

Extraordinary Board of Directors: held in Public

Wed 22 October 2025, 09:30 - 10:00

Hybrid meeting held on MS teams and in New mill room 4.10

Agenda

09:30 - 09:30 1. Welcome and apologies for absence (verbal)

0 min

Information Linda Patterson

 Item 01.0 - Board of Directors - Agenda - held in public v1.pdf (2 pages)

09:30 - 09:35 2. Declaration of any conflicts of interest (enclosure)

5 min

Information Linda Patterson

Quality and Safety

**09:35 - 09:55 3. NHS England Emergency Preparedness, Resilience and Response
Assessment and Declaration (enclosure)**

20 min

Decision Kelly Barker

 EPRR Report BDCFT.pdf (5 pages)

 EPRR Core Standards 2025 Template - BDCFT (final v1).pdf (8 pages)

Governance and well led

09:55 - 09:55 4. Any other business (verbal)

0 min

Discussion Linda Patterson

09:55 - 10:00 5. Meeting evaluation (verbal)

5 min

Discussion Linda Patterson

Was the meeting conducted in line with the Trust values? (verbal)

Date of the Next Meeting: 4 December 2025 at 9am– final details to be confirmed by Corporate Governance Team

Close: Holly
17/10/2025 09:09:08

**Extraordinary Board of Directors –
held in public**

Date: Wednesday 22 October 2025

Time: 09.30 until 10.00

Venue: Meeting to be held on Microsoft Teams



We Care



We Listen



We Deliver

AGENDA

Strategic Priority			Lead	Time
GG	1	Welcome and apologies for absence (verbal)	LP	09.30
	2	Declaration of any conflicts of interest (enclosure)	-	-

Quality & Safety

BQS	3	NHS England Emergency Preparedness, Resilience & Response (EPRR) Assessment & Declaration	KB	09.35
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Governance & well led

GG	4	Any other business (verbal)	LP	09.55
	5	Meeting evaluation (verbal)	LP	
		Was the meeting conducted in line with the Trust values? (verbal)		

Date and time of next public meeting: 4 December 2025 at 9am

Final details to be confirmed by Corporate Governance Team

Strategic Priorities (Key)

Best Place to Work	Theme 1 – Looking after our people	BP2W:T1
	Theme 2 – Belonging in our organisation	BP2W:T2
	Theme 3 – New ways of working and delivering care	BP2W:T3

	Theme 4 – Growing for the future	BP2W:T4
Best Use of Resources	Theme 1: Financial sustainability	BUoR:T1
	Theme 2: Our environment and workspaces	BUoR:T2
	Theme 3: Giving back to our communities	BUoR:T3
Best Quality Services	Theme 1 – Access and Flow	BQS:T1
	Theme 2 – Learning for improvement	BQS:T2
	Theme 3 – Improving the experience of people using our services	BQS:T3
Best Partner	Co-production, working together, presence, insight	BP
Good Governance	Governance, accountability and effective oversight	GG

Close: Holly
17/10/2025 09:09:08

Board of Directors – Meeting held in Public

22 October 2025

Paper title:	NHS England Emergency Preparedness, Resilience & Response (EPRR) Assessment & Declaration	Agenda Item 03.0
Presented by:	Kelly Barker, Chief Operating Officer (and Accountable Emergency Officer)	
Prepared by:	Chris Wright, EPRR Manager	
Committees where content has been discussed previously		
Purpose of the paper Please check ONE box only:	<input checked="" type="checkbox"/> For approval	<input type="checkbox"/> For information
	<input type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	X
	Belonging to our organisation	X
	New ways of working and delivering care	X
	Growing for the future	X
Delivering Best Quality Services	Improving Access and Flow	X
	Learning for Improvement	X
	Improving the experience of people who use our services	X
Making Best Use of Resources	Financial sustainability	X
	Our environment and workplace	X
	Giving back to our communities	X
Being the Best Partner	Partnership	X
Good governance	Governance, accountability & oversight	X

Close: Holly
17/10/2025 09:09:08

Purpose of the report

NHS England requires all NHS organisations to annually assess their ability to meet their EPRR statutory obligations. This assurance is sought each autumn, and Trust Boards are to be made aware of the level of preparedness achieved. This report shows the results of our self-assessment for 2025

Executive Summary

NHS providers are required to provide annual assurance on their readiness to meet their Emergency Preparedness, Resilience & Response (EPRR) statutory obligations. Organisations must complete a formal self-assessment on several EPRR standards, as provided in the Civil Contingencies Act 2004, the Health & Social Care Act 2012, the Health Care Act 2022, NHS guidance and the NHS Operating Framework.

A regulated set of core items for all NHS providers is provided, with all questions to be answered showing the level achieved and actions to be taken to address any which fall below full compliance. BDCFT is assessed at **77.6%** (partially compliant), up from 65.2% (non-compliant last year).

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **Yes** (please set out in your paper what action has been taken to address this) **No**

Recommendation(s)

The Board of Directors is asked to:

- Note the findings of this report.
- Agree with the assessment of compliance as **PARTIALLY COMPLIANT**

Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: <ul style="list-style-type: none"> All
Care Quality Commission domains Please check <u>ALL</u> that apply	<input checked="" type="checkbox"/> Safe <input type="checkbox"/> Caring <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led <input checked="" type="checkbox"/> Responsive
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: <ul style="list-style-type: none"> Emergency Preparedness, Resilience & Response (EPRR) statutory obligations.

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Board of Directors – Meeting held in Public

22 October 2025

Comment by Accountable Emergency Officer (AEO)

NHS England requires all providers to conduct an annual self-assessment of EPRR competence against a multitude of exacting Core Standards. In recent years the assessment criteria have been the subject of much controversy and debate by providers and ICBs at local, regional and national level. As a result, NHS England had committed to introduce more balanced standard requirements for 2025. However, this year the standards remain unchanged, and surprisingly without any form of deep dive into a particular topic where a potentially increased risk or gap in appropriate response actions is perceived.

The peer review of self-assessments by partner organisations proved extremely effective last year and was generally heralded as a more proportionate and accurate reflection of the EPRR standards being achieved by providers. Those results were then reviewed and challenged where necessary during individual Trust meetings with their respective ICB to discuss their Core Standard submission. This system of ‘check and challenge’ is being used again this year, with the ICB advising that they will be concentrating their inspections on those aspects where providers have improved their previous red or amber ratings to now be green (i.e. fully compliant). For BDCFT, we have continued to improve our overall compliance rating and have increased our green rating by another 4 standards this year. These areas are specifically as follows:

- Inclusion of AEO role in job description of Chief Operating Officer.
- Introduction of an EPRR working programme, to reflect best working practice.
- Compiling and ratification of the Lockdown Policy.
- Improvement to EPRR training records capability, through introduction of external software package (CPDMe) to assist with personal training portfolios.
- Provision of 24/7 Loggist cover, as provided initially by the EPRR team.

Last year our self-assessment showed a compliance rate of 65.5%, which is now increased to **77.6%** overall and has elevated the Trust to partially compliant status. BDCFT has now fully completed (green rated) 45 out of the 58 standards required, and it is only the green rated items which count towards the competency assessment. Outside of that the Trust is partially compliant (amber rated) in 10 areas and there remain 3 (red rated) items where we have no level of compliance (*see diagram below*).

Close Holly
17/10/2025 09:09:08

Please select type of organisation:		Mental Health Providers			Publishing Approval Reference: 000719	
Click button to format the workbook						
Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant	Overall assessment:	Non compliant
Governance	6	6	0	0	Overall assessment:	Non compliant
Duty to risk assess	2	2	0	0		
Duty to maintain plans	11	11	0	0	Compliance Percentage:	77.59%
Command and control	2	1	1	0		
Training and exercising	4	3	1	0	Assurance Rating Thresholds Fully Compliant = 100% Substantially Compliant = 89-99% Partially Compliant = 77-88% Non Compliant = 76% or less Calculated using the number of FULLY compliant standards	
Response	5	5	0	0		
Warning and informing	4	4	0	0		
Cooperation	4	3	1	0		
Business Continuity	10	10	0	0		
Hazmat/CBRN	10	0	7	3		
Total	58	45	10	3		

The areas where BDCFT are less than fully compliant are concerned mostly with Chemical, Biological, Radiological & Nuclear (CBRN) capabilities. Further comment on each of the areas below full compliance is contained in this report.

EPRR Training Portfolios. In 2024, NHS England introduced a requirement for all those with incident management responsibilities, including on call directors and managers, to maintain personal EPRR training records. This is known to be a significantly time-consuming task for individuals to undertake. To assist staff members in managing their records accurately, the Trust has purchased an administrative package from an external specialist supplier. This contract was only put in place earlier this month, and it is therefore too early to assess the impact. However, it is expected that this digital package will be very useful for individuals, reducing the time needed to record their training, and will also ensure that the Trust is able to achieve the required standards for training record management in the future.

Local Health Resilience Partnership (LHRP) Attendance. The standards require that the AEO from each provider organisation should attend at least 75% of the quarterly meetings of this strategic level EPRR group. Further, it is not deemed acceptable for the Trust's EPRR specialist to represent their AEO at these meetings. BDCFT's AEO only attended 2 out of 4 in the reporting period due to the LHRP falling at the same time as Trust Board.

Chemical, Biological, Radiological & Nuclear (CBRN). The entire subject of CBRN capability remains a matter of grave concern for all community and mental health provider organisations. This has been raised as an ongoing risk at regional and national level, due to a marked difference between the requirements outlined in the Core Standards and the realistic capabilities of non-acute provider organisations. To address this, specialist CBRN training staff from Yorkshire Ambulance Service (YAS) have been tasked with assessing the actual facilities, resources and potential of non-acute. However, this is grossly under resourced, with just one person in place to cover the needs of all providers (also including acute hospitals) across the entire YAS geographical area of operations. Understandably, that individual dedicates most of their time to the training needs of those organisations which do conduct full CBRN activities, i.e. the acute providers, and therefore progress for the remainder is slow.

The discrepancy between standards and reality accounts for all 3 of BDCFT's non-compliant (red rated) items, and also 7 partially compliant (amber) areas where we are unable to reach the targets to be achieved. Overall, this equates to 10 out of 13 (76.92%) of the areas where the Trust is less than fully compliant.

Our self-assessment accurately depicts the credible level of response BDCFT could provide in response to a CBRN incident. That is based on the equipment, facilities and staff training that were established to give immediate care for such casualties who arrive at Trust sites (i.e. dry decontamination), pending the arrival of specialist staff and equipment from the ambulance service's Hazardous Area Response Team (HART) to deliver more appropriate care and an effective decontamination capability.

Summary

A good deal of progress has been made in our EPRR competency levels, with a 12% uplift to become fully compliant in areas that were previously assessed as below standard. The introduction of additional staff into the EPRR Team has meant that they now have the increased capacity to address many of the areas where continuous improvement is within their control to manage, and this has been a major contributing factor in the Trust's ability to deliver EPRR training to meet the exacting requirements of the National Occupational Standards. Additionally, within the past two weeks a contract with an external company has been approved to assist our on-call managers and directors in the recording and upkeep of their EPRR training portfolios. It is too early to assess the effectiveness of this initiative, but it is anticipated that it will help to resolve 3 of our amber rated items for next year, as part of our continuous improvement objectives.

Our completed assessment return has been compared and peer reviewed with other community and mental health provider organisations across the whole of the Yorkshire and Humber region, and our findings largely reflect their own. BDCFT has comparable levels of compliance with both LYPFT and SWYFT.

We will continue to work collectively with fellow MH and community Trusts, ICB and NHS England EPRR leads on the areas where improvements can be made to redress areas of non-compliance. Any emerging risks or issues will be communicated up through the appropriate organisation and system structures.

BDCFT retains a realistic level of assurance and compliance against the NHS England framework and remain confident in our ability to maintain effective EPRR measures for any incidents which may affect delivery of our services. This is borne out by the effectiveness of the Trust response to recent events where our contingency measures have been activated. Overall, the Trust Board should be assured that our EPRR systems and processes remain appropriate, realistic and proportionate to provide an effective response to incidents and emergencies.

Kelly Barker

Chief Operating Officer (Accountable Emergency Officer)

Bradford District Care Foundation Trust

30th September 2025

Please select type of organisation:
Click button to format the workbook

Mental Health Providers

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	1	1	0
Training and exercising	4	3	1	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	3	1	0
Business Continuity	10	10	0	0
Hazmat/CBRN	10	0	7	3
CBRN Support to acute Trusts	0	0	0	0
Total	58	45	10	3

Overall assessment: Partially compliant

Assurance Rating Thresholds

Fully Compliant = 100%
Substantially Compliant = 89-99%
Partially Compliant = 77-88%
Non Compliant = 76% or less

Calculated using the number of FULLY compliant standards

Compliance Percentage:

77.59%

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
Domain 1 - Governance				
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence <ul style="list-style-type: none"> Name and role of appointed individual AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: <ul style="list-style-type: none"> Business objectives and processes Key suppliers and contractual arrangements Risk assessment(s) Functions and / or organisation, structural and staff changes. 	The policy should: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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.
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	These reports should be taken to a public board, and as a minimum, include an overview on: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: <ul style="list-style-type: none"> 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.	Evidence <ul style="list-style-type: none"> Reporting process explicitly described within the EPRR policy statement Annual work plan
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.	Evidence <ul style="list-style-type: none"> 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
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.	Evidence <ul style="list-style-type: none"> 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
Domain 2 - Duty to risk assess				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Evidence that EPRR risks are regularly considered and recorded <ul style="list-style-type: none"> 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
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	Evidence <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
Domain 3 - Duty to maintain Plans				
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence <ul style="list-style-type: none"> Consultation process in place for plans and arrangements Changes to arrangements as a result of consultation are recorded
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.	Arrangements should be: <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
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.	Arrangements should be: <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), wildfire.
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.	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 Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/
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	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

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
14	Duty to maintain plans	Courtermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass courtermeasure deployment	<p>Arrangements should be:</p> <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 <p>Mass Courtermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination.</p> <p>There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Courtermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass courtermeasure arrangements.</p> <p>Commissioners may be required to commission new services to support mass courtermeasure distribution locally, this will be dependant on the incident.</p>
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.	<p>Arrangements should be:</p> <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 <p>Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.</p>
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.	<p>Arrangements should be:</p> <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
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.	<p>Arrangements should be:</p> <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
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.	<p>Arrangements should be:</p> <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
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.	<p>Arrangements should be:</p> <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
Domain 4 - Command and control				
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	<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 OCHs business critical services for providers and commissioners
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	<ul style="list-style-type: none"> Process explicitly described within the EPRR policy or statement of intent <p>The identified individual:</p> <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.
Domain 5 - Training and exercising				
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	<p>Evidence</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
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)	<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>Evidence</p> <ul style="list-style-type: none"> Exercising Schedule which includes as a minimum one Business Continuity exercise Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	<p>Evidence</p> <ul style="list-style-type: none"> Training records Evidence of personal training and exercising portfolios for key staff
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.	<p>As part of mandatory training</p> <p>Exercise and Training attendance records reported to Board</p>

Domain 6 - Response

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	<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.
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.	Planning arrangements are easily accessible - both electronically and local copies
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).	<ul style="list-style-type: none"> Business Continuity Response plans Arrangements in place that mitigate escalation to business continuity incident Escalation processes
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(e) to ensure support to the decision maker	<ul style="list-style-type: none"> Documented processes for accessing and utilising loggists Training records
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.	<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
Domain 7 - Warning and informing				
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	<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.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	<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. Clearly 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).
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.	<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 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
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	<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
Domain 8 - Cooperation				
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	<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.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	<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
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.	<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
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.	<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
Domain 9 - Business Continuity				
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	<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 adaptation planning
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.	<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

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
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).	<p>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.</p> <p>Documented process on how BIA will be conducted, including:</p> <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. <p>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:</p> <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.
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:	<p>Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation.</p> <p>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:</p> <ul style="list-style-type: none"> 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 <p>Confirm the type of exercise the organisation has undertaken to meet this sub standard:</p> <ul style="list-style-type: none"> Discussion based exercise Scenario Exercises Simulation Exercises Live exercise Test Undertake a debrief <p>Evidence</p> <p>Post exercise/ testing reports and action plans</p>
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.	<p>Confirm the type of exercise the organisation has undertaken to meet this sub standard:</p> <ul style="list-style-type: none"> Discussion based exercise Scenario Exercises Simulation Exercises Live exercise Test Undertake a debrief <p>Evidence</p> <p>Post exercise/ testing reports and action plans</p>
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.	<p>Evidence</p> <ul style="list-style-type: none"> Statement of compliance Action plan to obtain compliance if not achieved
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.	<p>Business continuity policy</p> <ul style="list-style-type: none"> BCMS performance reporting Board papers
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.	<ul style="list-style-type: none"> 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
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.	<ul style="list-style-type: none"> 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 <p>Continuous Improvement can be identified via the following routes:</p> <ul style="list-style-type: none"> 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 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 <p>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</p>
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.	<ul style="list-style-type: none"> 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 <p>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</p>
Domain 10 - CBRN				
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	<p>Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation</p>
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	<p>Evidence of the risk assessment process undertaken - including -</p> <ol style="list-style-type: none"> governance for risk assessment process assessment of impacts on staff impact assessment(s) on estates and infrastructure - including access and egress management of potentially hazardous waste impact assessments of Hazmat/CBRN decontamination on critical facilities and services <p>Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA</p>
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	<p>Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient</p> <p>Documented plans include evidence of the following:</p> <ul style="list-style-type: none"> Command and control structures Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability Procedures to manage and coordinate communications with other key stakeholders and other responders Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control Distinction between dry and wet decontamination and the decision making process for the appropriate deployment Identification of lockdown/isolation procedures for patients waiting for decontamination Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance Arrangements for staff decontamination and access to staff welfare Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes Plans for the management of hazardous waste Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IQR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	<p>Documented plans include evidence of the following:</p> <ul style="list-style-type: none"> Command and control structures Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability Procedures to manage and coordinate communications with other key stakeholders and other responders Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control Distinction between dry and wet decontamination and the decision making process for the appropriate deployment Identification of lockdown/isolation procedures for patients waiting for decontamination Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance Arrangements for staff decontamination and access to staff welfare Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes Plans for the management of hazardous waste Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident

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60	Hazmat/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> <p>Equipment is proportionate with the organisation's risk assessment of equipment - such as for the management of non-ambulant or collapsed patients</p> <ul style="list-style-type: none"> - Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/epr-decontamination-equipment-check-list.xlsx - 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 	<p>This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).</p> <p>There are appropriate risk assessments and SOPs for any specialist equipment</p> <p>Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required.</p> <p>Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.</p>
61	Hazmat/CBRN	Equipment - Preventive Programme of Maintenance	<p>There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident.</p> <p>Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations</p> <p>The PPM should include where applicable:</p> <ul style="list-style-type: none"> - PRPS Suits - Decontamination structures - Disrobe and robe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes <p>There is a named individual (or role) responsible for completing these checks</p>	<p>Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment</p> <ul style="list-style-type: none"> - Record of regular equipment checks, including date completed and by whom - Report of any missing equipment <p>Organisations using PPE and specialist equipment should document the method for its disposal when required</p> <p>Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR</p> <p>Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment</p> <p>Records of maintenance and annual servicing</p> <p>Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53</p>
63	Hazmat/CBRN	Hazmat/CBRN training resource	<p>The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments</p>	<p>Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy)</p> <p>Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination</p> <p>Documented evidence of training records for Hazmat/CBRN training - including for:</p> <ul style="list-style-type: none"> - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that they have undertaken <p>Developed training programme to deliver capability against the risk assessment</p>
64	Hazmat/CBRN	Staff training - recognition and decontamination	<p>The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination.</p> <p>Staff that may make contact with a potentially contaminated patient, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres)</p> <p>Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented</p> <p>Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE.</p> <p>This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7</p>	<p>Evidence of trust training slides/programme and designated audience</p> <p>Evidence that the trust training includes reference to the relevant current guidance (where necessary)</p> <p>Staff competency records</p>
65	Hazmat/CBRN	PPE Access	<p>Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE.</p> <p>This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7</p>	<p>Completed equipment inventories, including completion date</p> <p>Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination</p> <p>Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS</p>
66	Hazmat/CBRN	Exercising	<p>Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme</p>	<p>Evidence</p> <ul style="list-style-type: none"> - Exercising Schedule which includes Hazmat/CBRN exercise - Post exercise reports and embedding learning

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence
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Please select type of organisation:
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Mental Health Providers

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	1	1	0
Training and exercising	4	3	1	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	3	1	0
Business Continuity	10	10	0	0
Hazmat/CBRN	10	0	7	3
Total	58	45	10	3

Overall assessment: Non compliant

Compliance Percentage: 77.59%

Assurance Rating Thresholds
 Fully Compliant = 100%
 Substantially Compliant = 89-99%
 Partially Compliant = 77-88%
 Non Compliant = 76% or less
 Calculated using the number of FULLY compliant standards

Standards	Fully Comp	Partial Comp	Non-Comp
58	38	17	3
58	45	12	3

Percentage 65.52%
 Percentage 77.59%

Total for 2024
 Total for 2025