Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR 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 EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
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, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Dr Kanchan Rege, Chief Medical Officer, is AEO Supported by Celia Kendrick, Head of Resilience & Emergency Preapredness	Fully compliant	n/a	AEO	n/a	no change
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. 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. 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 • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust's "Emergency Preparedness, Resilience and Response Strategic Framework" includes all key elements. It is updated annually and approved by the Hospital Management Committee. Last published August 2021 and due for renewal August 2022.	Fully compliant	n/a	HREP	n/a	Framework revised and republished August 2021
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	EPRR Annual Report is produced each August to include the findings from the Core Standards self assessment. It includes details of all exercises, training sessions and incidents the organisation has been involved in. The report is then tabled for Public Board meeting in September with the results of the Core Standards self assessment.	Fully compliant	n/a	HREP	n/a	
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR roles and functions are described within the NWAngliaFT EPRR Strategic Framework,which is ratified by HMC/board. The EPRR team form part of the portfolio for the Chief Medical Officer as AEO within the Corporate division and are detailed as part of the Care Quality Directorate. In 2020/21 the EPRR team was substantivel increased by 0.6 wte band 8 and 0.8 wte band 3. Job descriptions are iin place for HREP, Deputy EPRR Lead Resilience Co-ordinator, and EPRR Administrative Assistant.	Fully compliant	n/a	AEO	n/a	
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	The NWAngliaFT EPRR Strategic Framework includes details of how each incident and exercise will undergo review/debrief and an action plan formulated to address any lessons identified. The Emergency Preparedness Committee (EPC) has a standing agenda item to review progress with all action plans.	Fully compliant	n/a	HREP	n/a	
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 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	All EPRR related risks are on the corporate risk register and are reviewed at least 6 monthly depending on their risk rating and actions being taken to reduce the risk.	Fully compliant	n/a	HREP	n/a	
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The EPC has a standing agenda item to review all EPRR risks. Risks are regularly reviewed in line with the Trust's policy by the HREP and an action card detailing actions that have been taken or that are to be taken in the coming months are completed and uploaded monthly for 'significant' and 'high' risks.	Fully compliant	n/a	HREP	n/a	
Domain 3 - Duty to maintain plans											

No.	Duty	Sub-category	Description		Arrangements should be	Evidence	Compliance				
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Critical Internal Incident Plan(s) in place with action cards in two versions, one to cover operational bed capacity related issues and one to cover non-capacity issues. Both have been used within the past 12 months to manage different types of incidents. In line with Trust policy the plans are first approved at EPC and then by the Hospital Management Committee. Last updated and republished April 2021. Training requirements are detailed within the NWAngliaFT EPRR Strategic Framework.	Fully compliant	n/a	HREP	n/a	
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major Incident (including mass casualty) Plan(s) in place for all three hospital sites. Plans are updated at least annually, but more often if there are changes to national guidance, learning from incidents or changes in the organisation. In line with Trust policy, the plans are first level approved at EPC and then second level approved by by the Hospital Management Committee. A revised, merged single plan is almost completed and will be approved and published by the end of 2021.Training requirements are detailed within the NWAngliaFT EPRR Strategic Framework.	Fully compliant	n/a	HREP	n/a	
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Heatwave Plan is in place for all sites, and complies with the current Heatwave Plan for England. Last activated in July 2021. The plan is approved at EPC. Training requirements are detailed within the NWAngliaFT EPRR Strategic Framework.	Fully compliant	n/a	HREP	n/a	
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Cold and Adverse Weather Plan is in place and complies with current guidance. It is approved at EPC, and training requirements are detailed within the NWAngliaFT EPRR Strategic Framework. The plan is due for revision at the end of October 2021.	Fully compliant	n/a	HREP	n/a	
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Mass casualty arrangements are detailed within the Major Incident Plan and are in line with the national and regional conops. The plan is first level approved by the EPC and second level approved by HMC and are the revised version is due for publication in Nov 2021. Training standards are detailed within the NWAngliaFT EPRR Strategic Framework.	Fully compliant	n/a	HREP	n/a	
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Unique identification numbers are in place and pre-designated at all the sites. Each number has a corresponding notes pack pre-filled with the necessary documentation which is pre-numbered including wristbands. The Trust's patient administration systems are not capable of issuing non-sequential numbers, and the numbers have to be compatible with this system to allow electronic records to be completed and on line diagnostic requests and results etc. Patients are identified using the majax number, sex, estimated age group and phonetic alphabet based 'name' in line with the latest guidance. NHS England are aware that we are unable to give non-sequential numbers. Pathology services are happy with this sytem. Risk assessment is in place to record the lower risk associated with using numbers as issued by the system, in comparison to randomising the given numbers into non-sequential order.	Fully compliant	n/a	HREP	n/a	
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation & Shelter Plan is in place across all sites. It is first level approved by the EPC and second level apporved by the Hospital Management Committee. Training requirements are detailed within the NWAngliaFT EPRR Strategic Framework. The plan is undergoing further revision due to the addition of SMART evacuation system, and changes necessitated in evacuation routes at the Hinchingbrooke site due to the RAAC plank risk.	Fully compliant	n/a	HREP	n/a	
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown practical procedure is in place for all sites led by the non-clinical risk and security teams. This has been tested both in working hours and outside of normal office hours. Responsiility for the plan has transferred to EPRR and a revised plan to support the practical procedures is due for publication in September 2021	Fully compliant	n/a	HREP	n/a	

#	Domain	Sub-topic	Description	Y/N	Arrangements	Evidence	Compliance		Action owner	
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Responsibility for this plan was recently transferred to EPRR. A new plan has been drafted and is due for publication in October 2020.	Fully compliant	n/a	HREP	n/a

Domain 4 - Command and control

#	Domain	Sub-topic	Description	Y/N	Arrangements	Evidence	Compliance		Action owner	
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. 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 • Include 24 hour arrangements for alerting managers and other key staff.	Declared incidents are notified to switchboard who enact the relevant plan. The command team are the first points of contact by switchboard to ensure the Tactical Control Team is formed quickly. EPRR are also informed, but the Senior Manager on Call (SMOC) for the PCH site takes command of the incident until relieved by the COO or DOC. Initial contact for any non-delcared incident queries or escalation is via the SMOC who can escalate to the Director on Call (DOC) at any time 24/7	Fully compliant	n/a	HREP	n/a

Domain 5 - Training and exercising

Domain 6 - Response

#	Domain	Sub-topic	Description	Y/N	Arrangements	Evidence	Compliance		Action owner	
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		There is a fully equipped ICC at the main PCH, with back up facilities both at the Hinchingbrooke site and off site at Thorpe Wood Police station. Each plan details activation, actions and membership of the Tactical Command Team	Fully compliant	n/a	HREP	n/a
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	There are BCPs in standard Trust format in place across all wards and departments. All are available on the intranet and a hard copy is in each control room.	Fully compliant	n/a	HREP	n/a
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	Part of the role of the TCT and detailed within their action cards.	Fully compliant	n/a	HREP	n/a
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Hard copies are in key areas and staff have ID card sized laminates with their action cards giving website addresses to access them (and other algorithms) electronically	Fully compliant	n/a	HREP	n/a
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Hard copies are in key areas and staff have ID card sized laminates with their action cards giving website addresses to access them (and other algorithms) electronically	Fully compliant	n/a	HREP	n/a

Domain 7 - Warning and informing

#	Domain	Sub-topic	Description	Y/N	Arrangements	Evidence	Compliance		Action owner	
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Partner agencies and communications lead are members of the Trust's Emergency Preparedness Committee. Communications team have specific action cards in each plan with clear comms strategies, and the TCT and loggist collate and record all information requests and responses.	Fully compliant	n/a	HREP	n/a
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Communications plans in place in each plan for managing communication with patients, staff, partner agencies, the media and the public.	Fully compliant	n/a	HREP	n/a
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Communications plans in place in each plan for managing communication with patients, staff, partner agencies, the media and the public.	Fully compliant	n/a	HREP	n/a

Domain 8 - Cooperation

#	Domain	Sub-topic	Description	Y/N	Arrangements	Evidence	Compliance		Action owner	
42	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. 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 • Signed mutual aid agreements where appropriate	Processes for requesting of mutual aid detsailed in the plans for the Tactical Control Team. Available in hard copy format in the major incident control room. Requests for mutual aid managed via normal command arrangements. As an acute provider, Trust would not unilaterally request MACA.	Fully compliant	n/a	HREP	n/a
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding 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	n/a				

#	Domain	Item	Description		Evidence	Trust Position	Compliance		Lead	
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England 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	n/a				
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity 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 and the Civil Contingencies Act 2004 'duty to communicate with the public'.	There is a county wide Information Sharing Framework Agreement in place, also information sharing protocols with police and ambulance services.	Fully compliant	n/a	HREP	n/a

Domain 9 - Business Continuity

#	Domain	Item	Description		Evidence	Trust Position	Compliance		Lead	
47	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 Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Detailed within the Trust's Emergency Preparedness Strategic Framework	Fully compliant	n/a	HREP	n/a
48	Business Continuity	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.	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 • Stakeholders	Detailed within the Trust's Emergency Preparedness Strategic Framework, and each invidival department's BCP (which are all on the Trust's BCP template).	Fully compliant	n/a	HREP	n/a
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Annual completion of compliance statement in place	Fully compliant	n/a	HREP	n/a
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Each department at each site is covered by a BCP. Each has plans for utilities failure, IT/telephony failure, staff shortage, key equipment shortage, or failure etc. All BCPs are reveiwed at least annually. Compliance is monitored by monthly status updates to each senior management team and via EPC.	Fully compliant	n/a	HREP	n/a
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Formal internal audit last conducted June 2018. Results included in board report and discussed at EPC. Compliance monitored quarterly at EPC and databse showing status of each BCP shared with Divisions monthly.	Fully compliant	n/a	HREP	n/a
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	In the Trust's EPRR Strategic Framework and monthly status reports to senior managers for each division. Also monitored at EPC, and each BCP reviewed by HREP prior to submission to EPC for formal approval	Fully compliant	n/a	HREP	n/a
55	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 work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Providers' BCPs undergo same process as Trust BCPs	Fully compliant	n/a	HREP	n/a

Domain 10: CBRN

#	Domain	Item	Description		Evidence	Trust Position	Compliance		Lead	
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Detailed on action cards in HazMat Plan and on ED crib sheets	Fully compliant	n/a	HREP	n/a
57	CBRN	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	HazMat Plan in place with site specific action cards for each site covering command and control, safety, and decontamination arrangements etc in detail for both chemical and radiation incidents	Fully compliant	n/a	HREP	n/a
58	CBRN	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	Risk assessment in place and added to corporate risk register. HazMat Plans detail all actions to be taken including waste disposal.	Fully compliant	n/a	HREP	n/a
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	Staff training opportunities declined during 2020 due to operational/covid pressures and the inability to maintain social distancing and share training suits. This has resulted in reduced numbers of fully PRPS trained staff. Recovery plan in place with protected sessions running through Sept/Oct.	Partially compliant	Training sessions planned throughout Sept/Oct with protected attendance time agreed with EDs.	Deputy EPRR Lead	Compliant by end Oct 21

60	CBRN	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/wp-content/uploads/2018/07/eprr-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/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	Database of suits held and maintained by Resilience Co-ordinator. Full range of additional equipment held at both EDs and inventory held on equipment database.	Fully compliant	n/a	Deputy EPRR Lead	n/a
62	CBRN	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 by whom. • Report of any missing equipment	Checking of decontamination units is part of PPM and is managed by PFI partners at PCH and by retained estates personnel at HH. Maintenance and replacement/refurbishment etc of suits is led by the Resilience Co-ordinator with regualr checks in place on live and training kits. RAMGENE monitors checked monthly at all sites, and annually by EA Regional Radiation Protection Service.	Fully compliant	n/a	Deputy EPRR Lead	n/a
63	CBRN	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	PPM for decontamination units is managed by PFI partners at PCH and by retained estates personnel at HH. Maintenace and replacement/refurbishment etc of suits is led by the Resilience Co-ordinator. RAMGENE monitors checked monthly at all sites, and annually by EA Regional Radiation Protection Service.	Fully compliant	n/a	Deputy EPRR Lead	n/a
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	Monitoring, life extension, refurbishment, replacement and disposal of suits Is managed by the Resilience Co-ordinator.Destruction certificates retained.	Fully compliant	n/a	Resilience Co-ordinator	n/a
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	Deputy EPRR Lead is responsible for all EPRR related training including CBRN/HazMat.He is an HMIMMS instructor/director and fully trained in CBRN/HazMat with extensive experience.	Fully compliant	n/a	Deputy EPRR Lead	n/a

67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	Deputy EPRR Lead is supported by core trainers within ED	Fully compliant	n/a	Deputy EPRR Lead	n/a				
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• 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/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All 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 • A range of staff roles are trained in decontamination technique	Decontamination training in place on both main sites. Training includes isolation of the patient, IOR, JESIP guidance, revised CBRN PHE guidance.	Fully compliant	n/a	Deputy EPRR Lead	n/a				
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		FFP3 supplies in place across the organisation and in major incident resilience stocks. Fit testing ongoing as part of normal practice.	Fully compliant	n/a	HREP	n/a				

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR 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 EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART										
Domain: Capability										
H1	HART	HART tactical capabilities	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	HART	National Capability Matrices for HART	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	HART	Compliance with National Standard Operating Procedures	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	HART	Staff competence	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	HART	Protected training hours	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						
H6	HART	Training records	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y						
H7	HART	Registration as Paramedics	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	HART	Six operational HART staff on duty	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	HART	Completion of Physical Competency Assessment	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	HART	Mandatory six month completion of Physical Competency Assessment	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H11	HART	Returned to duty Physical Competency Assessment	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H12	HART	Commander competence	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										

H13	HART	Effective deployment policy	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	HART	Identification appropriate incidents / patients	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	HART	Notification of changes to capability delivery	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	HART	Recording resource levels	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						
H17	HART	Record of compliance with response time standards	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	HART	Local risk assessments	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	HART	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	HART	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	HART	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	HART	Change Request Process	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H23	HART	Initial deployment requirement	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
H24	HART	Additional deployment requirement	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						
H25	HART	Attendance at strategic sites of interest	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						
H26	HART	Mutual aid	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
Domain: Logistics										
H27	HART	Capital depreciation and revenue replacement schemes	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	HART	Interoperable equipment	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						

H29	HART	Equipment procurement via national buying frameworks	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	HART	Fleet compliance with national specification	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	HART	Equipment maintenance	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	HART	Equipment asset register	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must 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).	Y						
H33	HART	Capital estate provision	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA										
Domain: Capability										
M1	MTFA	Maintenance of national specified MTFA capability	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	MTFA	Compliance with safe system of work	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	MTFA	Interoperability	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	MTFA	Compliance with Standard Operating Procedures	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
M5	MTFA	Ten competent MTFA staff on duty	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	MTFA	Completion of a Physical Competency Assessment	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	MTFA	Staff competency	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						
M8	MTFA	Training records	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y						
M9	MTFA	Commander competence	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	MTFA	Provision of clinical training	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						
M11	MTFA	Staff training requirements	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	MTFA	Effective deployment policy	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	MTFA	Identification appropriate incidents / patients	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						

M14	MTFA	Change Management Process	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y					
M15	MTFA	Record of compliance with response time standards	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y					
M16	MTFA	Notification of changes to capability delivery	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y					
M17	MTFA	Recording resource levels	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y					
M18	MTFA	Local risk assessments	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y					
M19	MTFA	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y					
M20	MTFA	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y					
M21	MTFA	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y					
Domain: Response time standards									
M22	MTFA	Readiness to deploy to Model Response Sites	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y					
M23	MTFA	10minute response time	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y					
Domain: Logistics									
M24	MTFA	PPE availability	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y					
M25	MTFA	Equipment procurement via national buying frameworks	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y					
M26	MTFA	Equipment maintenance	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y					
M27	MTFA	Revenue depreciation scheme	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y					
M28	MTFA	MTFA asset register	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y					
CBRN									
Domain: Capability									

B1	CBRN	Tactical capabilities	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y					
B2	CBRN	National Capability Matrices for CBRN.	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y					
B3	CBRN	Compliance with National Standard Operating Procedures	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y					
B4	CBRN	Access to specialist scientific advice	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y					
Domain: Human resources									
B5	CBRN	Commander competence	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y					
B6	CBRN	Arrangements to manage staff exposure and contamination	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y					
B7	CBRN	Monitoring and recording responder deployment	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y					
B8	CBRN	Adequate CBRN staff establishment	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y					
B9	CBRN	CBRN Lead trainer	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y					
B10	CBRN	CBRN trainers	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y					
B11	CBRN	Training standard	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y					
B12	CBRN	FFP3 access	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y					
B13	CBRN	IOR training for operational staff	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y					
Domain: administration									
B14	CBRN	HAZMAT / CBRN plan	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y					
B15	CBRN	Deployment process for CBRN staff	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y					
B16	CBRN	Identification of locations to establish CBRN facilities	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y					
B17	CBRN	CBRN arrangements alignment with guidance	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y					
B18	CBRN	Communication management	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y					
B19	CBRN	Access to national reserve stocks	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y					
B20	CBRN	Management of hazardous waste	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y					
B21	CBRN	Recovery arrangements	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y					

B22	CBRN	CBRN local risk assessments	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y							
B23	CBRN	Risk assessments for high risk areas	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y							

Domain: Response time standards

B24	CBRN	Model response locations - deployment	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y							

Domain: logistics

B25	CBRN	Interoperable equipment	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y							
B26	CBRN	Equipment procurement via national buying frameworks	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y							
B27	CBRN	Equipment maintenance - British or EN standards	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y							
B28	CBRN	Equipment maintenance - National Equipment Data Sheet	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y							
B29	CBRN	Equipment maintenance - assets register	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must 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).	Y							
B30	CBRN	PRPS - minimum number of suits	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y							
B31	CBRN	PRPS - replacement plan	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y							
B32	CBRN	Individual / role responsible fore CBRN assets	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y							

Mass Casualty Vehicles
Domain: Administration

V1	MassCas	MCV accommodation	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y							
V2	MassCas	Maintenance and insurance	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y							
V3	MassCas	Mobilisation arrangements	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y							
V4	MassCas	Mass oxygen delivery system	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y							

Domain: NHS England Mass Casualties Concept of Operations

V6	MassCas	Mass casualty response arrangements	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.	Y							
V7	MassCas	Arrangements to work with NACC	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y							
V8	MassCas	EOC arrangements	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y							
V9	MassCas	Casualty management arrangements	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y							
V10	MassCas	Casualty Clearing Station arrangements	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y							

V11	MassCas	Management of non-NHS resource	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	MassCas	Management of secondary patient transfers	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						

Command and control
Domain: General

C1	C2	Consistency with NHS England EPRR Framework	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	C2	Consistency with Standards for NHS Ambulance Service Command and Control.	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						
C3	C2	NARU notification process	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						
C4	C2	AEO governance and responsibility	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						

Domain: Human resource

C5	C2	Command role availability	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	C2	Support role availability	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						
C7	C2	Recruitment and selection criteria	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards.\n\nNo personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command).\n\nThis standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	C2	Contractual responsibilities of command functions	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	C2	Access to PPE	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	C2	Suitable communication systems	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						

Domain: Decision making

C11	C2	Risk management	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						

C12	C2	Use of JESIP JDM	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	C2	Command decisions	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	C2	Retaining records	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	C2	Decision logging	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						
C16	C2	Access to loggist	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	C2	Lessons identified	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	C2	Strategic commander competence - National Occupational Standards	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C19	C2	Strategic commander competence - nationally recognised course	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	C2	Tactical commander competence - National Occupational Standards	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C21	C2	Tactical commander competence - nationally recognised course	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C22	C2	Operational commander competence - National Occupational Standards	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C23	C2	Operational commander competence - nationally recognised course	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	C2	Commanders - maintenance of CPD	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						

C25	C2	Commanders - exercise attendance	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y					
C26	C2	Training and CDP - suspension of non-compliant commanders	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y					
C27	C2	Assessment of commander competence and CDP evidence	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y					
C28	C2	NILO / Tactical Advisor - training	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y					
C29	C2	NILO / Tactical Advisor - CPD	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y					
C30	C2	Loggist - training	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y					
C31	C2	Loggist - CPD	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y					
C32	C2	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y					
C33	C2	Medical Advisor of Forward Doctor - exercise attendance	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y					
C34	C2	Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y					
C35	C2	Control room familiarisation with capabilities	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y					
C36	C2	Responders awareness of NARU major incident action cards	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y					

JESIP
Domain: Embedding doctrine

J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y					
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y					
J3	JESIP	Five JESIP principles for joint working	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y					
J4	JESIP	Use of METHANE	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y					
J5	JESIP	Joint Decision Model - advocate use of	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y					
J6	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y					
J7	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y					
Domain: Training									
J8	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y					
J9	JESIP	Awareness of JESIP - control room staff	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y					
J10	JESIP	Awareness of JESIP - Commanders and Control Room managers / supervisors	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y					
J11	JESIP	Training records - staff requiring training	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y					
J12	JESIP	Command function - interoperability command course	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y					
J13	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y					
J14	JESIP	Commanders - interoperability command course	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y					
J15	JESIP	Participation in multiagency exercise	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y					
J16	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y					
J17	JESIP	Training - review process	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y					
J18	JESIP	JESIP trainers	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y					
Domain: Assurance									
J19	JESIP	JESIP self-assessment survey	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y					

J20	JESIP	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	JESIP	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	JESIP	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	JESIP	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply											
Domain: Oxygen Suuply											
DD1	Oxygen Supply	Medical gasses - governance	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•☐Committee meets annually as a minimum •☐Committee has signed off terms of reference •☐Minutes of Committee meetings are maintained •☐Actions from the Committee are managed effectively •☐Committee reports progress and any issues to the Chief Executive •☐Committee develops and maintains organisational policies and procedures •☐Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •☐Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •☐The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	Committee meets quarterly with full TORs, reporting structure, actions and minutes in place. Plans, SOPs developed and maintained, risks in place and reported accordingly. AE report received and attends where necessary.	Fully compliant	n/a	Director of Estates & Facilities	n/a	
DD2	Oxygen Supply	Medical gasses - planning	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•☐The organisation has reviewed and updated the plans and are they available for view •☐The organisation has assessed its maximum anticipated flow rate using the national toolkit •☐The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •☐The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •☐The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •☐Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •☐The organisation has breaching points available to support access for additional equipment as required •☐The organisation has a developed plan for ward level education and training on good housekeeping practices •☐The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	All BCPs in clinical areas include actions re oxygen supply, and all are published on intranet. Infrastructure upgrades evidenced within plans. Cylinder delivery locations agreed with BOC. SOPs in place. Breaching points for additional equipment in place though limited at older site.	Partially compliant	Review national toolkit and ensure review. Confirm ward level training is evidenced. Review training requirements at next MGPS committee meeting.	Medical Gas Committee	6-9 months	
DD3	Oxygen Supply	Medical gasses - planning	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•☐The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •☐The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •☐The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •☐Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	Evidenced by BOC agreement, PPMs, AE audits and SOPs in place	Fully compliant	n/a	Director of Estates & Facilities	n/a	
DD4	Oxygen Supply	Medical gasses -workforce	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•☐Job descriptions/person specifications are available to cover each identified role •☐Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •☐Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •☐Medical gas training forms part of the induction package for all staff.	Y	Evidenced within policies. Rotation in place with outsourced service providersevidenced by QC results and permit books. Not included in induction for all staff.	Partially compliant	Review training requirements at next MGPS committee meeting.	Medical Gas Committee	6 months	
DD5	Oxygen Supply	Oxygen systems - escalation	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•☐SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •☐Staff are informed and aware of the requirements for increasing de-icing of vaporisers •☐SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	Evidenced by SOPs in place and PPM	Fully compliant	n/a	Director of Estates & Facilities	n/a	
DD6	Oxygen Supply	Oxygen systems	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•☐Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	Evidenced on AE report	Fully compliant	n/a	Director of Estates & Facilities	n/a	
DD7	Oxygen Supply	Oxygen systems	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•☐Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •☐Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	Available and reviewed under the AE audit. No full risk assessment in place in line with HTM at the HH site as it was built prior to the HTM.	Partially compliant	AE report actions to be funded and completed	Medical Gas Committee	2-3 yrs	Extensive non-compliance at HH to be rectified