1.1 This paper provides a report on the Trust's emergency preparedness to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response Framework (EPRR) 2015.

1.2. The Trust has a mature suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with local and regional stakeholders to ensure cohesion with their plans.

1.3. The paper reports on the training and exercising programme and the development of emergency planning arrangements and plans. The report gives a summary of instances in which the Trust has had to respond to extraordinary circumstances.

2.0 Background

2.1 EPRR is a core function of the NHS and is a statutory requirement of the Civil Contingencies Act (CCA) 2004. Responding to emergencies is also a key function within the NHS Act (2006) as amended by the Health and Social Care Act (2012). The role of NHS England relates to potentially disruptive threats and the need to take command of the NHS, as required, during emergency situations. These are wide ranging and may be anything from extreme weather conditions to outbreak of an infectious disease, a major transport accident or a terrorist incident.

2.2 In December 2022, the Government have published the UK Resilience Framework which sets out an ambitious new vision and approach to the UK's resilience up to 2030, and as such, a full review of the Civil Contingencies Act 2004 is underway.

2.3 Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the Trust must be prepared for. It is essential that there is a continued focus on the Trust's Emergency Preparedness and Business Continuity arrangements. It is important that the Trust maintains and continues to advance its reputation within the EPRR arena and contributes towards the Region's Preparedness.

2.4 The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at the local level.

As a category one responder, the Trust is subject to the following civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning.
- put in place emergency plans.
- put in place business continuity management arrangements.
- 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 coordination.
- cooperate with other local responders to enhance coordination and efficiency.

3.0 Overall Level of Compliance

3.1 In accordance with the requirements laid out in the EPRR 2022-2023 Assurance Process Letter (25/05/2023), the overall level of compliance is based on the total percentage of standards that the Trust is Fully Compliant with.

In respect of the Shrewsbury and Telford Hospitals NHS Trust, the Trust is assessed against 62 standards and has self-assessed against the Core Standards for Emergency Preparedness, Resilience and Response as follows:

Fully Compliant	Partially Compliant	Non-Compliant
53	9	0

According to the rating thresholds, SaTH has a self-assessed level of compliance of **Partially Compliant.** Please note that this is subject to change depending on the outcome of the Confirm and Challenge Process.

The details of the standards that the Trust is reporting partial compliance are as follows:

Partially Compliant
Infectious Disease
New and Emerging Pandemics
Mass Countermeasures
Incident Communications Plan x 2
Business Continuity
DSPT
Lock down
Protected individuals

The Shropshire and Telford and Wrekin ICB, on behalf of NHS England, will be undertaking a Confirm and Challenge Meeting to review and discuss the Trusts compliance on the 26th October 2023.

4.0 Audits

4.1 NHS England maintains its statutory duty to seek formal assurance of NHS providers EPRR readiness, discharged through the EPRR annual assurance process. Following the 2022/2023 Confirm and Challenge process, NHSE re-assessed SaTH as partially compliant. The 2022/2023 EPRR assurance process requires SaTH to undertake a self- assessment against the full and updated Core Standards. SaTH will be reporting that the organisation is Partially Compliant, being fully compliant with 53 out of the full 62 core standards, giving an overall 85.4% compliance.

There are no significant risks, however actions to be taken to improve compliance are included in the action plan for 2023/2024 and are noted in the Self-Assessment and the EPRR Work Programme.

The completed Self-Assessment can be found at Appendix 1.

4.2 West Midlands Ambulance Service undertook and audit of the Trusts Chemical, Biological, Radiological, Nuclear (CBRN) capabilities in January 2023 on behalf of National Ambulance Resilience Unit (NARU). Areas of good practice were noted along with areas for improvement such as ED Reception Training, CBRN and the donning and doffing of associated Personal Protective Equipment which have been addressed throughout 2022/23. NARU continue to work with the NHS ambulance services to ensure they maintain specialist capabilities and are fully prepared to respond to any incidents that may occur.

During the WMAS Audit on 13.01.2023, the decontamination tent at RSH was deemed damaged beyond repair. A business case was submitted to replace the tent and the trust took delivery of the new asset on 06.09.2023. Training and awareness sessions will be held with the Estates and ED Teams.

The recommendations set out within the audits have been accepted and actioned.

5.0 Debriefing from Live Events and Exercises

5.1 The COVID-19 incident status was officially stood down on the 18th May 2023. Trusts were required to maintain a Single Point of Contact (SPOC) function Monday-Friday 09:00-17:00 in order to co-ordinate and submit daily and weekly returns to NHSE.

The Trust continues to manage the SPOC function through the EPRR workstream.

5.3 SaTH has also responded to a number of incidents throughout 2022/2023. Post incident debriefs have taken place and post incident reports written with clear recommendations and action plans in place.

- **Critical Incidents**

The Trust has declared Critical Incidents in light of extreme site pressures as follows:

- 14.04.2022
- 12.05.2022
- 21.06.2022
- 04.07.2022
- 08.07.2022
- 26.07.2022
- 11.08.2022
- 27.09.2022
- 18.11.2022
- 05.12.2022
- 20.12.2022
- 21.03.2023
- 09.05.2023
- 01.08.2023
- 11.09.2023

- **IT Outage 22.06.2023**

At 09:28 on 22.06.2023, SaTH's Head of Digital Service Delivery notified the EPRR team of network related issues impacting upon end users accessing non- critical clinical and non- clinical applications at the RSH Site and the Shrewsbury Business Park.

The majority of IT systems were re-instated by 12 noon on 23.06.2023.

A Root Cause Analysis is underway and will be shared in due course.

- **Heatwave July 2022** - A Red Extreme heat national severe weather warning was issued by the Met Office and UK Health Security Agency (UKHSA) issued its first Level 4 heat- health alert. As a result of this, SaTH invoked the Trusts Heatwave Plan and established command and control arrangements to ensure that any issues in relation to patient and staff welfare were addressed in a timely manner.

- **Industrial Action**

    - 13-15th March Junior Doctors: an average of 220/253 Junior Doctors participated in Strike Action.

    - 11-15th April Junior Doctors an average of 192/253 Junior Doctors participated in Strike Action.

    - 14th-17th June Junior Doctors an average of 99/ 253 Junior Doctors participated in Strike Action.

    - 13-18th July Junior Doctors an average of 162/241 Junior Doctors participated in Strike Action.

    - 20-21st July Consultants an average if 26/200 Consultants participated in Strike Action.

    - 11th-15th August Junior Doctors highest number on Friday 11th August where 143/353 Junior Doctors participated in Strike Action

    - 24th-25th August Consultants an average of 17/133 Consultants participated in Strike Action.

  Further dates for Industrial Action are planned as follows:

    - BMA Consultants strikes commence at 7am Tuesday 19th until 7am on Thursday 21st September and again commence 7am Monday 2nd October until 7am Thursday 5th October. (Christmas Day cover for all dates)
    - BMA Junior Doctors strikes commence at 7am Wednesday 20th September until 7am Saturday 23rd September (Christmas day cover will be on 20th, but a full walkout is expected on 21st and 22nd) and then again commences 7am Monday 2nd October until 7am Thursday 5th October (all dates, Christmas Day cover).

  The Trust continues to develop contingency arrangements to maintain patient safety during these periods.

- **Women and Children's Generator Failure – 16.06.2023**

  The Women and Children's Department experienced a localised power outage at circa 13:50 on 16.06.2023. Initially a Business Continuity Incident was declared, followed by a Critical Incident on the 17.06.2023 due to regional mutual aid being sought by NHSE West Midlands Regional Team along with the Maternity Network via the OPEL Framework. Women and Children's services were subsequently closed. These services were re-opened following a series of successful tests of the generators on 20.06.2023. SaTH operated in critical incident status with support from other acute providers up until the 20.6.2023.

  The faulty fuel delivery pump on Generator 5 has since been replaced and tested.

  SaTH carried out simulated mains failure tests on the low voltage side of the system. This test best replicates the situation that occurred on 16/06/2023.

  Business Continuity Plans have been further strengthened. A detailed relocation plan has been developed to supplement the existing business continuity plans to support the on-call teams should a similar incident occur in the future.

  The clinical services were fully restored and SaTH were not reliant upon mutual aid from 20/6/2023, when the decision was taken to re-open services to Women and Children.

  A "Black Start" Exercise took place as planned on Wed 5th July at 09:30. All available technical staff were on standby with additional services of specialist contractors. Formal notice of a successful Blackstart through EPRR routes was submitted.

  Estates will be publishing a separate detailed board report in due course. BAF

  risk 6 is being updated to reflect the generator incident.

  A regional debrief was conducted on the 26th July 2023 and SaTH are awaiting the formal post incident report.

6.0 Exercising

In line with the Core Standards, the Trust has developed and facilitated a number of exercises during 2022/2023 as follows:

- Exercise Bouger 22.08.2022- A multi-agency whole site evacuation exercise aimed to test the system response to an incident resulting in the need to evacuate the Royal Shrewsbury Hospital.
- Exercise Mighty Oak 15.02.2023- A multi-agency Local Resilience Forum Exercise aimed at testing the response to a national power outage.
- Exercise Waste-side 04.07.2023 - A multi-agency exercise, led by SaTH, aimed at testing the CBRN plan.
- SMOC Command Post Exercises- Bi Monthly. As one of the recommendations from Exercise Rainbow, these sessions give the Senior Managers on Call an opportunity to rehearse the response to a Major Incident in an immersive environment in the Incident Command Centres.

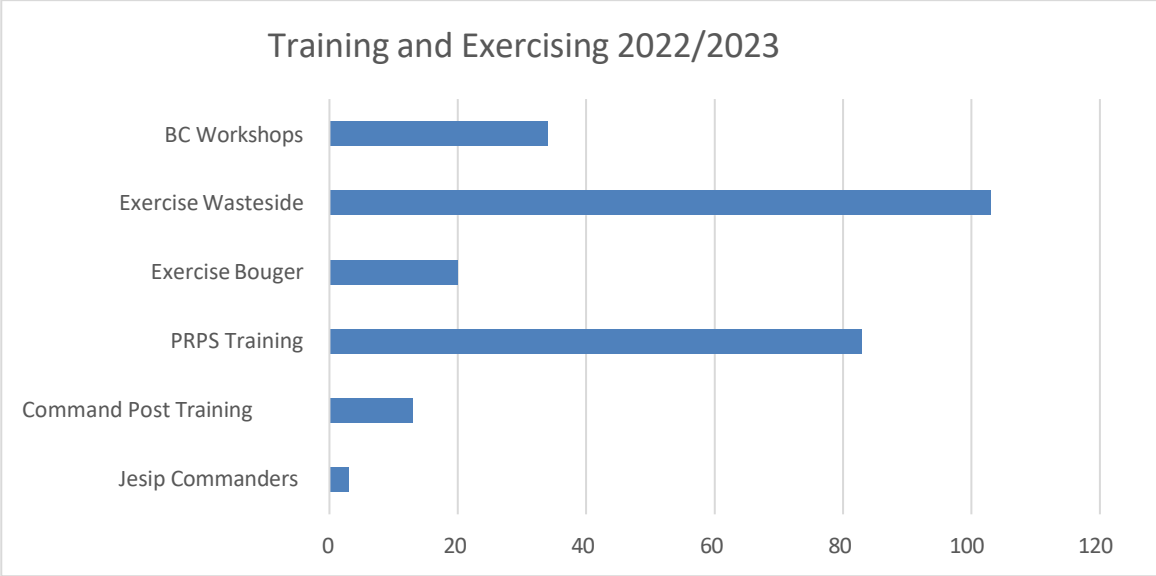
7.0 Training, Exercising and Testing

7.1 The Trust has a rolling programme of training along with a programme of live, tabletop and communication exercises. The exercises are designed to test and develop our plans and afford an opportunity for staff to participate as part of their continued professional development.

7.2 The Trust is required to carry out exercises as follows:

- Communication Exercise – minimum frequency – every 6 months
- Table-top Exercise – minimum frequency – every 12 months
- Live Play Exercise- minimum frequency – every 3 years
- Command post exercise – minimum frequency – every three years

7.3 The table below details the training and exercises undertaken from April 2022 to July 2023. A total of 256 people have been trained or praticipated in exercises during this period.



7.4 It should be noted that several training, exercising and testing events have been cancelled/ rescheduled due to Industrial Action and other concurrent incidents. These events have either been re-scheduled or will be at an appropriate time.

7.5 The Chief Operating and the Director of Nursing will both be attending the Multi Agency Gold Command (MAGIC) training developed and run by the College of Policing as soon as new dates are released.

7.6 Wherever possible, the Trust strives to ensure that our testing and exercising is held in a multi-agency context. This is to provide familiarisation with other organisations and to assist with benchmarking our response with our partners. Exercises provide invaluable insight into the operationalisation of our plans and also highlight any gaps in our response arrangements that might need to be further developed.

8.0 Work Programme 2023-2024

8.1 The work programme for the forthcoming financial year will be dependent on the continuing Trust response to Industrial Action, operational response issues, the

management of the Single Point of Contact function and the EPRR work programme, which will be reviewed and prioritised accordingly.

8.2 The main focus will be to ensure that all response plans are fit for purpose following internal & external debriefs and changes to national plans, delivery of the Trust wide training programme and continuation of the BCM project. A Business Continuity Summit is taking place on the 6th October 2023 to ensure all BCP's are robust in readiness for the EPR cutover.

8.3 The Work programme will also focus on the development of a new system and trust wide countermeasures plan to be written and implemented across the Trust, using the learning from the COVID-19 vaccination programme and alignment of the Evacuation & Shelter plan.

8.4 Emergency Department training will continue this year, dates are already in the diary for all of the sites, and the training ensures a consistent approach across the Trust. These sessions will only go ahead if it is operationally possible, however in the event of extreme site pressures/ concurrent incidents, these sessions may need to be cancelled at short notice.

8.5 All training will now be in line with the NHS Minimum Occupational Standards, the National Occupational Standards & Skills for Justice Requirements as stipulated within the Core Standards.

9.0 Risks and actions

9.1 The National Security Risk Assessment (NSRA) and the National Risk Register (NRR) are reviewed every 2 years. The NSRA was published in autumn 2022 and the NRR was published on 03/08/2023 . The risks included in these assessments are considered at the Local Resilience Forum and plans, policies and procedures are developed in line with the most likely and highest impact risks.

9.2 The Government published the updated National Risk Register on Thursday 3rd August, the document can be found here: https://www.gov.uk/government/publications/national-risk-register-2023.

This iteration, compared to previous versions outlines many of the Risks the UK faces in much more detail with a lot more transparency. Much of the content and context within this version was previously limited to those who had been vetted to have access to "Official Sensitive" documentation. This marked change is welcoming and will mean that we can share much more detail with our colleagues during training & exercising and with the communities we serve which supports the governments aspirations to become the most resilient nation in the world by 2203 through their vision of a Whole Society approach to Resilience.

The publication of these risks will support the requirements of the Trust to consider these risks corporately in line with the Core Standards for EPRR.

The "Red risks" are outlined below, and we'll be continuing to prioritise our planning, training and exercising programme using a risk based approach.

NRR Risk Ref	Risk Description
9	Large Scale CBRN Attacks
26a	Failure of the National Electricity Transmission System
54	Pandemic
10	Conventional attacks on infrastructure
47	Severe space weather
50	Low temperatures and heavy snow
55	Outbreak of an emerging infectious disease
63	Nuclear mis-calculation not involving the UK
3	Terrorist attacks in venues and public spaces
31b	Technological failure at a UK critical financial market infrastructure
46	Disaster response in the Overseas Territories
62	Attack on a UK ally or partner outside NATO or a mutual security agreement requiring international assistance

10.0 Conclusion

10.1 The EPRR work programme for 2023/24 will include:

- Updating plans and standard operating procedures to take account of changes to the National Security Risk Assessment and the National Risk Register.
- Development of the Mass Countermeasures Plan.
- Development of Business Continuity Arrangements.
- Development of crisis communications plans.
- Development of the Pandemic Influenza Plan.
- Development of online training modules on the LMS platform.

10.2 The past year has seen good developments in the Trust's resilience arrangements; however, more work is required at the service level to achieve full resilience.

10.3 The Trust should be undertaking a more detailed and comprehensive training and exercising programme; however, this requires an agreement and commitment for staff to be released to attend.

10.4 The Board is asked to approve the annual report and note the following:

- Current compliance against the NHS England Core Standards for EPRR.
- Training and exercising programme for 2023/2024.
- Lessons learnt and recommendations from live incidents/disruptive challenges that the Trust has managed and learning from a range of exercises that the trust has facilitated during 2022/2023.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational 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. Green (fully compliant) = Fully compliant with core standard.	Action to be taken
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable 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.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	CS1 Chief Operating Officer JD Sara Biffen as AEO CS1a NED Portfolio	Fully compliant	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • 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. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	X:\EmergencyPlanning\PLANS TO GO TO HSS&F\SaTH Major Incident Overview Document v4.0.docx	Fully compliant	
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • 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. Evidence • 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 activitites.		Fully compliant	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	CS4 EPRR Work Programme 2023/24	Fully compliant	
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.	Y	Evidence • 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	1 x FTE Emergency Planning Manager and newly recruited B5 Emergency Planning Officer. See Page 6 of the EPRM JD for Organisational Diagram CS5 Evidence Link	Fully compliant	
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.	Y	Evidence • 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	Add Debrief Reports Wastside Ex Bouger Women and Children's Generator Failure College of policing guidance/ certificates	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.	Y	• 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	Include updated Heat Risk Include updated risk Matrix Inlucde RMC ToR	Fully compliant	

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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	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	James Webb sending 25.08.2023	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 stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	CS9 Policy Consultation Process/ Checklist	Fully compliant	
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.	Y	Arrangements should be: • 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	EJB 25.08.2023	Fully compliant	
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.	Y	Arrangements should be: • 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.	CS11 Cold Weather Plan CS11 Heatwave Plan	Fully compliant	
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.	Y	Arrangements should be: • 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 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/	Current Pandemic Influenza Policy is scheduled for review on the EPRR Work Programme for review in September 2022. This will reflect organisational learning from the COVID-19 Pandemic.	Partially compliant	Plan to be trained and exercised- included in work programme
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	Y	Arrangements should be: • 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	Current Pandemic Influenza Policy is scheduled for review on the EPRR Work Programme and scheduled for review in September 2022. This will reflect organisational learning from the COVID-19 Pandemic.	Partially compliant	Plan to be updated, trained and exercised- included in work programme

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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	Y	Arrangements should be: • 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 Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. 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. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Currently working with system partners to develop a multi agency plan. SaTH do not have the PGD/ Licences to be able to prescribe and dispense medicines to outpatients.	Partially compliant	System wide plan to be developed, trained and exercised, incluced in work programme
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.	Y	Arrangements should be: • 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 Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.		Fully compliant	
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.	Y	Arrangements should be: • 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	X:\EmergencyPlanning\Core Standards\2023-2024\Evidence Log\CS16\Evacuation And Shelter Plan 2023. 2024.docx X:\EmergencyPlanning\Core Standards\2023-2024\Evidence Log\CS16\22.08.2022 EVAC & SHELTER Exercise Slides (2).pptx Evidence Log\CS16\Bouger debrief 2022.doc X:\EmergencyPlanning\Core Standards\2023-2024\Evidence Log\CS16\Attendance List.xlsx	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.	Y	Arrangements should be: • 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	Evidence Log\CS17	Partially compliant	Plan to be updated in line with the PROTECT Duty/ Martyns Law , trained and exercised- included in work programme
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.	Y	Arrangements should be: • 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	Evidence Log\CS18\SY05 Counter Terrorism procedures SaTH v1.4.pdf	Partially compliant	Plan to be devleoped further in line with the PROTECT Duty

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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.	Y	Arrangements should be: • 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	Evidence Log\CS19\2023 03 01 Excess Deaths Plan v 3.0 Final Draft.doc	Fully compliant	
Domain 4 - Command and control								
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.	Y	• 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	Evidence Log\CS20\Copy of Competencies.xlsx Evidence Log\CS20\SaTH on Call Roles and Responsibilities June 2023.docx	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	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • 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.	Evidence Log\CS21\Command Post Exercise Welcome Brief.pptx	Fully compliant	
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.	Y	Evidence • 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	Evidence Log\CS22	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)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Evidence Log\CS4\2023_2024 EPRR Work Programme.xlsx	Fully compliant	
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	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Evidence Log\CS24\2021_2022 EPRR Training and Exercising Record.xlsx	Fully compliant	
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.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Evidence Log\CS24\2021_2022 EPRR Training and Exercising Record.xlsx	Fully compliant	
Domain 6 - Response								

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational 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. Green (fully compliant) = Fully compliant with core standard.	Action to be taken
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.	Y	• 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.	Evidence Log\CS21\Command Post Exercise Welcome Brief.pptx	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.	Y	Planning arrangements are easily accessible - both electronically and local copies	Evidence Log\CS27\CS27 SaTH Major Incident Page.docx	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).	Y	• 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	Y	• Documented processes for accessing and utilising loggists • Training records	Evidence Log\CS29\2023 06 13 list of trained loggists.xlsx	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.	Y	• 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	Evidence Log\CS30	Fully compliant	
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.	Y	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)	Y	Guidance is available to appropriate staff either electronically or hard copies		Fully compliant	
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.	Y	• 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.	Evidence Log\CS33\SaTH Major Incident Plan 2023.docx	Partially compliant	Work with the comms team to develop a crisis comms plan and training strategy- included in work programme
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• 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).	Evidence Log\CS34	Partially compliant	Work with the comms team to develop a crisis comms plan and training strategy- included in work programme

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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.	Y	• 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	Evidence Log\CS35	Fully compliant
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• 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.	Evidence Log\CS36 Major Incident Plan Evidence Log\CS36 Social Media Policy	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.	Y	• 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.	Evidence Log\CS37\180723 STW LHRP Minutes V3 NW.docx	Fully compliant	
38	**Cooperation**	**LRF / BRF 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.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Evidence Log\CS38 2023 07 06 COG Minutes	Fully compliant	
39	**Cooperation**	**Mutual aid arrangements**	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.	Y	• 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	Evidence Log\CS39\SaTH Major Incident Plan 2023.docx Evidence Log\CS39\2023 01 06 Fire Rescue Service MOU.docx	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.		• 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.		• 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.		• 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.	Y	• 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	Evidence Log\CS43\2023 WMLRF Information Sharing Agreement.doc	Fully compliant	
Domain 9 - Business Continuity								
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 ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • 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	Evidence Log\CS44\Business Continuity Planning Policy V8 (3).docx	Fully compliant	

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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.	Y	BCMS should detail: • 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	Evidence Log\CS46\ BC Planning Policy	Fully compliant	
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).	Y	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.	Evidence Log\CS46\RSH ED Business Impact Analysis.docx Evidence Log\CS46\Blank SaTH BCP Template 2023.docx	Fully compliant	
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is	Evidence Log\CS47\BCP Matrix May 2023 .xlsx Evidence Log\CS47\Critical Care BCP Feb2023 V1.docx	Partially compliant	BC Summit taking place 06.10.2023
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.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	BC Summitt planned for 06.10.2023	Fully compliant	
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.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Evidence Log\CS49\22-23 DSPT requirements and update v2 with audit indicators.xlsx	Partially compliant	Work in progress, working towards standard.
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.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	Evidence Log\CS50\Business Continuity Planning Policy V8 (3).docx Evidence Log\CS50\BCP Matrix May 2023 .xlsx	Fully compliant	
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.	Y	• 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	Evidence Log\CS51\BCP Internal Audit.docx	Fully compliant	

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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.	Y	• 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	Evidence Log\CS52\Business Continuity Planning Policy V8 (3).docx	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.	Y	• 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	Evidence Log\CS53\1. Contract Management planner 2022.xlsx	Fully compliant	
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		• Exercising Schedule • Evidence of post exercise reports and embedding learning		Not applicable	
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	Y	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	Evidence Log\CS55\SaTH.. CBRN Plan June 2023.docx	Fully compliant	
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	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	Evidence Log\CS56\SaTH.. CBRN Plan June 2023.docx	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	Y	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	Evidence Log\CS57\SaTH.. CBRN Plan June 2023.docx	Fully compliant	

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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 arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •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 •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Evidence Log\CS58	Fully compliant	
59	Hazmat/CBRN	Decontamination capability availability 24 /7	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	Y	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	Evidence Log\CS59\Acute Trust CBRN Review 2022 - PRH - Summary of Findings.docx Evidence Log\CS59\Acute Trust CBRN Review 2022 - RSH - Summary of Findings.docx	Fully compliant	
60	Hazmat/CBRN	Equipment and supplies	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.	Y	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).	Evidence Log\CS60\Major incident stock SATH 2023.xlsx Evidence Log\CS60\Improvised wet decontamination SOP 1.2.docx	Fully compliant	
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	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. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe 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 There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing 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	Evidence Log\CS61\Major incident stock SATH 2022.xlsx	Fully compliant	
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	Evidence Log\CS62\ER membership cert (1).pdf	Fully compliant	

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63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	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	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - 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 Developed training prgramme to deliver capability against the risk assessment	Training Attendance Record	Fully compliant	
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. 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) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Evidence Log\CS64\2023 ED Major Incident Training.pptx	Fully compliant	
65	**Hazmat/CBRN**	**PPE Access**	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. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Evidence Log\CS65	Fully compliant	
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Ex Wasteside post Exercise Report	Fully compliant	
68	**CBRN Support to acute Trusts**	**Capability**	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • 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 specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.		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: -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. Specific plans, technical drawings, risk assessments, etc. that outline: -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?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).		Not applicable	

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational 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. Green (fully compliant) = Fully compliant with core standard.	Action to be taken
69	**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	
70	**CBRN Support to acute Trusts**	**Capability Review Frequency**	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).		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	
71	**CBRN Support to acute Trusts**	**Capability Review report**	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.		Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of those. Dip sample of last 10 years of reports, e.g., please provide reports from 2015, 2018, and 2022 to show adherence to the retention of reports for 10 years.		Not applicable	
72	**CBRN Support to acute Trusts**	**Train the trainer**	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.		Written statement as to how this is achieved, which can then be further investigated during inspection. Evidence of training records and/or a documented training schedule. Provision of suitable training documentation – syllabus, lesson plans, etc., that shows the detail of training delivered.		Not applicable	
73	**CBRN Support to acute Trusts**	**Aligned training**	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.		NARU can provide the latest version number of associated training packages. This can then be cross-referenced against lesson plans and training packages in acute Trusts to ensure up-to-date national training is being delivered.		Not applicable	
74	**CBRN Support to acute Trusts**	**Training sessions**	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.		Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is delivered to acute Trusts, how often, etc.).		Not applicable	

Fully Compliant	53
Partially Compliant	9
Percentage	85.48387097

62 standards for Aacutes- Total

fully copmpliant	100%	62
Substantially compliant	99-89%	61-55
Partially Compliant	88-77%	54-48
Non Complaint		

Emergency Planning Resilience and Response Plans and Procedures