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Domain 1 - Governance									
1	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	The appointed Accountable Emergency Officer is the Interim Chief Operating Officer The role of AEO is currently part of the COO role portfolio as agreed with the CEO.	Fully compliant	Role of AEO will be added to JD of COO for recruitment of new COO - to commence Autumn 2022	Eilish Midlane	
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds	DN643 Critical Incident Plan - review due July 2023. Published on intranet. BCPs are reviewed annually. Emergency Preparedness Committee Terms of Reference reviewed annually - Reviewed at committee on 18.05.22. Review due April 23. Access to funds to support EP agreed through departmental/operational funds eg Smart Evacuation package; training; tabbards; catering for Exercise Sheldon	Fully compliant		Eilish Midlane	
3	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	Reports to Board by exception following incidents. Annual EPRR Executive Director Report Quarterly EPRR reports to Emergency Planning committee which reports to Performance Committee, a sub-committee of the Board [exceptions to Board would be reported at Chair's discretion]. Trust Secretary provided assurance that the EPRR annual report went to Board in October 2021 [paper & minutes are in Board folders and on forward planner for October 2022]. The annual assessment of EPRR against core standards to be taken at the Performance Committee & it is on mtg forward plan for September 2022. **NB**: this does not cover off the quarterly reports so do we need to look again at the annual reporting route so that assurance is built up from the quarterly reporting process?	Fully compliant		Eilish Midlane	
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Annual Work plan in place with regular quarterly reports to the Emergency Planning Committee providing progress updates. DN643 Critical Incident Plan	Fully compliant		Achanda Neale	

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5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Eilish Midlane - Executive Director Achanda Neale - Operational Emergency Planning Lead Andrew Selby - Director of Estates & Facilities Named Fire Officers - Andrew Selby and Martin Ward (attended: IFE Fire Safety in the design and management in healthcare premises course in 24th -28th of May 2021). Emergency Planning Support - Chris Seaman, Quality Compliance Officer	Fully compliant		Eilish Midlane	
6	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the **review and embed into EPRR arrangements**.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Refer to DN643 Critical Incident Plan. Reporting of recent critical incidents / AAR process Participation in regional sharing of lessons Exercises WALKER, LEMUR and upcoming SHELDON	Fully compliant		Achanda Neale	
Domain 2 - Duty to risk assess									
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. **This process should consider all relevant risk registers including community and national risk registers.**	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Business Continuity Plans are reviewed annually BCPs and Risk are standing agendas item at the EPC quarterly meeting Tick box available on incident reporting system - [Datix] if an incident triggered a BCP or the Critical Incident Plan Operational Lead for EPRR has met with the Risk Manager to review how risks on the Risk Register can also be linked to EPRR as well as with the relevant divisions/departments. Looking to align these to the C & P Community Risk Register as a starting point and for continuity with the regional picture.	Fully compliant		Achanda Neale	
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally **and externally**	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Business Continuity Plans Critical Incident Plan DN643 Risk is now a standing item on the EPC agenda 2 current risks on register - both reviewed and emerging risks now discussed at every forum AARs introduced in 2022 as part of incident recovery and learning Regional sharing is through Exec Local Resiliance Forum to identify risks and update against work programmes. Through ICS structure, risks are reported through ICS Audit & Risk Committee [sub comm of IC Board]. Use of professional networks evidenced recently with the theft of cables - alerted other partners through professional networks	Fully compliant		Achanda Neale	

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Domain 3 - Duty to maintain Plans									
9	**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 Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Critical Incident Plan DN643 Exercise Robin and post exercise report. Shared findings with EPC, OEG, Bronze & Silver workshop, Q&R in quarterly EPRR report Friday 01 July 2022 was the first official day of Cambridgeshire & Peterborough Integrated Care System (ICS). The NHS Cambridgeshire & Peterborough Integrated Care Board (ICB), from 01 July are now categorised as Category 1 responders, and the ICB will comply with the legislation within the CCA. In EPRR we are used to working collaboratively with all our multi-agency partners, however, the ICS/ICB aim is to create more opportunities to do this. Collaboration with CUH with interhospital transfers between RPH / HLRI and CUH - see DN766	Fully compliant			Ongoing review of cross campus working to review communications. There is a campus group, and there are a number of sub groups for this - transport, security, sustainability, construction etc. any campus issues are shared at these meetings as part of collaborative planning. RPH are represented at all of these groups. Confirmation of review date of DN766 needed
10	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Critical Incident Plan DN643 Staff training and regular exercises, eg ROBIN in 2021 in conjunction with CUH Exercise Sheldon planned for Sept 2022 Any learning and incidents is shared with on-call teams at the quarterly workshops of April and July 2022. Further workshops planned for Oct 22 and Jan 23. On 18th July in response to oxygen incident we activitated the IMT and declared an internal incident. Table top digital cyber attack exercise enacted at Bronze/Silver manager workshop July 2021 meeting	Fully compliant		Achanda Neale	

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11	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	DN633 Heatwave Plan reviewed and given Chair's action on 28.06.21 and presented at EPC on 11.08.21 Review due June 24 Bad Weather Policy [Adverse weather policy refers to staff travel] DN032 - reviewed at JSC and approved on 22.07.21 Review due July 24 There is a schedule of salting and snow clearance and triggers to activate this are within the Skanska helpdesk based on adverse weather warning and outside air temperatures. With Estates & Facilities Trust representative attended UKHSA Heatwave Plan for England & Summar 2022 Preparedness Programme webinar on 29.04.22. Reported to EPC in Q4 EPRR report As part of the estate annual planning we review new guidance as it is released, if there is new guidance on hot and adverse weather please can this be shared, but in terms of the recent hot temperatures experienced in the UK where temperatures in Cambridgeexceeded 38 degrees, the hospital was able to maintain all temperatures and operating parameters without any additional enginerring provision, and therefore believe we are well placed to manage temperatures up to 40 degree.	Fully compliant		Oonagh Monkhouse / Andrew Selby	
12	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	DN730 Season Flu Preparation Plan (review date Sept 22) DN157 - Reducing the risk of the spread of Influenza Guidelines (review date Mar 25 DB799 Infection Control Living with COVID (review date due Nov 22) DN317 Priority for use of Isolation Rooms guidelines -(review due Nov 23) DB441 Personal Protective Equipment procedure (reivew due Mar 24) DN572 FIT testing procedure (review due Dec 23) DN818 Mycobacterium Abscessus IC policy (review due Mar 25) Monkey Pox isolation and infection control guidance has been added to DN089 Isolation and Standard Precautions Guidance. The IPC Team continue to be informed in any changes in guidance by the UKHSA as well as Regional Monkeypox Update Calls.	Fully compliant		Kathy Randall	DHSC guidance re FFP3 resilience All FFP3 users should be fit tested and using at least two different masks (ideally three) FFP3 users should interchangeably wear the masks they are fit tested for Trusts should ensure that a range of FFP3 masks are available to users on the frontline and overall should not exceed 25% usage on any one type mask Frontline stocks should be managed at no more than 7-10 days per SKU Trusts will register FFP3 users and fit test results in ESR and review individual usage every quarter.

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13	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	DB799 Infection Control Living with COVID (review date due Nov 22) DN317 Priority for use of Isolation Rooms guidelines -(review due Nov 23) DB441 Personal Protective Equipment procedure (reivew due Mar 24) DN572 FIT testing procedure (review due Dec 23) Monkey Pox isolation and infection control guidance has been added to DN089 Isolation and Standard Precautions Guidance. The IPC Team continue to be informed in any changes in guidance by the UKHSA as well as Regional Monkeypox Update Calls.	Fully compliant		Kathy Randall	
14	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements.	We have successfully ramped up a community vacination clinic on site. The suppliers of the marquee and furniture are approved suppliers to the Trust and therefore this plan could be invoked again quickly - in less that 72hrs	Fully compliant		Andrew Selby	
15	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an	Royal Papworth's role is reflected in the LRF Mass Casualty Plan. A unique identifer number could be given to a patient through Lorenzo if necessary; other health records connected subsequently. Operation Robin in conjunction with CUH took place on 30.09.21.	Fully compliant		Achanda Neale	

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16	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	DN830 Evacuation Plan reviewed May 2021 (Review due Sept 2023) Exercise Sheldon in Sept 22 will test evacuation plan. Ad hoc training on Smart evacuation ongoing by Education Team - in the moment training in clinical areas as well as with teams as capacity allows such as on theatre audit days, Sister's meetings and quarterly on-call workshops Highlight on Smart Evacuation MoW and in Weekly Briefing w/c 05.09.22	Fully compliant		Achanda Neale	
17	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Procedure DN574 - [Next review due April 24] THis procedure was implemented in recent security alert on 12.07.22. Refer to AAR: s/EPRR/After Action Reviews The lockdown plan has been tested and proved effective at controlling access, and is consistent with latest guidance. As part of the operation Consort review the local special branch have reviewed the policy and felt it to be suitable and sufficent. DN769 Bomb policy reviewed as a result of recent security alert on 12.07.22. An ongoing review of frequency of policy review and testing is planned in the next year.	Fully compliant		Andrew Selby	
18	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	A generic risk assessment for VIPs is completed and updated prior to or in the course of each new VIP visit, where possible. Following the discharge of a Category One (Principal VIP), a debrief will be held at the earliest opportunity following stand down to ensure that any learning is captured and this procedure is updated if required. DN562 VIP procedure [due for Review April 2024] Operation consort (poilice document) has recently been reviewed jointly by Director of Estates & Facilities and the police with no substantial changes. The recent visit of the Duchess of Gloucester opening the HLRI - risk assessment for the HLRI visit was completed by the University security advisor as HLRI is UoC building. Please see above comment at Standard 17 for review and testing	Fully compliant		Andrew Selby	

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19	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Not applicable to site - no mortuary facility at RPH. CUH provides this service.	Not applicable			
Domain 4 - Command and control									
20	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Critical Incident Plan DN643 On call via switchboard On site presence 24/7 with Bronze manager Current switchboard procedure is a manual call/page to on-call staff. Ongoing work to implement 'Confirmer' automatic incident alert to all on-call staff messaging work/mobile/home phones and pagers - not yet live IMT stood up in response to power outage in Feb 22, theft incident and damage to oxygen supply in July 2022 and recent digital/cyber incident Oncall Handbook V13.4 reviewed Aug 22 - awaiting sign off at next Emergency Planning Committee in November 22	Fully compliant		Achanda Neale	
21	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Critical Incident Plan DN643 On-call handbook Aware of the NHS England EPRR Competencies: https://www.england.nhs.uk/publication/minimum-occupational-standards-for-emergency-preparedness-resilience-and-response-eprr/ Staff are trained Informal peer support for staff new to oncall rota Action card for all roles are contained with the Critical Incident Plan Oncall handbook details roles and responsibilities and prepartion for the role. Oncall workshops are quarterly. See previous comments around training. FtF Fire training session in October 2021 at next oncall workshop.	Fully compliant		Achanda Neale	
Domain 5 - Training and exercising									
22	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • 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	See comments above [21]	Fully compliant		Achanda Neale	

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23	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Exercise Sheldon - tabletop in person exercise planned for 15 September 2022 Comm testing to be organsed Exercise Starburst [Starlight postponed]	Partially compliant		Achanda Neale	
24	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	EPRR training records of staff held centrally and includes exercise attendance Personal training records held individually by staff Responder training not relevant to Trust Annual IPRs include and record discussion of corporate and personal objectives against role requirement/profile **confirm whether applicable to site** - AN to check NWAFT. What are the Minimum Occupational Standards? EPRR Specialist Advisor, BCP Lead, Ambulance Commanders	Fully compliant		Achanda Neale	
25	**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	See previous comments regarding review of policies/training, reports to Board.	Fully compliant		Achanda Neale	
Domain 6 - Response									
26	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Critical Incident Plan DN643 Operations Centre on 4th floor C&C centre on ground floor in Rm 4 or Rehab room CDC control room on first floor. Action cards in place for all locations. Investigating off site facility jointly with CUH. RPH back up site is now HLRI Battle box was reviewed on 14.07.22 and updated. Checks on BB for operational readiness introduced - to be undertaken by Operational Lead for EPRR, monthly or after any incident when the BB was used.	Fully compliant		Achanda Neale	
27	**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	BCPs are reviewed annually Paper copies of BCPs are held in BB and electronic copies on Trust EPRR intranet site, with copies held locally	Fully compliant		Achanda Neale	

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28	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Copies of BCPs are in Battle Box and on the Intranet and also stored centrally (electronic) Link on Intranet home documents page to BCPs on EP site Ongoing review of BCPs by COO and EPRR Operational Lead - see quarterly EPRR reports for progress	Fully compliant	Consider further comms re BCP	Achanda Neale	
29	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	Training currently sits with Officer Manager of CEO office. Training pack taken from official training provided by CUH provided, newly trained loggists have observed, shadowed Command & Control before undertaking a solo session. Loggists trained pre Covid attended course at CUH and register sits with Estates & Facilities. In the event of a critical or major incident switchboard have the contact details of the Officer Manager who will then assign a trained loggist. There are individual logs of the most recent incidents as evidence.	Fully compliant		Office Manager, CEO Office	
30	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Lockdown Procedure DN574 - Approved at July Estates Business Unit meeting [Next review due 2023] Sitrep process stored N:\Shared\OPERATIONAL SITE MANAGEMENT\COVID19\Clinical Admin Submissions\SOP Covid Submissions and Collating v4 [review Sept 22]	Fully compliant		Eilish Midlane	
31	**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	Not applicable to site - RPH is unliekly to ever be involved in mass casualty response, other than supporting the local health community in creating capacity by taking transfers, but this is likely to be smaller in number than mass casualties and planned	Not applicable			
32	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	Not applicable to site - The site doesn't provide a decontamination service, there is a policy in the event of a self presenter	Not applicable			
Domain 7 - Warning and informing									

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33	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The Comms team is aware of the process for reporting potential incidents to partners regionally through the ICS and NHSE/I. An out of hours communication on-call system 24/7 is in place to allow access to trained comms support for senior leaders during an incident. Comms be tested in Ex Starburst in Sept 22. CPLRF Warn and Inform Plans are available in the EPRR folder	Fully compliant		Communications	
34	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	See DN643 Critical Incident Plan (section 11) Communications action card in place A process for briefing partners, including NHS England regional communications team and ICS communications team, is in place. Comms action card 5 remains accurate.	Fully compliant		Communications	
35	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Member of Local Health Resilience Partnership (LHRP), including attending at meetings where possible Support the enactment of local, regional and national health-related messages as appropriate, e.g. hot weather advice. Communications forms part of a business continuity plan which details how we would communicate with staff, patients and other stakeholders in an emergency situation Communications has a vital role as part of the local incident management team (our command and control centre) to ensure appropriate communication between the hospital and its stakeholders takes place in an emergency situation. The organisation will ensure there is a communications representative (contacted via 24/7 on-call system) at every command and control meeting; the communications team will provide strategic advice to the Gold commander about appropriate communications around the incident, for example to staff, patients, the public and media, and will advise on appropriate communication channels to do so. This could include but is not limited to staff bulletins and website/social media. We have communications policies, including a staff social media policy (3,16 in our Digital Acceptable Use Policy) that would support appropriate communications in a MI or local incident scenario. There are 24/7 processes in place to work closely with NHS England and other regional stakeholders to disseminate important information via our internal and external communications channels. The Trust's FOI team logs Freedom of Information Requests. The communications team has a process for logging media enquiries during a MI or local incident scenario. We have a document control process for new plans and policies which are	Fully compliant		Communications	

Ref	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	Action to be taken	Lead	Comments
36	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • 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	Communications has a register of Gold managers who are media trained. The on-call communications team can provide strategic advice to the Gold commander about appropriate communications around the incident, for example to staff, patients, the public and media, and will advise on appropriate communication channels to do so.	Fully compliant		Communications	
Domain 8 - Cooperation									
37	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Minutes stored in S Drive EPRR/CPLRF/LRPH executive group Nov 21 mtg attended by EM and ETA May 22 mtg not attended by RPH Aug 22 mtg attended by EM	Fully compliant	Implement process to retrieve minutes from EPRR In-box	Eilish Midlane	
38	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Minutes retrieved from EPRR Inbox and stored in S Drive EPRR/CPLRF/LRPH working group - same comment re retrieval above applies HSCEPG Mtg 01.02.22 - No RPH attendee HSCEPT Mtg 15.06.22 - was this cancelled? HSCEPG Mtg 25.04.22 - No RPH attendee What is the expectation of our attendance ICS are the health representative at the LRF who will cascade key messages and escalate issues with RPH. NB: have arrangements with ICS.	Partially compliant	Implement process to retrieve minutes from EPRR In-box AN to query at check and challenge session	Achanda Neale	
39	**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	• 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	Mutual Aid Plan in place [referenced in LRF's policies and procedures] Requests for mutual aid such as in Radiology with CUH os often brought to the weekly Access meetings chaired by the COO Amvale SOP for extra ambulances [Jan-Mar 22] at the request of the then CCG that we assisted with mutual aid requests - evidence is in N drive/shared/Opererational Site Management/Amvale Ambulance Project 2022	Fully compliant		Achanda Neale	
40	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	Not applicable to site See AS comments above re mass casualty	Not applicable			
41	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency	Not applicable to site	Not applicable			

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42	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas	Information share with ICS / NHSE etc. See point 37 for Comms info sharing EPRR inbox - flow of communication national/regionally etc.	Fully compliant		Communications	
43	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Information share with ICS / NHSE etc. See point 37 for Comms info sharing	Fully compliant		Achanda Neale	
Domain 9 - Business Continuity									
44	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	DN513 Business Continuity Policy (due for review April 23) There is a robust annual check and challenge process chaired by the COO	Fully compliant		Andrew Selby	
45	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles	Business Continuity Plan Workbook Refer to DN513 above DN868 Lorenzo Business Continuity Plan recently reviewed and approved by the Lorenzo EPR Design Authority latest review outstanding Established cycle of review for BCPs with Exec oversight. BCPs format reviewed to reflect appropriate terminology.	Fully compliant	Review of Lorenzo EPR Design Authority due	Achanda Neale	
46	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • 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: • Determining impacts over time should demonstrate to top	This is part of the annual BCP review process and part of the RPH EPRR workplan signed off at EPC meeting on 18.05.22 Refer to DN513 Business Continuity Policy Datix report shows: - Did this require activation of the MI policy?- 1 incident - Has this incident involved the initiation of a BCP? - 11 incidents After Action Reviews We predict what we think will happen via BCP and in AAR we review what we did and what happened and may to update the BCP as reality may inform business impact	Fully compliant		Achanda Neale	

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47	**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	All BCPs undergoing review to a standard template [review to be completed in 2023] Annual reviews began Mar 2022 with Deep Dives scheduled for March 2023 and BCP owners informed. 2022 BCP reviews continue.	Fully compliant		Achanda Neale	
48	**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	Quarterly on-call workshops hosting discussion based exercises. After action reviews in place. Digital phishing - concerned ESR profiles e-mail - malware discussed at oncall workshop in April 2022. AARs discussed at May 22 EPC - making these standard practice Annual table top review of BCPs	Fully compliant		Achanda Neale	
49	**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	IG Toolkit submitted on 28.06.22. Assurance given that RPH is compliant with standards and DSP Toolkit status is publicly available at https://www.dsptoolkit.nhs.uk/OrganisationSearch/RGM	Fully compliant		Andy Raynes	
50	**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	Business Continuity Plans are reviewed annually See earlier standards 3 and 47. Monitoring of KPIs should be reviewed annually at EPC	Partially compliant	AN to query at check and challenge meeting re KPIs	Eilish Midlane	
51	**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	Business Continuity Plans are reviewed annually See earlier standard 47 EPC receive updates of BCP reviews. Annual BCP review by Exec Lead for EPRR	Fully compliant		Eilish Midlane	

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52	**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 Plans are reviewed annually See earlier standard 47 EPC receive updates of BCP reviews. Annual BCP review by Exec Lead for EPRR	Fully compliant		Eilish Midlane	
53	**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	Contract BCPs: OCS - with Estates & Facilities Skanska - with Estates & Facilities SBS - NHS SBS CBP & Resilience Management Framework and policy Project Co - With Estates & Facilities To be monitored via EPC Within the PFI contract there is a contract requirement for the service providers to update (at a minimum period of annually) and share these BCPs with the Trust, when Estates attend the BCP review we will be bringing the providers BCPs with us, however as part of the PFI working we have reviewed and assessed these to ensure they are interoperable. Cambridge Perfusion - E-mail assurance given 26.08.22 from Finance of in date contract	Fully compliant	Do we need this as an action for the next EPC?	Eilish Midlane	
54	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning	Not applicable to site	Not applicable			
Domain 10 - CBRN									

Ref	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	Action to be taken	Lead	Comments
55	**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	Refer to DN771 Self Presenters policy [Review June 23] and telephony advice available from ALERT Team/ bronze on call 24/7 Action card within DN771 gives information how to seek advice. Relevant staff have undertaken Self-presenter training Training to be repeated 3 yearly. New staff yet to be identified and to undertake Training LearnZone access in development	Fully compliant	Identify new staff to undertake training	Achanda Neale	
56	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • 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	Refer to DN771 Self Presenters policy [due for review June 2023] See standard 66	Fully compliant		Achanda Neale	
57	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	COSHH and high risk chemicals on site. Link with Skanska and OCS about substances in the Service Yard. Trust risk register is managed by Trust's Risk Manager with input from Emergency Planning Team as appropriate Spill kits now placed at the Ambulance entrance and in the Blood Transfusion modular build. Health & Safety Committee - does not currently have line of sight on the Risk assessments? There is a contact requirement to the service providers to undertake full COSHH risk assessments on all chemicals on site, these are monitored on a 3 monthly basis by the PFI monitoring team, but also by the service providers. In terms of the substance in the service these are not high risk chemicals it is water with disinfection and glycerine. Estates attend the Health and safety committee,	Fully compliant		Andrew Selby	
58	**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	Not applicable to site	Not applicable			

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59	**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. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/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/eprr-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	CBRNE kit bag stored in a designated location close to main reception (specified within DN771), contents are audited on a monthly basis by the Quality Compliance Team to ensure full stock levels. Completed monthly inventory check - register of checks available	Fully compliant		Chris Seaman	
60	**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.	Y	Completed equipment inventories; including completion date	Not applicable to site	Not applicable			
61	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and b	Not applicable to site	Not applicable			
62	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Not applicable to site	Not applicable			
63	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Not applicable to site	Not applicable			
64	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	Not applicable to site	Not applicable			
65	**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	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Not applicable to site	Not applicable			

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66	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Not applicable to site	Not applicable		Achanda Neale	
67	**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	Evidence training utilises advice within: • 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.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	DN771, training program in place with individuals identified as key staff - SoC/BoC, main receptionists, outpatients reception, ALERT team and porters security staff. Registers of attendance retained. Laminated first response action cards are in place in key locations across the Trust - main reception, outpatients reception, with the matrons, ALERT team and in the CBRNE kit bag. EPC agreed training should be 3 yearly cycle andplans underway to include on digital training platform with reminders. Training to be repeated 3 yearly. LearnZone access in development	Fully compliant	New staff to be identified and to undertake Training	Achanda Neale	
68	**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		Database of staff trained and fitted to use FF3 hoods as a monthly workforce report: s/shared/workforce reports PPE is available 24/7 on level 4 Fit testing program in place and monthly compliance reported to ICPPC monthly and quarterly to EPC. A fit testing report is generated from ESR and reviewed by ward managers and our fit testing team every month. This is reviewed a monthly divisional Performance meetings and reported on Matrons' Quality Reports. Appropriate staff are tested on a minimum of two masks. Breaks are given every four hours and staff have the opportunity to wear a respirator hood should they experience any skin discomfort. Estates keep an up-to-date spreadsheet of FFP3 supplies and estimated usage and alert EPR if there are any concerns . Staff are re-fit tested every two years or more frequently if their face shape changes. We are exploring the use of alternate masks once push deliveries are discontinued.	Fully compliant		Kathy Randall	