Appendix 1 – EPRR Core Standards Compliance Matrix 2018/19

Key – RAG Rating

RAG	Definition
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 Standards

Ref	Standard	Detail	Evidence of Assurance	RAG 18/19
Domain 1 -Governance				
1	**Appointed AEO**	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, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Chief Operating Officer is the AEO	
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisations: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	EPRR policy in place.	

3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Presented at September 2018 Public Board, additional paper proposed March 2019 to include training, incidents and update to core standards progress.	
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Annual work plan in place.	
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Confirmation to be sought from the board.	
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Process described within the EPRR policy.	
Domain - Duty to asses risk				
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	EPRR risks are considered and recorded and risks are represented and recorded on the organisations risk register. Updates provided by NHS E on national and local risks.	
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	EPRR risks are considered in the organisation's risk management policy and referenced in the EPRR policy.	

Domain 3 - Duty to maintain plans				
9	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Recent plans shared with EP manager at BDCT and CCG's, pandemic flu shared with PHE and CCG.	
10	**Planning arrangements**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the **following risks / capabilities below:**		
11	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Incident Response plan in place.	
12	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Major Incident plan in place, 24/7 on call staff available.	
13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Heatwave information on intranet, alert system in place via global emails. Risk Assessment in place for adverse weather.	
14	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Cold weather information on intranet, alert system in place via global emails. Risk assessment in place for adverse weather.	
15	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Updated policy has been approved West Yorkshire Pandemic Flu Guidance document in place.	
16	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Trust outbreak plan in place, Protocol for Management Viral Haemorrhagic Fevers. Fit testing information on Infection Prevention and Control intranet page.	

17	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination.	CBRN plan available, Trust outbreak plan, Bradford MBC plans, and West Yorkshire Pandemic Flu Guidance document in place.	
18	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Guidance document from NHS England available, local documentation needed.	
19	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Further evidence and clarification for this process to be sought.	
20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	NHS England plan in on call pack, draft evacuation plan for BTHFT due to go to EMT September 2018 for approval. Plan to go in on call folder, Trust fire policies and training in place.	
21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Lockdown policy in place, CCTV control room, 24/7 security presence.	
22	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage ‘protected individuals'; including VIPs, high profile patients and visitors to the site.	Guidance documents in place.	
23	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	SLA in place and guidance documents in place.	
Domain 4 - Command and control				

24	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Described within the EPRR policy. 24 hour arrangements for alerting managers and other key staff. Weekend escalation plans and situation reports completed,	
25	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • 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.	Majority of Silver and Gold Commanders have received SLIC, TLIC (2016) and JESIP (Several sessions 2017). Joint Decision Model training, Shadowing for 3 months done with new on call staff with pairing of new staff with experienced on call done. On call manager handbook to be introduced October/early November 2018. JDM & JESIP built into EPRR policy and information in ICC. ICC awareness sessions delivered October 2018, further sessions planned to mop up on staff.	
Domain 5 - Training and exercising				
26	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Process described within the EPRR policy statement. Need to have a training needs analysis for all staff on call and those performing a role within the ICC.	
27	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. 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.***	Live test completed June 2017 Communications test done September 2018 Table top September 2017, next one due September 2018	

28	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Need to be able to evidence personal training and exercising portfolios for key staff. Training records available for trust organised training.	
Domain 6 - Response				
30	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Documented processes for establishing an ICC has been updated. 3 locations have been agreed for use as ICC's.	
31	**Access to planning arrangements**	Version controlled hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Planning arrangements are easily accessible - both electronically and hard copies.	
32	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Business Continuity Response plans, action cards in Incident Response plan.	
33	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Documented processes for accessing and utilising Loggists including action cards. Further training to be organised to increase number of Loggists.	
34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Documented processes for completing, signing off and submitting SitReps Incident response plan has templates available. Daily internal SitReps completed.	

35	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Guidance provided by NHS England.	
36	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Guidance is available to appropriate staff either electronically or hard copies.	
Domain 7 - Warning and informing				
37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident. • Have emergency communications response arrangements in place	Communications policy, social media policy in place, CCG and NHSE on call details available on how to communicate out of hours in weekend packs, IRP discusses Warning & Informing procedures. MAJAX WhatsApp group for WY acute Trusts.	
38	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	As above, global emails/red border emails sent to staff. Trust website banner can be altered at any time of day by Communications team, use of Trust Twitter account to advise public.	
39	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Media policy and WY media plan available. Communications team have media contact list. Pre identified staff for media depending on issue. Further media training to be arranged within 12 months. Holding statements available.	
Domain 8 - Cooperation				
40	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Intention of regular attendance planned.	
41	**LRF / BRF attendance**	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 other responders.	NHS E attends on behalf of Trust.	

42	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	MACA process in EPRR policy. Resilience teleconferences with local stakeholders allows for the request of aid, these are done daily over winter and as required at other times.	
46	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Arrangements have been clarified.	
Domain 9 - Business Continuity				
47	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Covered in Business Continuity framework and EPRR policy.	
48	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Covered in Business Continuity framework and EPRR policy.	
49	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Covered in Business Continuity framework.	
50	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance provided as evidence	
51	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Incident response plan in place, 5 areas stated are on the risk register and risk assessments to be shared with internal stakeholders Recovery referenced in EPRR policy, need to ensure that they are updated annually.	

52	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises and status of any corrective action are annually reported to the board.	EPRR policy and Business continuity framework in place Board papers produced, Reports done on Serious Incident's, exercises & tests.	
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Audit Yorkshire commissioned for EPRR. Internal audit report will be shared with board.	
54	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	EPRR policy and Business continuity framework in place. Internal audit process, Serious Incident's reports undertaken which include action plans.	
55	**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' arrangements work with their own.	Referenced in EPRR policy. "In general we rely on the Business Continuity provisions in the 'NHS Terms & Conditions of Contract' for goods and services which cover the majority of our suppliers. In areas considered high risk we request further details of Business Continuity Plans from those suppliers, originally at tender stage, and hold their BCP on file. Process referenced in EPRR policy & Business continuity framework "	
Domain 10: CBRN				
56	**Telephony advice for CBRN exposure**	Staff has access to telephone advice for managing patients involved in CBRN exposure incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	
57	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	CBRN plan, live exercise with partners agencies June 2017	

58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN ***decontamination risk assessment***s are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Full Impact assessment of CBRN decontamination on other key facilities has been undertaken	
59	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 24 /7	
60	**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.	Dedicated secure storeroom. Equipment inventories undertaken.	
61	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Above minimum number of suits held by trust, process through NHSE for straight replacement of out of date suits.	
62	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Record of equipment checks, including date completed and by whom. Named AED staff in place.	

63	**Equipment PPM**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	PPM's in place	
64	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Plans in place when suits are expired.	
65	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	Evidence of training records in place.	
66	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Training done in AED on a regular basis and available for other areas in Trust where necessary.	
67	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Evidence of training records in place for Trust trainers.	
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Training and guidance material on intranet based on current guidance, CBRN plan available. A range of staff roles are trained in decontamination technique.	
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	Trainers in place at Trust, fit testing information on the intranet, training available for new staff.	