EPRR Core Standards and Annual Report

Author: Aaron Vogel Sponsor: Tim Lynch **Trust Board paper K**

Executive Summary

Context

The Trust is required to take part in a self-assessment against the national EPRR (Emergency Preparedness, Resilience and Response) core-standards. This paper provides a summary of the current compliance (90%) with actions to rectify. It also provides detail of the wider progress made in Emergency Planning for the last 12 months. There are improvements to be made primarily in education, training and exercising as well as improving the governance arrangements supporting EPRR in terms of Director level input in engaging with multi agency partners.

Questions

1. Is the Trust Board satisfied with progress over the past 12 months?
2. Is the Trust Board willing to support improvements in training and exercising and support the development of emergency planning within the Trust?
3. Is the Trust Board willing to sign off and pass onto NHS England for scrutiny?

Conclusion

1. Compliance is rated as partial with 9 standards not being fully addressed (one standard is counted twice)
2. New structure to support Emergency Planning within the Trust provides more resilience and cover at the director level to improve involvement in planning and engagement with multi agency partners
3. Training and exercising uptake requires improvement and the Emergency Planning committee are committed to improving training and exercising within the Trust for key staff.

Input Sought

We would welcome Trust Board input regarding approval and sign off so that it can be submitted to NHS England for scrutiny.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

2. Safe, high quality, patient centred healthcare [Yes]
3. Effective, integrated emergency care [Yes]
4. Consistently meeting national access standards [Yes]
5. Integrated care in partnership with others [Yes]
6. Enhanced delivery in research, innovation & ed' [Yes]
7. A caring, professional, engaged workforce [Yes]
8. Clinically sustainable services with excellent facilities [Not applicable]
9. Financially sustainable NHS organisation [Not applicable]
10. Enabled by excellent IM&T [Not applicable]

11. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
	All emergency planning risks are currently under review			

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [No]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

12. Related **Patient and Public Involvement** actions taken, or to be taken: [Insert here]

13. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]

14. Scheduled date for the **next paper** on this topic: [September 2018]

15. Executive Summaries should not exceed **1 page**. [My paper doe comply]

16. Papers should not exceed **7 pages.** [My paper does not comply]

University Hospitals of Leicester NHS Trust

Annual Resilience Report

August 2017

Aaron Vogel
Emergency Planning Officer

Contents

Executive Summary

This annual report highlights the significant improvements that have been made in relation to Emergency Preparedness within the Trust between July 2015 and July 2016. Most notable improvements have been made in;

1. Compliance against national standards and audit recommendations
2. Response to the Junior Doctors industrial action
3. Development and delivery of Exercise Autumn Power
4. Preparations for Leicester City Football Club Victory Parade
5. Major Incident training and exercising.

Further improvements for the year will focus on more training and exercises on a local level, improving the call out arrangements during a major incident, preparation for the opening of the new Emergency Department and delivering against cost improvement targets.

1. Introduction

1.1. Emergency Preparedness, Resilience and Response (EPRR) is key to ensuring that the Trust is able to respond to a variety of incidents whilst continuing to provide its essential services. The Civil Contingencies Act (CCA) 2004 and Health and Social

Care Act 2012, places a number of statutory duties on the Trust as a Category 1 Responder. These duties include:

- Risk assessment to inform contingency planning
- Emergency planning
- Business continuity planning
- Co-operation with other responders
- Information sharing with other responders
- Warning, informing and advising the public in the event of an emergency

1.2. These are reinforced through requirements under the Care Quality Commission, Trust Development Authority (TDA) Planning Framework, NHS England Core Standards for EPRR and International Standards (ISO) 22301.

1.3. The purpose of this annual report is to provide the organisation with an update on the delivery of EPRR activities within the Trust during 2016/17 providing assurance that the Trust is meeting its statutory EPRR duties. This report provides an overview of the plans that have been reviewed, the multi-agency partnership work that the Trust has been involved in and the training and exercises that Trust staff have participated in. The report also identifies the key emergency planning priorities for 2016/17.

2. Background

2.1. The past 12 months have resulted in continued improvement in the implementation and development of Emergency Planning within the Trust with continued improvement against the NHS England EPRR Core Standards. NHS England agreed that the Trust was “fully compliant” against the requirements of the National EPRR Core Standards.

2.2. Throughout the year there have been a number of challenges that the Team has had to respond to, most notably this was focused on preparation for the opening of the new Emergency Department responding to the cyber-attack that affected the NHS in May, the move to critical terrorist threat level in May and preparation for Exercise Soteria, which tested the Trust’s response to a Major Incident. In addition the Trust’s Major Incident, Friends and Relatives’ Reception Centre Plans and CBRN plans have all been updated. Staff training and exercising have continued, but not at the high levels achieved in previous years. The team are working hard to rectify this, with more adaptable and more easily implementable packages of training and exercising events to roll out.

2.3. The Emergency Planning and Business Continuity Committee continue to meet quarterly to oversee EPRR activity within the Trust ensuring delivery against the following objectives;

a. Facilitate the development of plans and procedures to deal with the response to an incident

b. Develop a strategy for Undertaking Business Continuity and Emergency Planning within the Trust

c. To assess the risks to the organisation with regards to Emergency Planning and Business Continuity making reference to national and local risk assessments

d. Provide regular reports to the Trust Executive to assess and assure the ability of the Trust to respond and recover from major incidents

e. Provide support and identification of service's and individual's responsibilities in the event of an incident

f. Ensure that all polices and plans are aligned internally and externally with partner organisations through appropriate representation and involvement with multi agency groups including the Local Resilience Forum and Local Health Resilience Partnership.

g. To ensure delivery against statutory obligations including the Civil Contingencies Act 2004, Health and Social Care Act 2012, Care Quality Commission Regulations 9 and 24 (regulated activities) outcomes 4 and 6, Trust Development Authority (TDA) Planning Framework, NHS England Core Standards for EPRR and International Standards (ISO) 22301.

h. To ensure that appropriate training and exercising of staff and procedures is undertaken, including local training and where necessary multi agency training and exercises

i. To ensure that lessons identified from incident and exercise debriefs are shared and acted upon

j. To ensure appropriate reporting structures exist within the CMGs and Corporate Services to enable successful delivery of the committee's work plan

2.4. The committee is currently focused on the development of business continuity across the Trust to ensure coordination of planning and incident response activity, most notably in relation to the numerous construction and reconfiguration projects that are currently on going. Other focuses include training, exercising, incident reporting, learning from incidents, risk management and funding support.

2.5. Externally the Trust regularly engages with members of partner organisations to ensure cooperation and integration of activities. Locally, the Trust is a member of the Leicester, Leicestershire and Rutland (LLR) Local Resilience Forum (LRF), chaired by the Police. The Trust is represented at practitioner working groups by the Emergency Planning Officer and at the executive board by the Deputy Director of Operations. The Trust is also represented at the Local Health Resilience

Partnership (LHRP) by the same representation. The LHRP ensures specific coordination of local NHS organisations in relation to EPRR.

3. EPRR Core Standards

3.1. NHS England requires providers of NHS funded care to provide assurance against the National Core Standards in relation to Emergency Preparedness, Resilience and Response (EPRR). As part of the review NHS England has established that each year will include a 'deep dive' around specific issues. This year the deep dive has included arrangements on Governance. The other Core Standards have remained unchanged. For July 2016 return, NHS England assured that UHL were "fully compliant" with the requirements of the core standards. This included assurance of the programme of work to address any gaps.

3.2. The self-assessment is due to be signed off by the Trust Executive in August 2017 where it will be reviewed and formally assessed by NHS England in the third quarter of the year.

Table 1 EPRR Core Standards Compliance July 2016-August 2017

	June 2016		August 2017	
	Total	%	Total	%
GREEN	87	91.6	80	81
AMBER	8	8.4	10	11
RED	0	0	0	0
Total	95	100	90	100

3.3. Table 1 shows a slight reduction in overall compliance; however the Trust continues to be significantly compliant with the standards. Of the 10 amber standards; 5 relate to training and education – predominately with regards to formalised training and maintenance of key competencies, future exercises and involvement of staff in multi-agency exercises. 3 further amber standards relate to the role of the Accountable Emergency Officer and their involvement within the LHRP and LRF board meetings and internal Emergency Planning Committee. The final 2 amber are both related to the numbers of Powered Respirator Protective Suits which the Trust is awaiting resupply from the national replacement programme.

4. Risk Assessment

4.1. The Trust is required under the Civil Contingencies Act to assess the risk of an emergency occurring. The Trust does this internally and externally in conjunction with other emergency responders to develop a Community Risk Register.

4.2. The main purpose of the Community Risk Register is to assess the risks to the health and wider community in order to address risks and strengthen our capabilities. It allows the responding agencies of the Resilience Forum to focus multi agency emergency planning resources on a rational basis of priority and need. This work contributes to reducing our vulnerability to it and reducing the impact of it, should it materialise. The fact that a risk is included in the register does not mean

that any particular incident will happen. Nevertheless, the possibility, however remote, has been recognised and the relevant agencies including University Hospitals of Leicester NHS Trust have arrangements in place to mitigate the effects of such incidents. How the risks have been assessed is identified in table 2 and how those risks relate to the Trust is identified in table 3, these have been reviewed and risk scores revised in line with current planning assumptions.

Table 2 LLR LRF Community Risk Register Priority 1 Risks (September 2016)

Risk	Risk rating
Influenza type disease (pandemic)	Very High
Total failure of GB's National Electricity Transmission Network	Very High
Emerging infectious diseases	High
Severe effusive (gas rich) volcanic eruption overseas	High
Actual or threatened significant disruption to fuel supplies including as a result of industrial action by tanker drivers or refinery staff, or effective blockades at key refineries / terminals by protestors	High
Natural Disaster - Heat wave	High
Severe Space Weather	High
Localised industrial accident involving small toxic release	High
Large toxic chemical release	High
Local/Urban Flooding (Fluvial or surface run-off)	High

Table 3 UHL Emergency Planning Risks

Risk	Score
Influenza Type Disease Pandemic causing disruption to services	12
No notice loss of telecommunications	12
Flooding from fluvial and pluvial sources	8
Denial of access to part of, or whole of a site resulting in relocation of clinical services	8
National road fuel shortage	6
Release of hazardous chemical affecting the community resulting in contaminated self-presenters	6
Severe Weather Heat wave	6
Severe Weather Low Temperatures	6

5. Emergency Plans

5.1.1. There are a wide range of Emergency Plans that have been developed within the Trust. Some focus on service areas and individual CMGs whilst others focus on Trust wide responses. These plans are all being reviewed with the aim to ensure consistent and coordinated planning and response measures across the Trust. The below table shows the current suite of plans that are managed by the Emergency Planning Team.

Table 4 Emergency Plans

Plan
Relatives' Reception Centre

Operation Consort
CBRN Plan
Bomb Threat Response Plan
UHL Pandemic Influenza
UHL VHF Patient Management
Major Incident
Major Incident - Section B
Business Continuity Policy
UHL Internal Incident
Evacuation

5.2. **Evacuation Plans**

5.2.1. In extreme situations it may become necessary to evacuate parts of, or the whole of a hospital site to safeguard the health and wellbeing of patients, staff and visitors. Based on evacuation workshops held last year the team have been working with the Emergency Services, Leicester Tigers, and De Montfort University to develop plans as to how we could evacuate and temporarily relocated large numbers of patients, staff and visitors.

5.3. **Major Incident Plan**

5.3.1. The Trust's Major Incident Plan continues to be the foundations of the Trust's incident response plans. This year sections were updated to reflect the completion of the new Emergency Department and remains fit for purpose. The plan is made up of section A which details the Trust wide response, management and corporate responsibilities, whilst section B detailed the relevant service area response arrangements based on a standardised template to ensure consistency across the Trust.

5.3.2. The plan includes the following information:

- Response management structures and call-out procedures
- Tactical and strategic responsibilities – corporate
- Operational responsibilities – relevant service areas
- Patient Management
- Mutual Aid arrangements including reporting processes
- Communications strategy, including communicating with stakeholders and the public
- Action cards
- Recovery plans

5.3.3. The plan is currently under review in order to fit the Trust's template for policies and to ensure that it incorporates learning from Exercise Soteria.

5.4. **Business Continuity Management**

5.4.1. Business Continuity Management (BCM) helps manage the risks to the delivery of Trust services. It put into place arrangements to ensure that in the event of a disruption, services can continue to operate to protect essential functions and users of the service.

5.5. CBRN

5.5.1. Within the new Emergency Department there is now a built in decontamination facility that has been designed specifically for large numbers of self-presenters. This new facility allows for rapid access to decontamination for casualties as well as reduced stress on staff who previously had to erect a temporary decontamination tent outside. The new facility has been designed to provide enhanced privacy and dignity during the decontamination process.

5.6. Call Out System

5.6.1. A review of the internal communications call out procedure concluded that for two supervisors approximately 90 minutes to complete is not suitable and other means of notification should be implemented. This process only notified the on call staff which would then have had to undertake their own call outs to notify relevant staff within their service. To improve the responsiveness, a new system was purchased in September that automated much of the process. It has the ability to notify staff by text, phone call and email almost instantly and records the responses received by staff so that hospital commanders can see what staff they have available to call upon during an incident. To date (4th August 2017) there are over 1800 members of staff on this system. This is mainly management and on call medical staff with nursing staff from the Emergency Department, Theatres and Critical Care also included. More groups of staff are being identified to be included.

5.6.2. Challenges with this approach will be to keep the numbers and contacts within the system up to date and support from the CMGs in this matter will be greatly appreciated.

6. Live Incidents, Exercises and Training

6.1. Live Incidents

6.1.1. This year has been largely incident free the only two incidents that occurred that required activation of specific command and control arrangements, and were not related to capacity were due cyber-attacks. One of these was an internal malware attack which restricted access to files on network drives and the second was the cyber-attack that affected the wider NHS. In the later UHL was not affected directly as a result of the attack but more as a result in taking measures to protect the Trust from infestation. The Trust stepped up its preparedness around the heightened terrorist threat levels, but this did not require activation of any specific response arrangements.

6.1.2. Nationally during 2017 there were a number of incidents, most notably the terrorist attacks at Westminster, Manchester and London plus the Grenfell Tower fire. The Trust has received findings from the debriefs around those incidents and has begun to incorporate the learning into the Trust's incident response plans. In relation to the Grenfell Tower fire, the Trust continues to engage with the Fire Service and wider partners to ensure adequate fire safety, this area of work is undertaken by Estates and Facilities supported, where necessary, by the Emergency Planning Team.

6.2. Training and Exercise

6.2.1. A key part of any preparedness arrangements is to ensure that staff are appropriately trained to implement the required response and that the response arrangements are suitably validated.

6.2.2. Since July 2016 the Emergency Planning Team has facilitated in the delivery of training and exercises to 201 members of staff predominately as a result of Exercise Soteria in July 2017 (see below). Training has also been provided within the ED mandatory training, however at time of writing this report these figures were not available. Capacity to provide training was restricted by the preparation for the new emergency department and the development of Exercise Soteria.

6.2.3. Training and Exercises have been developed and delivered across a number of key areas, most notably Major Incident Response, and has included;

- Exercise Tiberinus – exercise to test the response to flooding within Leicester City Centre
- Loggist Training – to ensure that UHL has sufficiently trained members of staff who can act as a loggist during an incident
- Exercise Soteria – tested UHL's response to a Major Incident
- Anaesthetic Trainees – familiarisation with the Major Incident plan and their role within it.
- ED Mandatory Training – this year has focused on the Major Incident and CBRN responses within the new the new department.

Further areas of training to be developed include, additional training for CMG staff for Internal and Major Incidents and loss of critical services and localised Major Incident exercises.

6.3. Exercise Soteria

6.3.1. Exercise Soteria was designed to test the Trust's Major Incident Plan and involved over 130 players, including UHL staff, Police, Army and other NHS providers. The exercise took place predominantly at the Leicester Royal Infirmary and tested how casualties were received, triaged and treated in the Emergency Department and then onward

treatment in other areas of the Hospital. The exercise was conducted onsite to test the suitability of the command rooms, equipment and IT systems that would be used in a Major Incident. A number of recommendations have been identified predominately around communication, suitability and functionality of IT systems, engagement between hospital services, the management of relatives' and the requirement for future exercises and training. For more detail please consult the Exercise Soteria debrief report.

6.4. Communications Tests

6.4.1. All NHS Trusts are required to conduct a communications test at least every six months. To improve familiarity from 2016 the Trust has decided to undertake these tests every four times a year utilising the new automated call out system. There are two type of test, test 1 tests all the contact numbers so everyone on the system gets the same message and confirms that details are correct, test 2 tests the programming of the system as some areas have different messages or different delivery options that require testing to confirm that they work. Each test is undertaken at least twice a year (4 tests in total). The latest tests to be conducted are listed as;

- 10th July 2017 – test option 2
- 25th May 2017 – test option 1
- 23rd February 2017 – test option 2
- 28th November 2016 – test option 1

6.4.2. Results of these tests are regularly reported to the Emergency Planning Committee. The results of the latest test show that; of the 1690 contacts who were contacted, 1052 (62%) of them confirmed receipt of the message. Of those that confirmed receipt 833 (79%) confirmed that they were either available to respond or were at work. The average time in which it took for the staff to respond was 1 hour and 14 minutes, this improves to 54 minutes if you discount responses received after 10th July. This is a dramatic improvement on the old system. As well as the automated system, switchboard still notifies the arrest and trauma teams based on all three sites.

7. Co-operation and Information Sharing with other Responders

7.1. The Trust takes an active role in sharing information in relation to Emergency Planning and Business Continuity. The Deputy Director of Operations and the Emergency Planning Officer attend a number of meetings which bring together health partners and stakeholders to discuss common areas of planning, ensure integrated planning, training and exercising and share best practice. The Trust is represented on the following groups and forums:

- LLR Local Resilience Forum at Executive and Practitioner levels
- LLR Health Resilience Partnership at Executive and Practitioner levels
- LLR Surge and Resilience Planning Group

8. Priorities for 2017 / 2018

8.1. There are a number of priority areas for 2017 / 2018. These are based on the requirements to maintain the capability to respond to an incident, regardless of scale, time or place.

8.2. The priorities for the coming year are to:

1. Ensure that plans for Internal Incident/Service Disruption are embedded within the Trust.
2. Ensure resilience and service delivery is maintained throughout the transition into the new Emergency Department. This will include extensive training and exercising arrangements to ensure processes are prepared for the operational 'go live' of the department.
3. Continued development and regular review of existing arrangements ensuring that they are embedded within the Trust, including; Pandemic Influenza, CBRN, Major Incidents.
4. To further develop training and exercises to increase the number of staff involved beyond 2016/2017 figures.
5. Further develop and test business continuity plans across the organisation to ensure continued delivery of its most critical services in the event of a business continuity disruption.
6. Continue to engage with Service Area and CMG Emergency Planning leads
7. Continue to work with multi-agency responders in the development of plans and procedures
8. Develop new arrangements and systems for alerting staff of a major incident.
9. Ensure interoperability between CMG, Trust and multi-agency response plans
10. Continue to raise the profile of emergency preparedness within the organisation
11. Continue engagement and involvement in the redevelopment of the Trust site and infrastructure
12. Integrate all local health agencies emergency response procedures

9. Recommendations

9.1. The Committee is asked to:

- Receive this report as a statement of assurance of the preparedness of the Trust to provide an effective response to a range of incidents and emergencies
- Support the priorities for 2017/18

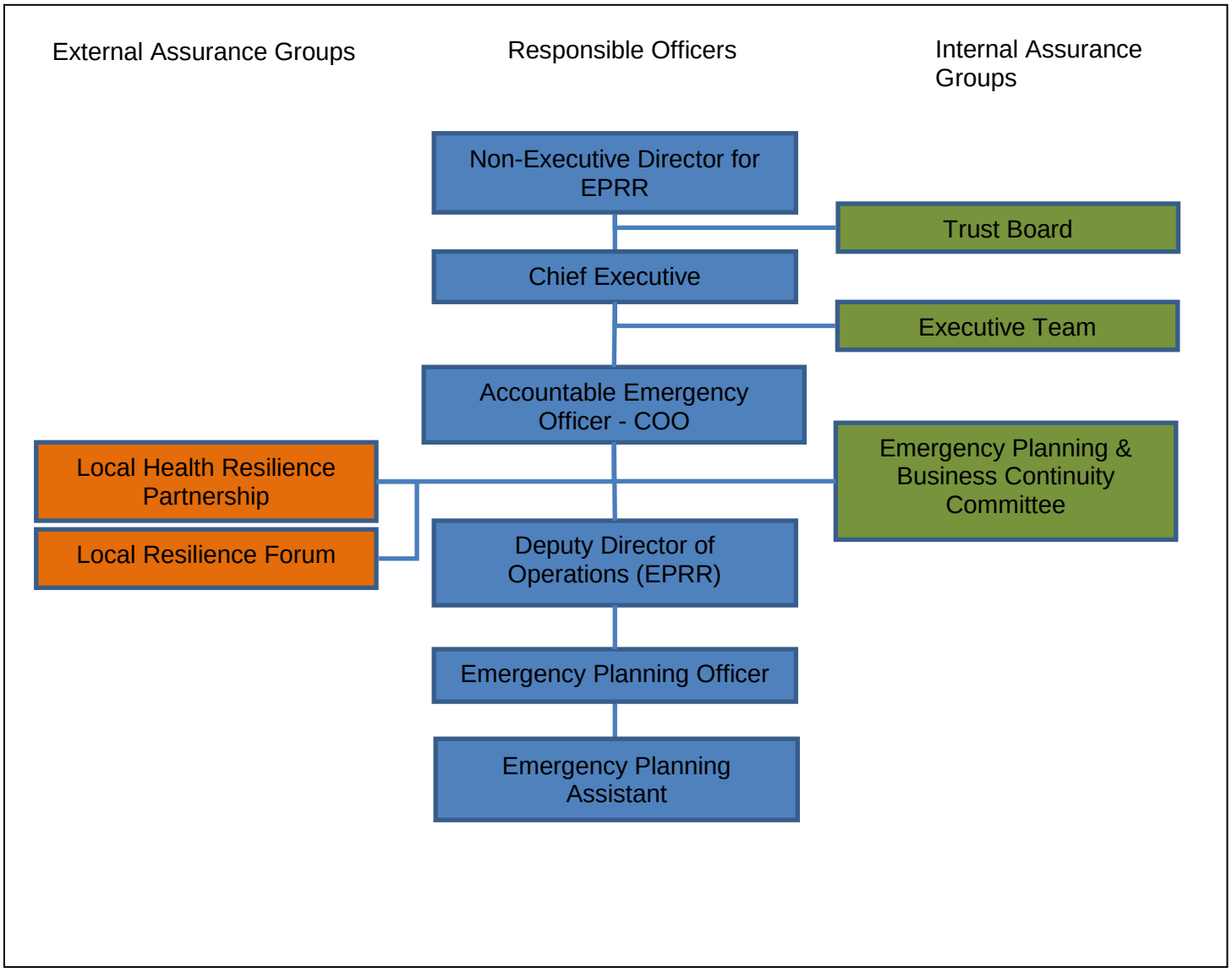

Figure 1 EPRR Reporting Structure

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Rationale	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	**GREEN**	Tim Lynch		
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy		**GREEN**	Annual Report and EPRR core standards outline work priorities for the next year.			
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation		**GREEN**	Business Continuity Policy outlines the generic framework and responsibities for the EPRR agenda within UHL. As more plans are converted into the Policy and Guidelines format there will be specific policies for each plan.			
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.		**GREEN**	Annual Report and EPRR core standards submissions are presented to the Trust Board, Via Trust Exec and Emergency Planning committee			
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages;	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	GREEN	Risks are documented on Datix and Trust Risk Register and reviewed annually			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.			GREEN	Risks are based on the Community Risk Register. Likelihood is used from the CRR and then an impact against UHL is assessed to determine overall impact to UHL			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.		GREEN	Where high risks are idnetified these are flagged up with partners. For example CBRN and Flood risk is documented in multi-agency response plans.			
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	GREEN	Major Incident Plan is in place - currently under review			
9		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)		GREEN	Internal Incident Plan			
10		HAZMAT/ CBRN - see separate checklist on tab overleaf		GREEN	CBRN Plan			
11		Severe Weather (heatwave, flooding, snow and cold weather)		GREEN	Internal Incident Plan			
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)		GREEN	UHL Pandemic Influenza Plan			
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)		GREEN	Details for access to these are within the CBRN Plan			
14		Mass Casualties		GREEN	For UHL there won't be any difference from the response as per the Major Incident Plan			
15		Fuel Disruption		GREEN	Internal Incident Plan			
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)		GREEN	Major Incident Plan references links to network details however network plans are still patchy and unclear. UHL has detailed ECMO plans.			
17		Infectious Disease Outbreak		GREEN	VHF Policy, Infection Outbreak Policy and UHL Pandemic Influenza Plan all have details and framework of response that would be utilised.			
18		Evacuation		GREEN	Evacuation plan is in place			
19		Lockdown		GREEN	Lockdown plan is in place			
20		Utilities, IT and Telecommunications Failure		GREEN	Internal Incident Plan			
21		Excess Deaths/ Mass Fatalities		GREEN	LRF Multi-agency response plans with specific details around use of LGH as a temporary mortuary for Mass Fatalities.			

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Rationale	Action to be taken	Lead	Timescale
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	GREEN	Plans contain all the key information and UHL specific requirements. The quality of the plans is often commented by other agencies and NHS Trusts.			
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	GREEN	All plans identify the rationale for activation and trigger levels.			
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities		GREEN	Internal Incident Plan and Major Incident plan referrence critical services to maintain and the decissions required to flex these. These were part of the basis of the strike response.			
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management		GREEN	Op Consort Plan			
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		• Specifiy who has been consulted on the relevant documents/ plans etc.	GREEN	Yes - various meetings held outside of the LRF agenda to ensure relevant plans and arrangements are developed.			
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an incident.		GREEN	Details within all incident response plans			
Command and Control (C2)								
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	**GREEN**	Depending on the incident; Major Incident - ED Red Phone in ER - EMAS Pre-alerts Internal Incidents - Site Manager, SMOC and Director on Call. Switchboard maned 24/7 to undertake call outs			
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	**AMBER**	Training is delivered with these in mind but these aren't validated or tested.			
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	GREEN	Command and Control locations are documented in the Major Incident Plan.			
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.			GREEN	Loggists are trained and are part of the call out. Incident commanders are also trained to undertake basic logging whilst the loggists are mobilised.			
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.			GREEN	Within the Major Incident Plan			
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials		GREEN	These would be via emergency services liaison			
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident		GREEN	These would be via emergency services liaison and adhoc UHL Radiation Protection cover.			
Duty to communicate with the public								

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Rationale	Action to be taken	Lead	Timescale
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	GREEN	Within the Major Incident Plan there is a separate comms section within in Part B.			

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Rationale	Action to be taken	Lead	Timescale
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	GREEN	Within the Major Incident Plan there is a separate comms section within in Part B.			
Information Sharing – mandatory requirements								
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	GREEN	Information sharing protocols exist within the LHRP and LRF.			
Co-operation								
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	GREEN	Emergency Planner attends the LRF and LHRP Practitioner meetings			
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA			GREEN	As above			
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.		GREEN	Protocols exist and are referenced within the Major Incidnet Plan			
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.		GREEN	Work plan of LRF and LHRP support this.			
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level			AMBER	Requires improvement - needs to be Tim or Moira.			
Training And Exercising								
49	Arrangements include a curent training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type.	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at	GREEN	Training needs analysis exisits for key groups of staff and key topics			
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet		AMBER	More exercising needs to take place - learning from Exercise SOTERIA.			
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises			AMBER	There has been limited availability of LRF and multi-agency training available. New training has come up and staff are down to attend. Significant problems (director level) that once staff have booked on that they don't cancel last minute. This occurred on the MAGIC Course last year.			
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.			AMBER	This isn't evident but conversations at previous training events for directors that the National Occupational Standards are part of their appriasal			
2017 Deep Dive								
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	• Organisation's public Board/Governing Body report • Organisation's public website	GREEN	Yes - this Core standards submissions and annual report			
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	• Organisation's Annual Report • Organisation's public website	GREEN	Yes - this was included in last years Trust's public annual report			
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings	GREEN	Non-Exec Identified - Ian Crowe who is a member of the emergency planning committee.			
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	• Minutes of meetings	GREEN	Emergency Planning Committee meets quarterly			
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	• Minutes of meetings	AMBER	Requires improvement			
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	• Minutes of meetings	AMBER	Requires improvement - needs to be Tim or Moira.			

ALL STANDARDS	
GREEN	80
AMBER	10
RED	0

Core standard	Clarifying information	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Rationale	Action to be taken	Lead	Timescale
		CORE STANDARDS					
		GREEN	41				
		AMBER	5				
		RED	0				
		DEEP DIVE					
		GREEN	4				
		AMBER	2				
		RED	0				
		CBRN CORE STANDARDS					
		GREEN	12				
		AMBER	2				
		RED	0				
		CBRN EQUIPMENT					
		GREEN	23				
		AMBER	1				
		RED	0				

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)				Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Rationale	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**	**Evidence of assurance**					
	Preparedness							
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	GREEN	CBRN Plan			
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	• Site inspection • IT system screen dump	GREEN	Copies held on Insite, in ED Decon Room, Ops Control Room			
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	GREEN	On Datix			
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		• Resource provision / % staff trained and available • Rota / rostering arrangements	GREEN	All nursing staff within ED are trained to deal with CBRN incident.			
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	• Provision documented in plan / procedures • Staff awareness	GREEN	Details are in the plan			
	Decontamination Equipment							
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	GREEN	Yes - details on the shared drive - due annual review shortly			
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017		AMBER	Number of suits is down to 20 compared to the required 24. Awaiting delivery as part of the replacement programme by NARU and NHS England. Currently expericing delays. Currently a managable risk, although we were required recently to up our stock to 24. A further 15 suits will expire end of life (3 months after life extension date from previous servicing) in April.			

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)				Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Rationale	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**	**Evidence of assurance**					
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place		GREEN	process for underaking checks are in place; Estates will be responsible for the room and showers Medical Physics/Radiation Protection maintain the RAMGENE ED undertake regular flushing for legionella			
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment			GREEN	As above			
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)		GREEN	Agreed with Estates. PRPS will be cut up and disposed of in general waste.			
	Training							
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training			GREEN	Emergency Planner and ED Practice Development Nurse have undertaken train the trainer courses.			
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	GREEN	Utilise IOR training materials			
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.			GREEN	Yes - all nursing staff in ED receive CBRN training as part of their mandatory training			
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)		AMBER	This requires further development and training for reception staff.			

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		GREEN
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		GREEN
E5	Shower heads		GREEN
E6	Hose connectors and shower heads		GREEN
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		GREEN
E9	Waste water bladder		GREEN
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		AMBER
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		GREEN
	Ancillary		
E12	A facility to provide privacy and dignity to patients		GREEN
E13	Buckets, sponges, cloths and blue roll		GREEN
E14	Decontamination liquid (COSHH compliant)		GREEN
E15	Entry control board (including clock)		GREEN
E16	A means to prevent contamination of the water supply		GREEN
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		GREEN
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		GREEN
E20	Waste bins		GREEN
	Disposable gloves		GREEN
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		GREEN
E22	FFP3 masks		GREEN
E23	Cordon tape		GREEN
E24	Loud Hailer		GREEN
E25	Signage		GREEN
E26	Tabbards identifying members of the decontamination team		GREEN
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		GREEN
E29	Hooded paper suits	Use PRPS	
E30	Goggles	Use PRPS	
E31	FFP3 Masks - for HART personnel only	Use PRPS	
E32	Overshoes & Gloves	Use PRPS	