NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE YAS Public Board Meeting		**MEETING DATE** 28/11/2017	
TITLE of PAPER	Emergency Preparedness Response and Recovery(EPRR), Statement of Compliance 2017 -18	**PAPER REF**	6.2
STRATEGIC OBJECTIVE(S)	Provide a safe and caring service which demonstrates an efficient use of resources Work with partners to provide system leadership and resilience		
PURPOSE OF THE PAPER	The Board to approve the Emergency Preparedness, Response and Recovery (EPRR) Statement of Compliance as set out in the NHS England EPRR Assurance Core Standards Matrix 2017-18 underpinned by the NHS England planning framework and the NHS standard contract.		
For Approval	☒	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Jim Richardson, Head of Resilienct / Alan Baranowski, Divisional Commander	**ACCOUNTABLE DIRECTOR**	Julian Mark, Executive Medical Director

DISCUSSED AT / INFORMED BY
Head of EPRR, Head of Special Operations and CBRN specialists have reviewed the EPRR self-assessment template for compliance and developed an action for each improvement area. The report has been reviewed by the Accountable Emergency Officer and the action plan will be scrutinised by the three Local Health Resilience Partnership Boards at their next meeting.

PREVIOUSLY AGREED AT:	**Committee/Group:** Trust Executive Group	**Date:** 13/11/2017
RECOMMENDATION(S)	Approval of the EPRR Statement of Compliance, note the action plan and delivery timescales	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☐	☒
Resource Implications (Financial, Workforce, other - specify) *If 'Yes' – expand in Section 2. / attached paper*	☐	☒
Legal implications/Regulatory requirements If 'Yes' – expand in Section 2. / attached paper	☐	☒
Diversity and Inclusion Implications If 'Yes' – please attach to the back of this paper	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Choose a DOMAIN(s)	4: Responsive 5: Well led
NHSI Single Oversight Framework Choose a THEME(s)	2. Quality of Care (safe, effective, caring, responsive) 6. Leadership & Improvement Capability (Well-Led)

1. PURPOSE

1.1 The Board to approve the Emergency Preparedness, Response and Recovery (EPRR) Statement of Compliance as set out in the NHS England EPRR Core Standards Assurance Matrix 2017-18, the NHS England EPPR framework 2015.

The report also seeks to:-

- Inform the Board of the progress against the YAS Action Plan for 2016/17 and inform of any additional actions required following the assurance process conducted against the NHS England EPRR Core Standards Assurance Matrix 2017-18 (see appendix 3).

2. BACKGROUND

2.1 The NHS needs to plan for, respond to and recover from, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

2.2 All providers of NHS funded care are required to work towards towards meeting the requirements for EPRR as set out in the NHS England Core Standards Assurance Matrix, the NHS England planning EPRR framework 2015 and NHS standard contract.

2.3 NHS Trusts which are designated as Category 1 Responders under the Civil Contingencies Act (2004) are required to undertake a self-assessment against the core standards during August and September 2017.

2.4 The Accountable Emergency Officer (AEO) is required to take a Statement of Compliance (see appendix 1) and any necessary improvement plan (see appendix 2) to their Trust Board before submission to the NHS England EPRR Team.

2.5 Statements of Compliance and improvement plans will form part of the assurance to the NHS England Board and the Department of Health that robust and resilient EPRR arrangements are established and are maintained within NHS Organisations.

2.6 Within the Yorkshire Region all three NHS England Local Health and Resilience Partnerships (LHRPs) areas are undertaking the assurance process with their respective NHS Category One providers. YAS will provide a single self-assessment and action but three separate ‘Statements of Compliance’. This will in turn go towards providing a

regional statement of compliance to be submitted to the North of England EPRR Team.

2.7 The Head of EPRR, Head of Special Operations and CBRN specialist within YAS have carried out a self-assessment against the matrix (see appendix 3) and an action plan (see appendix 1) has been developed and will be submitted along with the Statements of Compliance once approved.

2.8 In addition the resilience department achieved ISO22301 further in 2013/4, it was revaluated by the ISO assessors and maintained ISO 22301 status initially for 2015/6 and subsequently again for 2016/17 and for 2017/18 going forward. Other YAS departments EOC, ICT, PTS have also maintained ISO22301 accreditation in 2016/17.

YAS Corporate Communications and YAS Procurement achieved ISO22301 accreditation this year, with HART, Air Ambulance and Fleet became accredited in Q3 2016. Both of these departments have maintained their accreditation in 2017 thus further endorsing our top management approach and commitment to resilient services.

The Self-Assessment Matrix differs from the previous in relation to EPRR requirements as this year there is a separation of CBRN requirements and a specific MFTFA capability element as well as a deep dive look in to resilience governance.

2.9 The actions plan shows on-going actions and their progress from the previous submission 2016/17 and any new actions required as a consequence of this year's 2017/18 self-assessment process (see appendix 2).

The Emergency Accountable Officer on behalf of the YAS Board will submit a formal statement of compliance for the Trust (shown below, see appendix 1)

3. NEXT STEPS

3.1 The Accountable Emergency Officer or their deputy along with the will attend the Local Heath Resilience Partnership meetings where the action plans will be reviewed and consider/action any feedback.

3.2 Initially the Accountable Emergency Officer will ensure the actions within the action plan are being progressed. Once in place, the Deputy Director of Operations and General Manager of Central Services will continue to ensure the actions within the action plan are being completed.

3.3 Once the statement of compliance is agreed it will need to be formalised with NHS England by returning a copy signed by the YAS Accountable Emergency. This has been provisionally submitted as substantial to meet NHS England's October returns deadline however

NHS England agreed to accepted conformation after the November board meeting as in previous years.

4. RISK ASSESSMENT

4.1 No changes are required to the Corporate Risk Register or Board Assurance Framework.

4.2 The Trust Board monitor via the Accountable Emergency Officer and appropriate governance processes the key responsibilities of YAS in relation to our statutory duty as a Category One responder.

5. RECOMMENDATIONS

1. Approve the Statement of Compliance (x 3 South and West Yorkshire, North Yorkshire and the Humber) at **Substantial**.

2. Note the Action Plan for 2017/8 and seek clarity as appropriate.

6. APPENDICES

Appendix 1	Example of Statement of Compliance Template 2017/8 (at intended level).
Appendix 2	EPRR Action Plan 2017/8 - revised post NHS England/NARU review and to be re-submitted once approved. NHS England Y&H are aware.
Appendix 3	England EPRR Core Standards Assurance Matrix 2017-18 (separate paper/excel document)

Appendix 1 Example

Yorkshire and the Humber Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Yorkshire Ambulance Service has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Choose an item. Compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	**Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.**
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	Ex Historian March 2017
A desktop exercise (required at least annually)	Ex Jasmine June 2017

A communications exercise (required at least every six months)	MERIT Comms Test July 2017

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incidents at North Lincolnshire and Goole NHS FT and Leeds Teaching Hospitals NHS Trust. A plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

01/11/2017 DR Julian Mark

Date of board / governing body meeting

Appendix 2

Yorkshire Ambulance Service

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
HAZMAT/ CBRN Core Standard 49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	Need to check regarding any ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus	Discuss with YAS IPC/Safety Lead Re-evaluate refresher training in relation to FFP3 both as part of standard staff training and also for SORT Staff	YAS Head of Safety has an ongoing FFP3 fit testing programme currently 50% compliance with identified staff within their team dedicated to delivering the testing as part of business as usual.
CBRN Equipment Check E22	FFP3 masks	Personal Issue to all frontline staff & carried on vehicles Need to check regarding any ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus	As AboveNational requirements of having 63 staff tra	As above
MTFA Core Standard 3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	Organisations 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.	To ensure that YAS adhere to the ined and operationally available. Increase number of AIT's from 63 to 70. Request to ensure we have 10 AIT's on duty 24/7. To develop a robust activation procedure over and above HART for the activation of both on/off duty AIT's.	Trevor B current increased numbers to 80 AIT, recruitment process and training commenced. Trevor B reviewed and revising model in terms of changes to kit and

				response model comprising of x2 MTFA vehicles with centralised kit that is generic in sizes as opposed to individual personal issue.
MTFA Core Standard 9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Almost all Commanders from different directorates have now undertaken a tactical commander course. The on scene commanders are all NILO/Tactical Advisers. They are required to undertake a live exercise to maintain their competency. In the absence of the NILO the duty HART C/S will carry out the role of the OSC until released by the NILO. Both the NILO's /HART C/S's have not attended any specific training related to OSC.	Develop a training package specific to the role of the OSC. Ensure all commanders are up to date with refresher training	Training programme in place with upwards of six training sessions a year (multi-agency). Part of Tactical commander cpd. All YAS Tactical Commanders going through the NARU Tactical Commander course that includes MTFA.
MTFA Core Standard 19	Organisations ensure that staff view the appropriate DVDs	The stay safe DVD is accessible to all staff via the intranet and has been for some time. Each awareness session that control room and Operational staff attend, are shown the film. The specialist responder film is shown to all new AITs on each initial course. Each re-qualification course also shows the film. The strategic commander DVD rollout is ongoing at the time of this submission.	Continue with roll our programme Senior Managers meeting to incorporate the DVD.	Golds all seen at senior meeting HART/AIT/Commanders part of course Dissemination to staff as part of the Special Ops section on the staff awareness courses and YAS and NARU Commander as well as on YAS ResWeb

HART Core Standard 13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.	Commanders not refreshed are identified.	Awaiting further courses to complete	As above

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
MTFA Core 3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations 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. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA	YAS is currently increasing numbers to 90 AIT trained, recruitment process and training commenced and is anticipated to be completed end of Q4 2017/18. However the availability cannot be guaranteed without a full roster change that may result in current staff resigned due to impact on their work, home life balance. Consideration needs to be given to a supernumerary standalone team similar to HART that would ensure this capability; however this would need significant national input and commissioning.	End Q4 for uplift completion

		staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.		
HART Core 5	The HART establishment is sufficient to yield the core staffing requirement.	Provide a current establishment list (of names and role - Operative or Team Leader) for all HART units within the Trust. The list should include any Operatives or Team Leaders that are currently on alternate duties or seconded away from HART.	The HART establishment has been increased in YAS from 42 to 46 following a successful business case to Commissioners. This business case was predicated on the need to maintain a minimum of six HART on duty at all times for a safe system of work. At the time of the review, the HART unit had 35 operational staff. Five staff are listed as being out on secondment leaving 11 gaps in the establishment. However, five new recruits are in training. A number of shifts were not covered by six staff despite the commissioned uplift in establishment numbers. One month was selected from the monitoring period and subject to a more detailed analysis. GRS and Proclus data was compared to the interim evidence. There was a two shift anomaly between the Proclus and GRS evidence but both indicated an average finding of 87% compliance compared with the interim evidence declaration for same month of 97.8%. There have, evidentially, been periods of full compliance with the enhanced numbers but recently (over the last 6 months) there has not been effective and robust management of the establishment to	End of Q4

			maintain the contract standard.	
CBRN 56	The CBRN establishment is sufficient to yield the core staffing requirement.	Provide a current establishment list (of names) for all CBRN/SORT trained (uplift) staff (i.e. staff that can deploy and run the wet decontamination facility).	There are currently 145 SORT Operatives trained. The trust is working towards a target of 150. These numbers are considerably higher to yield 10 than the aspirational MTFA establishment (which needs to yield the same number). YAS provided evidence which monitored the staffing level by hour. As a result, over the monitoring period there is only 12% compliance (i.e. shifts that had 10 available throughout the full duration of the shift). However, for a large number of these shifts, the Trust was compliant for a large proportion of the day. Based on shift analysis in the Proclus system, 4 shifts in the 3 month monitoring period had less than 10. So, for most of the time (98%) the required staffing levels are being maintained based on shift analysis. YAS is continuing to look at options to revise A&E rosters to ensure 10 per shift 24x7.	End of Q4
CBRN 66 Recent NHS England Key Lines of Enquiry (KLoE) audit stated CBRN 51	All frontline operational staff is able to initiate the Initial Operational Response (IOR) to a CBRN event.	A position statement on the percentage of frontline operational staff that are currently trained in IOR.	86% of the required staff groups are currently IOR trained. The minimum contractual requirement is 95%. However is seeking clarity from the recent audit, given that YAS has already distributed the IOR DVD to all frontline staff the 86% related to those who have completed the on-line e-learning package. YAS will identify those who are outstanding and will contact their Clinical supervisors to arrange completion however we feel we meet the criteria stipulated within the assurance matrix which doesn't reference contractual standards.	End of Q4

Recent NHS England Key Lines of Enquiry (KLoE) audit	KLoE Domain 5; Finance Covering areas across the NHS England EPRR Assurance Matrix 2017-18	HART income is below the national reference costs. This appears to have been the case for several years and appears to have gone unchallenged. This has created a £43,463 cost pressure year on year. The HART budget for 2016/17 was considerably overspent with significant contributions being made to corporate overheads. No appropriate impact assessment on the safety critical service lines was conducted prior to this contribution being made. There are some accounting irregularities in relation to documenting training expenditure for HART. However, the HART service lines are being maintained and, where equipment or training is requested, it has not been refused. Nevertheless, there are some internal financial management issues. For example; the HART Training Manager is unaware of what the training budget is and the Unit Managers did not know what an appropriate amount should be. Several examples were provided of safety critical training being sourced for free in the absence of an appropriate programmed training budget.	Initial challenge to the report producer's reference findings against how we report our financial evidence. Review of how HART and Special Operations financial reporting to align it to the contractual standards as highlighted in the KLoE report. Clear separation of HART training costs within the budget. This section of the budget is to be managed by the HART Training Manager, overseen by the Head of HART and Special Operations. Internal investigation in to HART reference costs against specialist commissioned funds to confirm if there is the highlighted shortfall and learn how this has occurred. Enquiries to then be made with Specialist Commissioners reference the shortfall between HART reference costs and specialist commissioned funds to close the shortfall.	End 2017

Appendix 3 **England EPRR Core Standards Assurance Matrix 2017-18**

As a separate excel document