NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE YAS Trust Board in Public		MEETING DATE 29/11/2018	
TITLE of PAPER	Annual NHS England Emergency Preparedness Resilience and Response (EPRR) Assurance Self-assessment process.	**PAPER REF**	4.2
STRATEGIC OBJECTIVE(S)	Work with partners to provide system leadership and resilience		
PURPOSE OF THE PAPER	To provide feedback on the current position in relation to the Annual NHS England EPRR Assurance Self-assessment process. To give an insight to the changes within the self-assessment process and to prepare the Board for the formal review and declaration of EPRR assurance required to be submitted to NHS England and Commissioners.		

For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Jeevan Gill - Regional General Manager Simone Mulcahy - Resilience Manager	**ACCOUNTABLE DIRECTOR**	Dr Julian Mark, Executive Medical Director/ Mr Nick Smith, Executive Director of Operations

DISCUSSED AT / INFORMED BY – include date(s) as appropriate (*free text – i.e. please provide an audit trail of the development(s)/proposal(s) subject of this paper*):

PREVIOUSLY AGREED AT:	**Committee/Group:** Private Trust Board Trust Executive Group	**Date:** 27/09/2018 12/11/2018
RECOMMENDATION(S)	The Board are asked to review the report and its content approving the EPRR self-assessment rating prior to submission to NHS England.	

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)**	1: Safe 2: Effective
NHSI Single Oversight Framework **Choose a THEME(s)**	2. Quality of Care (safe, effective, caring, responsive)

1.0 OVERVIEW

1.1 The Board will be required to approve the Emergency Preparedness, Response and Recovery (EPRR) Statement of Compliance as set out in the NHS England Core Standards and the Annual NHS EPRR self-assessment process.

1.2 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.

1.3 All providers of NHS funded care are required to work towards meeting the requirements for EPRR as set out in the NHS England Core Standards for EPRR and NHS standard contract (Service Condition 30).

1.4 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 before 31st October 2018.

1.5 The Accountable Emergency Officer (AEO) is required to make a Statement of Compliance on behalf of the Trust board underpinned by the completed self-assessment documentation to the Trust Board before submission to the NHS England and Commissioners.

1.6 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.

1.7 Within the Yorkshire and the Humber Region the NHS England EPRR teams are undertaking the assurance process with their respective NHS Category 1 providers. YAS will provide the self-assessment and a ‘Statement of Compliance.’

1.8 The Regional General Manager, Head of EPRR and Special Operations Manager within YAS have carried out a thorough self-assessment against the matrix and where required have developed an action plan which will be submitted along with the Statement of Compliance.

1.9 This year the annual deep dive section, where specific focus is given to an area of the EPRR function is around Command and Control in advance of the updated guidance for NHS Ambulance Service Commanders.

2.0 PROCESS

2.1 The Regional General Manager and Head of EPRR have taken part in internal reviews of the self-assessment documentation and have scrutinised the evidence requirements for each element. Where there is adequate evidence of compliance within the Trust’s resilience it has been recorded as a fully compliant.

2.2 Where it is identified that there are changes required to meet the compliance in an individual element and / or new elements of resilience are required that will

fall outside of the assurance return but will be completed within the next 12 months; these have been recorded as partially compliant and an action planned developed.

2.3 Where there are individual elements where we consider the Trust will not be compliant within 12 months despite having an action plan in place, and / or where we are wholly dependent on external support such as additional commissioning; the Trust will have to assess itself as non-compliant. The action plan will incorporate all partial and non-compliant elements.

3.0 EVIDENCE

3.1 To demonstrate compliance the Trust must be able to provide the information and data as requested within the self-assessment matrix document that withstands its own internal scrutiny and that of NHS England and Commissioners.

3.2 Once the Trust has undergone the confirm and challenge process NHS England will either uphold our self-assessment of assurance or require the Trust to change if having identified any evidenced of reduced compliance. Should this be apparent the Trust will either need to challenge the decision, and / or revise the action plan and published level of compliance.

4.0 YAS COMPLIANCE

4.1 YAS are substantially compliant in the EPRR Core Standards and fully compliant in the Deep Dive – Business Continuity. YAS are deemed non-compliant for Interoperable Capabilities. An action plan has been developed for all partial and non-compliant elements.

4.2 Each year a ‘deep dive’ is conducted to gain additional assurance into a specific area of EPRR. This year the focus is on Business Continuity and Command and Control.

EPRR Assurance Area	Assurance Rating
EPRR Core Standards	The Trust is 96% (47 fully compliant out of 49 standards) compliant with the 49 core standards.
Deep Dive – Business Continuity	The Trust is 100% complaint with all 8 deep dive areas for business continuity.
Command and Control / Specialist Capabilities	The Trust is 77% (125 fully compliant out of 163 standards) which is deemed non-compliant with the Command and Control / Specialist Capabilities. For each partially compliant area the Trust has developed an action plan to address. The Trust has identified 3 areas deemed as non-complaint. Each of these areas has an action plan in place to address.

5.0 NEXT STEPS

5.1 The AEO will review the self-assessment matrix and produce a statement of compliance, prior to submission to NHS England.

5.2 The AEO and Regional General Manager will ensure the actions within the action plan are completed and demonstrate this as part of the Trust's governance and monitoring structures.

5.3 Upon Trust approval the self-assessment matrix and statement of compliance submission to the Regional EPRR NHS England team will be made by 31st October 2018.

6.0 RECOMMENDATIONS

6.1 The Board are asked to review the report and its content approving the EPRR self-assessment rating prior to submission to NHS England.

Appendix 1 – EPRR Core Standards Compliance Matrix

Compliance level	Definition
Not compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

EPRR Core Standards

Number	Core Standard	Evidence of Assurance	Self-assessment RAG 2017 / 18	Self-assessment RAG 2018 / 19
	Governance			
1.	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.	Dr Julian Mark (Executive Medical Director)		
2.	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	The Trust has an EPRR Framework in place.		

	• 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 making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.			
3.	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 • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	The EPRR team produce bi-annual; board reports of the current status of EPRR within the Trust and the wider region measured against the EPRR Assurance Framework.		
4.	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	YAS through the Resilience Governance Group holds an annual work programme, this incorporates the EPRR action plan along with any risks and issues (local, community, LHRP, LRF), lessons learned from incidents and exercises as well as best practice guidance. During any internal business continuity incidents following a debrief YAS records lessons identified and develops an action plan for the department and monitors the implementation through the Resilience Governance Group. YAS also engages with partners are part of the LRF programmes around lessons		

		learned. YAS works with JESIP partners as part of the Joint Organisational Learning requirements placed upon us. YAS also works with other Ambulance Trusts as part of the ACCE subgroup - Emergency Preparedness and Resilience Group (EPRG) that endorses the use of Proclus Lid to capture learning at a national level. YAS EPRR team hold ISO 23301 BCMS award and have done for 2 years, 4 other key departments also attained his award this year. YAS also operates a successful BCM team that operate both within YAS and externally with other health providers. YAS has auditable documentation across the EPRR program that has been audited as part of ISO attainment, independent audit as well as internal audit and CQC assessment. YAS holds accessible plans to meet both the local and national risk profiles.		
5.	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.	YAS has a specific budget to underpin the delivery of EPRR across the region as well as its national obligations. The Trust is taking steps to embed a programme of commander training by August 2019.	n/a as did not form part of the 2017/18 assurance process	
6.	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	YAS use their internal system (Datix) to capture lessons alongside the use of Proclus Lid and Joint Organisational Learning (JOL). Within LRFs there is a lesson sharing MoU that YAS has signed up to.	n/a as did not form part of the 2017/18 assurance process	

Duty to Risk Assess				
7.	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.	YAS hold a risk register incorporating any EPRR risks. The risks include local, regional (LHRP, LFT) and national. These are reviewed regularly and updated.		
8.	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	All risks are held with the Resilience Governance Group, high impact risks are held on the corporate risk register. All risks are reviewed regularly and where possible mitigation actions are put in place to either eliminate risk or minimise impact.		
Duty to Maintain Plans				
9.	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Where an external party is included in the planning assumptions those parties are consulted and included in the development of the plans and guidance, e.g. Railtrack, NHS England, other Emergency Services, Prisons Service. The Trust's EPRR framework and Major Incident plan has been shared and developed in consultation with partners to ensure comprehensive and seamless plan.		
11.	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	YAS has site and type specific guidance and a Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		
12.	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	YAS has site and type specific guidance and a Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling		

		two year cycle, with the caveat of changing earlier if there is a significant change required.		
13.	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	YAS has site and type specific guidance and a Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		
14.	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.	YAS has site and type specific guidance and Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		
15.	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	YAS has site and type specific guidance and Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		
16.	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	YAS has site and type specific guidance and Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		
17.	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination.	YAS has site and type specific guidance and Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		

18.	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 increase capacity by 10% in 6 hours and 20% in 12 hours.	YAS has site and type specific guidance and Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		
20.	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 perform a whole site shelter and / or evacuation.	As part of a multi-agency LHRP / LRF plan		
21.	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	YAS sites are smart card access, with limited authorised access to key areas.		
22.	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	YAS has site and type specific guidance and Major Incident Procedure guidance (Plan) in place. These are updated as part of a rolling two year cycle, with the caveat of changing earlier if there is a significant change required.		
23.	Organisation has contributed to and understands its role in the multi-agency planning arrangements for excess deaths, including mortuary arrangements.	As part of a multi-agency LHRP / LRF plan		
	Command and Control			
24.	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	YAS operate a comprehensive and robust on call structure which manages all elements of its core business 24/7.		
25.	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR	On call commanders are trained to the appropriate level and maintain their skills by attending exercises as well as during normal business. There are some commanders that are outstanding their relevant NARU		

	competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	courses due to place availability. These are all booked on future courses. New competencies and skillsets are required as part of the revised Trust Commander Framework, implementation of this framework is ongoing.		
Training and Exercising				
26.	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	YAS undertook a Training Needs Analysis June 2018; this has feed into the new commander framework. All training records are updated on to OLM to maintain staff competency.		
27.	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	YAS Training and Exercise schedule sits with the Resilience Governance Group. Each department is required to test their Business Continuity Plans annually. Live and table top exercises are done in partnership with the LHRP and LRF.		
28.	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation.	To be addressed as part of implementing the new Commander Framework.		

29.	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems have been tested annually.	Systems tested regularly in line with the Business Continuity Plan for EOC. Fall back site also tested regularly.		
Response				
30.	The organisation has a pre-identified Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Pre-identified fall back location identified and tested. Identified in EOC / 111 / PTS Business Continuity Plans: loss of premises / ICT.	n/a as did not form part of the 2017/18 assurance process	
31.	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Hard copies of all plans, guidance documents stored in EOC / 111 / PTS which is accessible 24/7 to authorised staff.	n/a as did not form part of the 2017/18 assurance process	
32.	The organisations incident response arrangements encompass the management of business continuity incidents.	Business Continuity Plans in place and tested for each department regularly. All critical departments are now certified to ISO22301.		
33.	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	YAS have a 24/7 on call rota for Loggists. There are 3 on call at any one time. All on call Loggists are trained to PHE Decision Logging and maintain their CPD by attending exercises and pre-planned events as well as incident response.	n/a as did not form part of the 2017/18 assurance process	
34.	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.	YAS carries out these duties as part of its Gold Cell Command procedures and in tandem with the YAS Major Incident corporate Communications plan. YAS also supports this process through the Tactical Coordination Group (TCG) and Strategic Coordination Group (SCG) processes.		

Warning and Informing				
37.	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	YAS carries out these duties as part of its Gold Cell Command procedures and in tandem with the YAS Major Incident corporate Communications plan. YAS also supports this process through the TCG and SCG processes. YAS also has a Critical Incident Activation Guidance document which ensures stakeholders/partners are engaged.		
38.	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	YAS carries out these duties as part of its Gold Cell Command procedures and in tandem with the YAS Major Incident corporate Communications plan. YAS also supports this process through the TCG and SCG processes.		
39.	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Media strategy in place and managed by Corporate Communications. YAS work with multi-agency partners during incidents to develop and deliver partner media statements.	n/a as did not form part of the 2017/18 assurance process	
Cooperation				
40.	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	LHRP meetings attended by appropriate senior management with delegated authority.		
41.	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	LRF meetings attended by appropriate senior management.		
42.	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Mutual aid guidance document in place as well as supporting the National Mutual Aid Plan.		

43.	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 in major incident procedure and critical incident activation guidance. During a multiple LRF incident Strategic Command would be based at YAS HQ. Strategic Liaison Officer would be the YAS representative at SCGs.		
46.	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Information sharing adhered to across all 4 LRFs and via the control rooms. The critical incident activation guidance is aligned to information sharing with partners.		
Business Continuity				
47.	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	YAS has a Business Continuity Policy document, last revised June 2018	n/a as did not form part of the 2017/18 assurance process	
48.	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	The YAS Business Continuity Policy (June 2018) and BC Guidance document (August 2017) detail the Trusts Business Continuity aims and objectives, scope, process, resource requirements and expectations, risk management process, communication and implementation, monitoring and compliance of the Policy. Part of the ISO22301 certification requirements is that all Business Continuity risks are categorised and assessed in line with the organisations risk appetite/matrix. This is fully embedded in the Business Continuity system.	n/a as did not form part of the 2017/18 assurance process	
49.	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s) (BIA)	The Business Continuity Guidance document (August 2017) details the BIA process for the Trust.	n/a as did not form part of the 2017/18 assurance process	

50.	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	The Information Governance (IG) Toolkit is completed annually by the Trusts IG Manager.	n/a as did not form part of the 2017/18 assurance process	
51.	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 These plans will be updated regularly (at a minimum annually), or following organisational change.	All departments have a Business Continuity Plan which is reviewed and tested annually.	n/a as did not form part of the 2017/18 assurance process	
52.	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A Business Continuity dashboard is maintained showing the status of each department's BCMS. This is reported to the Resilience Governance Group who meets monthly to review the Trust BCMS, exercises, BC incidents. Each year the BC team carry out a Top management review with the Trust Exec on the BCMS, this also includes a strategic level exercise	n/a as did not form part of the 2017/18 assurance process	
53.	The organisation has a process for internal audit, and outcomes are included in the report to the board.	The Business Continuity Team has a five year audit plan in line with ISO22301 certification requirements.	n/a as did not form part of the 2017/18 assurance process	
54.	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	A corrective action log is maintained which details findings from all audits (internal and BSI led). In addition all Business Continuity incidents are recorded on the Trusts Datix system with actions logged and monitored to	n/a as did not form part of the 2017/18 assurance process	

		ensure lessons identified are actioned. Current outstanding taken from a rolling excel spreadsheet, available on request.		
55.	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	The Trust has in place a system to evaluate and score Suppliers Business Continuity Plans, against pre-determined criteria. All prospective suppliers are required to provide details of their BCMS; these are reviewed by the YAS BC team and scored accordingly.	n/a as did not form part of the 2017/18 assurance process	

Appendix 2: Action Plan – incorporating EPRR Core Standards and Command and Control / Specialist Capabilities

EPRR Core Standards Reference	Core standard description	Action to deliver improvement	Lead	Deadline for completion
25.	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	In line with the new YAS Commander Framework requirement that all commanders must be qualified at their appropriate level. To ensure all commanders achieve the competencies outlined within the framework.	Head of EPRR	August 2019
28.	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation.	To ensure all strategic and tactical commanders maintain their personal portfolio to the standards of the YAS Commander Framework	Head of EPRR	August 2019
Command and Control / Specialist Capabilities Reference	**Core standard description**	**Action to deliver improvement**	**Lead**	**Deadline for completion**
H8.	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	To ensure minimum of six operational HART staff are on duty at all times. A review of the current team configuration is underway.	Head of Special Operations	August 2019
H12.	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	A schedule of awareness to be provided to all commanders at Operational and Tactical level.	Head of EPRR	August 2019

H18.	Organisations must maintain a set of local HART risk assessments which complement 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.	Risk assessments to be updated. A review of local high risk sites to be defined and undertaken. Completion expected by end of September 2018. Re-affirmation with the Team leaders use of the Dictaphone and storage as per procedure.	Head of Special Operations	August 2019
H28	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Following the national review of capabilities, some equipment has changed and been revised. Work is ongoing to align the equipment with the new national capabilities matrices.	Head of Special Operations	August 2019
M1	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	YAS has a training schedule to increase the AIT staff numbers to 120 to ensure full compliance.	Head of Special Operations	August 2019
M5.	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.	YAS has a training schedule to increase the AIT staff numbers to 120 to ensure full compliance.	Head of Special Operations	August 2019
M8.	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.	Training records are updated following each AIT course. Compliance monitored at Resilience Governance Group.	Head of Special Operations	August 2019
M9.	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	In line with the new YAS Commander Framework requirement that all commanders must be competent in managing MTFA resources at a live incident. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019

M11.	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	In line with the new YAS Commander Framework ensure that all staff groups must receive training in the nationally recognised MTFA familiarisation training. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
M18.	Organisations must maintain a set of local MTFA risk assessments which complement 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.	MTFA risks have been identified and will be reviewed and updated.	Head of Special Operations	August 2019
M23.	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	YAS is increasing the AIT staff numbers to 120 to ensure full compliance.	Head of Special Operations	August 2019
M27.	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Arrangements are being finalised to agree a revenue depreciation scheme within the Trust.	Head of Special Operations	August 2019
B5.	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	In line with the new YAS Commander Framework requirement that all commanders must be competent in managing CBRN resources at a live incident. Compliance monitored at Resilience Governance Group.	Head of Special Operations	August 2019
B12.	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.	A review of the current use of FFP3 masks is underway, led by the YAS lead for IPC. Following the review recommendation actions will be managed through the Resilience Governance Group.	Claire Ashby	August 2019
B13.	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	YAS will carry out a refresh of IOR principles via Operational bulletins and e-learning.	Head of EPRR	August 2019

B31.	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.	Replacement plan in place. Funding arrangements to be finalised to agree a revenue depreciation scheme within the Trust.	Head of Special Operations	August 2019
V6.	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*.	Mass Casualty plan document to be updated in line with the national guidance.	Head of EPRR	August 2019
C1.	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	YAS Command and control arrangements are detailed in the Major Incident Procedure. The agreed YAS Commander Framework will ensure the organisation is fully compliant.	Head of EPRR	August 2019
C7.	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. No 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). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	YAS Command and control arrangements are detailed in the Major Incident Procedure. The agreed YAS Commander Framework will ensure the organisation is fully compliant.	Head of EPRR	August 2019
C18.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C19.	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	All YAS Strategic Commanders have attended / booked to attend the MAGIC course. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019

C20.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C21.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C22.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C23.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C24.	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C25.	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	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019

	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.			
C26.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C27.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
C33.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group..	Head of EPRR	August 2019
C36.	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.	Awaiting new NARU action cards to be produced so these can be issued to front line responders. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019

J8.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
J11.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
J13.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
J15.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
J16.	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
J17.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019
J22.	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.	The agreed YAS Commander Framework will ensure the organisation is fully compliant. Compliance monitored at Resilience Governance Group.	Head of EPRR	August 2019

Appendix 3

Yorkshire and the Humber Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019

STATEMENT OF COMPLIANCE

Yorkshire Ambulance Service NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Yorkshire Ambulance Service NHS Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

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.

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Signed by the organisation's Accountable Emergency Officer

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Date signed

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Date of Board/governing body meeting

Date presented at Public Board

Date published in organisations Annual Report