

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	Lead	Timescale	Comments
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	<u>Evidence</u> • Name and role of appointed individual • AEO responsibilities included in role/job description	Sajid Azeb is our COO is AEO. NEDs are kept updated through regular board and committee papers.	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. <u>Evidence</u> 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.	EPRR policy in date- September 2021, version 3, next scheduled review September 2024. EP manager is listed as reviewer. Appendix 1 lists exercising schedule.	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. <u>Evidence</u> • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Audit Committee received update of 2021-22 work undertaken in April 2022; September 2021 EPRR paper was sent to board, September 2022 board paper to be submitted.	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	<u>Evidence</u> • Reporting process explicitly described within the EPRR policy statement • Annual work plan	A work plan is in place, which captures learning from incidents and exercises and addresses any issues that may arise, Overseen by Dep. Director of Unplanned Care. Work plan has been to Health & Safety Committee August 2022. Purpose and Scope of the Policy covers all pertinent points. EPRR policy in place.	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	<u>Evidence</u> • 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	IRP lists roles and responsibilities and structure charts. Policy ratified by COO.	Partially Compliant	Need to ensure through new September CBU structure that where areas are not adequately covered by the generic BCP that they complete additional sections and support the Trust EPRR function.	S Milburn / S Amos	30/06/2023	
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	<u>Evidence</u> • 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	The EPRR Policy identifies one of its key purposes is to capture learning from incidents and exercises to inform the development of future EPRR arrangements. EPRR work plan details planned exercises and training. Debrief papers from exercises/incidents capture learning. Learning from activation of Business Continuity incidents is shared at the Operational Resilience Group and through papers to ETM/H&S C as necessary. Recent papers include loss of power to ED and July heatwave. A learning network is in place, which captures learning from incidents and exercises. BTHTF will participate in post incident debriefings and meetings with external partners as part of robust EPRR working practices	Fully Compliant				

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	<ul style="list-style-type: none"> • Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather 	Risk regularly reviewed and shared with the resilience group . The risk assessments are updated annually (or after an incident/event) to reflect current trends and stored on Datix. The assessment takes into account national and community risk assessments. Any changes to the risk assessment are agreed by the Trust's Resilience Group. Version control and consultation on amendments is maintained by the Emergency Planning Manager.	Fully Compliant
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	<u>Evidence</u> <ul style="list-style-type: none"> • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document 	The Emergency Preparedness, Resilience and Response Policy identifies the process for the management of risks as detailed in the Trust's Risk Management Strategy 2022.	Fully Compliant
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements <u>Evidence</u> <ul style="list-style-type: none"> • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded 	Plans shared for comment with local stakeholders such as ANHSFT, BDCT, CBMBC, WY Police, Bradford CCG.	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	<u>Arrangements should be:</u> <ul style="list-style-type: none"> • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 	The Trust has in place Incident Response Plan which incorporates Mass Casualty Arrangements. The plan provides a framework for the management, coordination and control, in support of Trust employees in carrying out their duties, during a major incident, critical incident or, mass casualty incident and in relation to business continuity incidents. Last Comms test from the IRP April 2022, plan reviewed August 2022 This plan can be activated in isolation or in conjunction with other specific major incident or business continuity plans. The plan is in line with current guidance and risk assessment, signed off by the appropriate mechanism and available to all staff. It outlines our training and exercise plan and required equipment.	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	<u>Arrangements should be:</u> <ul style="list-style-type: none"> • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfires 	Latest version of Severe Weather Plan reviewed in September 2021 and includes PHE and WY plans and in date. Plan in command rooms and on the intranet. Weather alerts added to 4 x daily sitreps and on call managers. Winter weather folder in ICC for ease of access. Heathwise July/August 22, work done to ensure resilience and staff awareness of actions to take during these periods.	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	<u>Arrangements should be:</u> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required <u>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</u>	IPC policies in place that cover Outbreak and recognition and management plan and standard IPC precautions policy. HCID, infection prevention policy, Respiratory virus infection protocol, Pandemic influenza, . FFP3 training is available x days a week by dedicated team and recorded on ESR. Dedicated PPE hub on site which manage mask usage. Emergency Preparedness and Service Delivery in the event of a Public Health Incident or Outbreak in Bradford Local Authority Area 2022 in place. Bradford system flu plan for 22/23 is going to be completed mid September by ICB.	Fully Compliant
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	<u>Arrangements should be:</u> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 	Bradford winter plan in place yearly. Trust pandemic flu plan in date. Emergency Preparedness and Service Delivery in the event of a Public Health Incident or Outbreak in Bradford Local Authority Area 2022 in place. Bradford partnership in Monkeypox outbreak with a protocol in place	Fully Compliant
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	<u>Arrangements should be:</u> <ul style="list-style-type: none"> • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required 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.	The Trust has in place a Chemical, Biological, Radiation & Nuclear Plan (December 2021). The plan is in line with current guidance and risk assessment, signed off by the appropriate mechanism and available to all staff. It outlines our training and exercise plans and required equipment. To support this there is the Bradford Flu plan and West Yorkshire resilience Forum pandemic influenza plan. NHS England Emergency Preparedness, Resilience and Response Guidance for the requesting and receipt of countermeasures April 2019 V3. Covid vaccination programme at BRI plus community support for testing and vaccination in the Bradford region. Still dealing with a current Covid pandemic. Request for countermeasures is responsibility of ED, covered in MAJAX training. Bradford system flu plan for 22/23 is going to be completed mid September by ICB.	Fully Compliant

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: <ul style="list-style-type: none">• current• in line with current national guidance• in line with risk assessment• tested regularly• signed off by the appropriate mechanism• shared appropriately with those required to use them• outline any equipment requirements• outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Mass casualties are covered in IRP. EPR process available and in date. Patient ID policy in date. Random name generator in place. Regional plan available. Trust Mass casualty surge plan in date.	Fully Compliant			Regional plan is currently being reviewed by a LRF subgroup. To test internally once new plan is issued.	
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: <ul style="list-style-type: none">• current• in line with current national guidance• in line with risk assessment• tested regularly• signed off by the appropriate mechanism• shared appropriately with those required to use them• outline any equipment requirements• outline any staff training required	Trust partial site evacuation plan that is current. Risk assessments in place and shared internally. Local fire evacuations plans for each department. August 2022 full evacuation of B block at SLH with debrief and recommendations written.	Partially Compliant	Current plan in date but is being updated to reflect national changes. Need to test the plan once it has progressed,	S Amos / J Stedman	31/03/2023	
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: <ul style="list-style-type: none">• current• in line with current national guidance• in line with risk assessment• tested regularly• signed off by the appropriate mechanism• shared appropriately with those required to use them• outline any equipment requirements• outline any staff training required	Lockdown policy in place, last reviewed September 2021. Maternity and child abductions plans in place - both need reviewing.	Partially Compliant	Tests need to be carried out, agreed with Matron to do this early October.		20/10/2022	Should go green if exercise happens.
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: <ul style="list-style-type: none">• current• in line with current national guidance• in line with risk assessment• tested regularly• signed off by the appropriate mechanism• shared appropriately with those required to use them• outline any equipment requirements• outline any staff training required	Recent VIP visit risk assessed and all elements of the plan worked. In date Comms policy.	Fully Compliant				
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: <ul style="list-style-type: none">• current• in line with current national guidance in line with DVI processes• in line with risk assessment• tested regularly• signed off by the appropriate mechanism• shared appropriately with those required to use them• outline any equipment requirements• outline any staff training required	SLA with Bradford mortuary. Additional mortuary capacity has already been added to support surges. SOP for over capacity process.	Partially Compliant	Need SLA, RA, SOP, DVI process, Test plan		30/09/2022	Will go green once evidence received.
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	<ul style="list-style-type: none">• Process explicitly described within the EPRR policy statement• On call Standards and expectations are set out• Add on call processes/handbook available to staff on call• Include 24 hour arrangements for alerting managers and other key staff.• CSUs where they are delivering OOHs business critical services for providers and commissioners	Described in EPRR policy, 'on call manager resource' packs available (currently being reviewed). BTHFT switchboard is manned 24/7 and has contact details for all On-Call staff to escalate and notify incidents with immediate effect. Links to all external key stakeholders available in IRP. Trust in week and weekend plans detail on call arrangements for other organisations. Clinical Site Team in Command Centre is first point of escalation out of hours. OCM WhatsApp group established. Regular OCM/OCE focus groups.	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	<ul style="list-style-type: none">• Process explicitly described within the EPRR policy or statement of intent The identified individual: <ul style="list-style-type: none">• Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards)• Has a specific process to adopt during the decision making• Is aware who should be consulted and informed during decision making• Should ensure appropriate records are maintained throughout.• Trained in accordance with the TNA identified frequency.	JDM training undertaken for majority of 1st & 2nd on call. On call personal log books issued. All Execs on call within BTHFT who may be required to act as Incident Commander or on an Incident Command Team, have been provided with training slot to complete the Principles of Health Command training. In addition to the above, those who act as Manager On Call will also be provided with the same training sessions (pending the creation of a tactical training course by NHS England in due course).	Partially Compliant	TNA to be updated to reflect the new addition of staff being trained in accordance with the NHS England EPRR competencies (National Minimum Occupational Standards). Once this is updated the relevant staff will need to be provided with training where any gaps exist.	S Milburn / S Amos	31/12/2023	

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	<p><u>Evidence</u></p> <ul style="list-style-type: none"> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff 	Referenced in EPRR policy. Attendance and training registers kept. Copies of training presentations available.	Partially Compliant	TNA to be updated to reflect the new addition of staff being trained in accordance with the NHS England EPRR competencies (National Minimum Occupational Standards) and the Principles of Health Command training. Process for collating evidence of personal training and exercising portfolios for key staff needs to be introduced (currently waiting for NHSE guidance on how this should be structured).	S Milburn / S Amos	31/12/2023
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	<p>Organisations should meet the following exercising and testing requirements:</p> <ul style="list-style-type: none"> • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. <p>The exercising programme must:</p> <ul style="list-style-type: none"> • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. <p>Lessons identified must be captured, recorded and acted upon as part of continuous improvement.</p> <p><u>Evidence</u></p> <ul style="list-style-type: none"> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning 	BTHFT has not taken part in many exercises during the last 3 years, due to being heavily involved in Covid-19 pandemic operations. This real event supersedes an exercise in identifying and testing our incident response plans and procedures. Exercises/testing is listed in EPRR policy. Last Comms test in June 2022. Table top exercise held July 2022. Future exercises listed in EPRR work plan	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.	Y	<p><u>Evidence</u></p> <ul style="list-style-type: none"> • Training records • Evidence of personal training and exercising portfolios for key staff 	Records kept of staff involved in exercises and planned training. This includes JDM training in 2022 and leadership training in 2021 for execs. Also OCM training for all staff 2021.	Partially Compliant	Evidence of personal training and exercising portfolios for key staff to be introduced -links in with action for standard 21.	S Milburn / S Amos	31/12/2023
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	April paper to Audit paper listed training for previous year. ICCs have key relevant plans in as paper copies. Electronic available on intranet and in electronic on call folder. Internal On call manager training for all OCM in 2021	Fully Compliant			
26	Response	Incident Co-ordination Centre (ICC)	<p>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.</p> <p>An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards.</p> <p>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.</p> <p>Arrangements should be supported with access to documentation for its activation and operation.</p>	Y	<ul style="list-style-type: none"> • Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions. 	Details of all ICCs in Incident Response Plan including fail-back locations. Action cards available. Provision of virtual meetings covered in IRP. Site maps available.	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	Each ICC has paper copies, all have version control, these were explained in OCM training 2021.	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	<ul style="list-style-type: none"> • Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes 	IRP covers each level of incidents and escalation process and how to deal with incidents.	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	<ul style="list-style-type: none"> • Documented processes for accessing and utilising loggists • Training records 	Training pack for loggists, list of loggists. 2 sessions delivered in 2022 to increase loggist pool. List of loggists with switchboard and CC ICC. On call staff through training are reminded of the importance of recording their decisions.	Fully Compliant			Loggist call out exercise planned for October 2022.

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	<ul style="list-style-type: none"> Documented processes for completing, quality assuring, signing off and submitting SitReps Evidence of testing and exercising The organisation has access to the standard SitRep Template 	Established daily process in place for distribution of daily internal sitreps which include site wide information on issues/incidents. NHS standard Sitrep details in the IRP , weekend on call pack also outlines the process for our region. A wide variety of daily, weekly and ad-hoc Sitreps completed successfully throughout the Covid pandemic response. Increased number of SDCS licences acquired to enhance effectiveness and ability to complete Sitreps via national reporting mechanisms through our Performance team 7 days a week where necessary.	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	Mass casualty national document available and on the intranet. Document covered in ED training, held as paper copy in sisters training office.	Fully Compliant
32	Response	Access to 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	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	Document covered in ED training, held as paper copy in sisters training office.	Fully Compliant
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	<ul style="list-style-type: none"> Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. Out of hours communication system (24/7, year-round) is in place to allow access to trained Comms support for senior leaders during an incident. This should include on call arrangements. Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry. 	The Trust has in place a Communication Policy & Social Media Policy (March 22/June 22) which details about a major incident and the communications role with staff, patients and stakeholders and the media. The social media policy details how staff should communicate information on personal accounts relating to the Trust. Sitreps in the Incident response plan contain a media section to collate the relevant information requests. Where necessary, the Police will lead on media communications for a consistent approach. Trust website banner can be altered at any time of day by Comms team to provide public information or this can be circulated by use of Trust Twitter account. Use of 'learning matters' to share learning internally where required. A global staff email can be sent 24/7 to provide staff with relevant information. The plan is in line with current guidance, signed off by the appropriate mechanism and available to all staff. It outlines that training will be undertaken as required. On call packs provide details of partner agencies to contact. The incident response plan details warning and informing arrangements for responders and public. Pre prepared emergency Comms are available for Execs to use. Action card in IRP for Comms team.	Fully Compliant
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	<ul style="list-style-type: none"> An incident communications plan has been developed and is available to on call communications staff The incident communications plan has been tested both in and out of hours Action cards have been developed for communications roles A requirement for briefing NHS England regional communications team has been established The plan has been tested, both in and out of hours as part of an exercise. Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate). 	in the IRP there is an in hours and an out of hours call cascade list, last tested April 2022, next test due in October 2022. Communication Policy 2022 covers all pertinent points on dealing with the media. Pre written media statements in main ICC and HQ. Communications team have an action card in the IRP. Comms team have a process for briefing NHSE, WYH&CP, BD&C partnership and other stakeholders as appropriate.	Fully Compliant
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	<ul style="list-style-type: none"> Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc.) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. A developed list of key local stakeholders (such as local elected officials, unions etc.) and an established a process by which to brief local stakeholders during an incident Appropriate channels for communicating with members of the public that can be used 24/7 if required Identified sites within the organisation for displaying of important public information (such as main points of access) Have in place a means of communicating with patients who have appointments booked or are receiving treatment. Have in place a plan to communicate with inpatients and their families or care givers. The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements 	The Trust has in place a Communication Policy & Social Media Policy (March 22/June 22) which details about a major incident and the communications role with staff, patients and stakeholders and the media. The social media policy details how staff should communicate information on personal accounts relating to the Trust. Sitreps in the Incident response plan contain a media section to collate the relevant information requests. Where necessary, the Police will lead on media communications for a consistent approach. Trust internet can be updated out of hours. Comms team can update patients etc. via our social media platforms. Comms team have a process for briefing NHSE, WYH&CP, BD&C partnership and other stakeholders as appropriate. IRP is in line with current guidance, signed off by the appropriate mechanism and available to all staff. It outlines that training will be undertaken as required. On call packs provide details of partner agencies to contact. The incident response plan details warning and informing arrangements for responders and public. Pre prepared emergency Comms are available for execs to use. Public communication screens available at BRI & SLH for patient information. The organisation publicly states its readiness and preparedness activities as part of the Annual Governance Statement within the Annual Report.	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	<ul style="list-style-type: none"> Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media Develop a pool of media spokespeople able to represent the organisation to the media at all times. Social Media policy and monitoring in place to identify and track information on social media relating to incidents. Setting up protocols for using social media to warn and inform Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response 	Pre written media statements for execs available out of hours. Only Execs have authority to talk to or delegate staff to deal with the media besides the Comms team. Media trained execs -Mel Pickup, Karen Dawber, Ray Smith, John Holden, Sajid Azeb.	Fully Compliant
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	<ul style="list-style-type: none"> Minutes of meetings Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities. 	Minutes kept. AEO is designated person or suitable deputy should represent the Trust	Fully Compliant
38	Cooperation	LRF / BRP Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	<ul style="list-style-type: none"> Minutes of meetings A governance agreement is in place if the organisation is represented and feeds back across the system 	Trust represented by NHSE / WYICB. Trust receives live incidents emails in to EP Manager and Clinical Site Team so action can be taken 24/7	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. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	<ul style="list-style-type: none"> Detailed documentation on the process for requesting, receiving and managing mutual aid requests Templates and other required documentation is available in ICC or as appendices to IRP Signed mutual aid agreements where appropriate 	NHSE regional plan- link in IRP. Bradford plan in date. MACA process listed in IRP.	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.	N/A	<ul style="list-style-type: none"> Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs Where an organisation sits across boundaries the reporting route should be clearly identified and known to all 		
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.	N/A	<ul style="list-style-type: none"> Detailed documentation on the process for managing the national health aspects of an emergency 		
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.	N/A	<ul style="list-style-type: none"> LHRP terms of reference Meeting minutes Meeting agendas 		
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	<ul style="list-style-type: none"> Documented and signed information sharing protocol Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004 	Document received for the Yorkshire region.	Fully Compliant
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the <u>ISO standard 22301</u> .	Y	<ul style="list-style-type: none"> The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: <ul style="list-style-type: none"> Provide the strategic direction from which the business continuity programme is delivered. Define the way in which the organisation will approach business continuity. Show evidence of being supported, approved and owned by top management. Be reflective of the organisation in terms of size, complexity and type of organisation. Document any standards or guidelines that are used as a benchmark for the BC programme. Consider short term and long term impacts on the organisation including climate change adaption planning 	Business Continuity Framework work July 2022 to be signed off by AEO before October 2022.	Fully Compliant
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	<ul style="list-style-type: none"> BCMS should detail: <ul style="list-style-type: none"> Scope e.g. key products and services within the scope and exclusions from the scope Objectives of the system The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties Specific roles within the BCMS including responsibilities, competencies and authorities. The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process Resource requirements Communications strategy with all staff to ensure they are aware of their roles alignment to the organisations strategy, objectives, operating environment and approach to risk. the outsourced activities and suppliers of products and suppliers. how the understanding of BC will be increased in the organisation 	Points all documented in the Business Continuity Framework work July 2022. EPRR risks stored on Datix,	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	<ul style="list-style-type: none"> 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. Documented process on how BIA will be conducted, including: <ul style="list-style-type: none"> the method to be used the frequency of review how the information will be used to inform planning how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: <ul style="list-style-type: none"> Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. A consistent approach to performing the BIA should be used throughout the organisation. BIA method used should be robust enough to ensure the information is collected consistently and impartially. 	Business Impact Analysis guidance included in Business Continuity framework, and each plan submitted is checked. All plans should be reviewed annually. Generic BIA available for any area who needs to produce a plan. Training is given to the BCP authors by the EP Manager where required. Requirement for all areas to have these in place	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 • information and data • premises • suppliers and contractors • IT and infrastructure	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 undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Incident response plan in place which details responding to and recovering from incidents. Trigger for activation/standby with appropriate incident response levels with reference to the EPRR Framework- Activation procedures, Escalation procedures - Stand down procedures are covered in the incident response plan. BC Framework document. 5 areas covered in various plans and in action cards of BCPs, also risk assessments in place and shared with internal stakeholders. Each service BCP includes their actions, recovery and maintenance of service delivery against each of the threats listed. BTHFT partial site evacuation plan identifies other clinical areas that can be used. All BCPs are based upon a Business Impact Assessment model as per NHSE guidance, produced in the spirit of ISO 22301 and details listed in the Trusts Business Continuity Framework. Staffing matron leaves plans daily to mitigate short term staff sickness for the command centre team to enact. EPRR intranet pages contain links to a variety of EPRR documents.	Fully Compliant
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.	Testing schedule is on EPRR work plan. Loss of O2 undertaken July 2022. Debrief of loss of power to ED available- May 2022.	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	Link to DSPT register has been provided and is reported to the board.	Fully Compliant
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	BC framework in place. Annual paper submitted to board, also to F&P academy and to Audit Committee	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	2 independent internal audits held in December 2021 which both provided significant assurance on the Trusts Business Continuity and IT disaster recovery across the Foundation Trust and having a robust Emergency Preparedness, Resilience and Response plan in place. Currently working through action plans, the Board are aware of the findings. Audit reports are included in annual EPRR report, and also shared with the Trust Board.	Fully Compliant
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	Business continuity framework, EPRR policy, ETM and Health & Safety Committee reports are submitted including action plans to ensure ongoing compliance. Annual board paper contains references to incidents and any action plans. One debrief paper has been submitted to EMT which has an action plan on. EPR downtime plan has an action plan following debrief. Quarterly OCM/OCE debrief meetings held with action log. Internal audit conducted to audits in December 2021, 1 on BC and one on EPRR.	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	Referenced in EPRR plan. In general we rely on the Business Continuity provisions in the NHS Terms & Conditions of Contract (paragraph 6) for goods and services which cover the majority of our suppliers. NHS supply chain a main provider of products who have resilience plans in place. 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.	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	N/A	• Exercising Schedule • Evidence of post exercise reports and embedding learning		
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	This is accessed directly from EPR. Also there is a link to National Poisoning centre on EPR. Information previously circulated to ED staff. Referenced in CBRN plan. ED intranet page has contact numbers.	Fully Compliant

56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	<p>Evidence of:</p> <ul style="list-style-type: none"> • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • 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 	CBRN plan which includes action cards to identify roles and responsibilities including security, incident response plan contains command and control structure and stand down and debrief process, key contacts - internal and external. ED have a text system set up for rapid request for staff to offer their availability to. Pre-identified area for decontamination tent to be erected with access to power, water and lighting. Training undertaken which includes use of decontamination tent and process to follow. Process for removal of waste listed in CBRN plan. Regular training including decontamination tent set up undertaken. Contact details in CBRN plan. ED reception staff trained on step 123, remove, remove, remove.	Fully Compliant
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: <ul style="list-style-type: none"> • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste. 	Y	<ul style="list-style-type: none"> • Impact assessment of CBRN decontamination on other key facilities 	Waste covered in CBRN plan.	Fully Compliant
58	CBRN	Decontamination capability availability 24 / 7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 / 7		Fully Compliant
59	CBRN	Equipment and supplies	<p>The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.</p> <ul style="list-style-type: none"> • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprtr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/epr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ 	Y	Completed equipment inventories, including completion date		Fully Compliant
60	CBRN	PRPS availability	<p>The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment.</p> <p>There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.</p>	Y	Completed equipment inventories, including completion date	ED supply cost code for servicing of suits.	Fully Compliant
61	CBRN	Equipment checks	<p>There are routine checks carried out on the decontamination equipment including:</p> <ul style="list-style-type: none"> • PRPS Suits • Decontamination structures • Disrobe and robe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. <p>There is a named individual responsible for completing these checks.</p>	Y	Record of equipment checks, including date completed and by whom.		Fully Compliant
62	CBRN	Equipment Preventative Programme of Maintenance	<p>There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for:</p> <ul style="list-style-type: none"> • PRPS Suits • Decontamination structures • Disrobe and robe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment 	Y	Completed PPM, including date completed, and by whom		Fully Compliant
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Any suits that are out of date are marked up and used as training suits, inventory kept. Where suits are no longer required, these are used aging in training to allow staff to practice cutting a staff member out of a suit in emergency and being able to see how the suit is made. Any pieces are cut small and disposed off in different bins by CBRN trainers.	Fully Compliant
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	Lead delivers MAJAX training at least 3 times a year & organises table top exercises for ED staff and new registrars.	Fully Compliant
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	<p>Evidence training utilises advice within:</p> <ul style="list-style-type: none"> • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ 		Fully Compliant
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	<ul style="list-style-type: none"> • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training 	All trainers deliver a minimum number of 3 sessions per year	Fully Compliant
67	CBRN	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.	Y	<p>Evidence training utilises advice within:</p> <ul style="list-style-type: none"> • Primary Care HAZMAT/ CBRN guidance • 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.londoncon.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique 		Fully Compliant

68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	List of staff trained up to 09/08 saved. PPE open to
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Fully Compliant
