Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG Emergency Preparedness, Resilience and Response (EPRR) Assurance 2021-2022

C

Governing Body meeting

2 September 2021

Author(s)	Sue Berry, EPRR Lead
Sponsor Director	Brian Hughes, Director of Commissioning and Performance

Purpose of Paper

To note the attached EPRR Self-assessment with the national Amended EPRR Core Standards 2021-2022.

Key Issues

This year NHSE/I are collecting assurance on a reduced number of EPRR core standards. This does not replace our statutory responsibility to be compliant with the full set of standards applicable to our organisation, but in recognising the demands over the last 18 months, NHSE/I not be seeking to obtain assurance on your compliance against a number of those standards previously issued.

The proposed level of compliance for 2021/22 is 'Fully Compliant'.

Is your report for Approval / Consideration / Noting

Noting and Approval

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

- Note the self-assessment, detailed on the attached spreadsheet
- Approve the proposed statement of compliance - attached

What assurance does this report provide to the Governing Body in relation to Governing Body Assurance Framework (GBAF) objectives?

Which of the CCG's Objectives does this paper support?

5. Organisational development to ensure the CCG meets organisational health and capability requirements

Description of Assurances for Governing Body

- Provides assurance that the CCG is compliant with national and statutory requirements.

Principal Risk 5.4

Inadequate adherence to principles of good governance and legal framework leading to

breach of regulations and consequent reputational or financial damage particularly at a period of change.
Are there any Resource Implications (including Financial, Staffing etc)?
None
Have you carried out an Equality Impact Assessment and is it attached?
Please attach if completed. Please explain if not, why not No specific issues associated with this report
Have you involved patients, carers and the public in the preparation of the report?
Not applicable

NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG Emergency Preparedness, Resilience and Response (EPRR) Assurance 2021-22

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1 Introduction / Background

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England and NHS Improvement asks commissioners and providers of NHS funded care to complete an EPRR assurance process. This process incorporates four stages:

i) Organisational self-assessment against NHS Core Standards for EPRR

ii) Local Health Resilience Partnership (LHRP) confirm and challenge

iii) NHS England and NHS Improvement regional EPRR confirm and challenge

iv) NHS England and NHS Improvement national EPRR confirm and challenge

The Civil Contingencies Act 2004, the NHS Act 2006 as amended by the Health and Social Care Act 2012, underpin EPRR within health and both Acts place EPRR duties on NHS England and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions require providers of NHS funded services to comply with NHSE EPRR guidance, The NHS Core Standards for EPRR are the minimum requirements commissioners and providers must meet and must therefore assure themselves against. This year NHSE/I are collecting assurance on a reduced number of EPRR core standards. This does not replace our statutory responsibility to be compliant with the full set of standards applicable to our organisation, but in recognising the demands over the last 18 months, NHSE/I not be seeking to obtain assurance on your compliance against a number of those standards previously issued.

2 Purpose

The purpose of the Amended Core Standards for EPRR 2021-22 are to:

- Enable health agencies across the country to share a common approach to EPRR
- Allow coordination of EPRR activities according to the organisation's size and scope
- Provide a consistent and cohesive framework for EPRR activities
- Inform the organisation's annual EPRR work programme

3 Core Standards for EPRR Domains

The NHS England Core Standards for EPRR are split into 11 domains:

i) Governance

ii) Duty to risk assess

iii) Duty to maintain plans

iv) Command and Control

v) Training and Exercise (not contained within this year's submission)

vi) Response

vii) Warning and informing

viii) Cooperation

ix) Business Continuity

x) CBRN

The applicability of each domain and core standard is dependent on the organisation's function and statutory requirements.

For 2021-22 assurance process Amended Core Standards will not ask for assurance on Training and Exercising but will still expect organisations to be compliant with this standard.

4 Deep dive

The 2021/22 EPRR annual assurance deep dive focusses on 'Oxygen Supply' and is aimed at acute trust and is therefore not applicable to the CCG.

5 Process

In summary the CCG is asked to

- Undertake a self-assessment against the relevant individual NHS EPRR Amended Core Standards; these individual ratings will then inform the overall organisational rating of compliance and preparedness

- Present the above outcomes to Governing Body

- Submit the Governing Body paper to the Local Health Resilience Partnership (LHRP) secretariat (by email england.yorkshire-eprr@nhs.net) by Thursday 29 October 2021

6 Timetable

26th July to 28th October 2021
Organisations to undertake self assessment and take the relevant documentation through their Trust Board.

29th October 2021
Deadline for organisational level submission to Regional EPRR team.

November 2021(date tbc)
Learning & Assurance sessions to take place at Regional level.

31st December 2021
Deadline for submission of full regional assurance

February 2022
National EPRR team to have completed confirm and challenge meetings with Regional teams.

March 2022
National EPRR assurance reported to the NHS England Board

7 Compliance

Following a complete review of the standards the CCG has identified compliance with all of the applicable standards. The CCG is therefore providing a response of **Fully Compliant**.

8 Recommendations

The Governing Body is asked to:

- Note the self-assessment, detailed on the attached spreadsheet
- Approve the proposed statement of compliance - attached

Paper prepared by Sue Berry, EPRR Lead

on behalf of Brian Hughes, Deputy Accountable Officer/Accountable Emergency Officer

August 2021

EPRR CORE STANDARDS

Ref	Domain	Standard	Detail	Clinical Commissioning Group	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		SRO Brian Hughes Deputy Accountable Officer, and appointed Accountable Emergency Officer (AEO). He receives overarching assurance on our EPRR work programme and signs our annual EPRR Statement of Assurance after it has been presented to Governing Body for approval. The AEO is supported in this role by the Corporate Services Risk and Governance Manager and the EPRR lead. The CCG has identified a Lay Member who sits on the Audit and Integrated Governance Committee oversees EPRR as part of their broad governance role. The Lay Member was nominated as the formal Governing Body Lead to support the AEO with effect from November 2017	Fully compliant				
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.	Business Continuity plan and EPRR policy in place and funding agreed across and between Sheffield City Council and Sheffield CCG.EPRR lead appointed and works alongside SRO and other EPRR leads in SYB and Y&H The CCG has several policies in place to support the EPRR Policy statement and its commitment. These policies consist of a Business Continuity Policy and Plan and a Emergency Preparedness, Resilience & Response Policy. The policies are complimented by our Health and Safety, Incident Reporting Policies together with our Risk Management Strategy. The CCG has local agreements in place with partners and providers which is overseen by Sheffield Health Emergency Planning Forum. References to treatment plans, exercises and funding are overseen by this group. The CCG has a wider on-call team covering South Yorkshire and Bassetlaw CCG's as part of the shared Health, Safety and Security Shared Services, that also share similar plans and provide access to training. The Responsible Officer for this Service is qualified in EPRR Management. The service is underpinned by a Memorandum of Understanding and hosted by Rotherham CCG.	Fully compliant				
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	September Governing Body public papers and regular EPRR updates to Governance Sub-committee Recently commissioned an independant debrief of Management of the Pandemic by YAS EPRR lead across the Sheffied partners with clear lessons learnt and areas for improvement identified. Compliance to Governing Body is expected to occur in September The 2021/22 submission is planned for approval by our Governing Body meeting taking place in public September 2021. All Governing Body public meeting papers are available on the CCG's website at http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm A regular assurance report on EPRR is provided to the Governance Sub-committee which is a sub-committee of the Audit and Integrated Governance Committee.	Fully compliant				
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	Policy due to be updated but does outline roles required: Loggist, EPRR lead and Executive Officer The AEO is supported by the Associate Director of Corporate Services and is overseen by an identified Lay Member. The Role of the Governance Sub-committee is to review and monitor compliance with the standards as well as compliance with the civil contingencies Act 2004. Approval of the EPRR is reserved to the Governing Body. Approval of the Business Continuity Policy and Plan is delegated to the Governance Sub-committee.	Fully compliant				

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	Full debrief has been captured from internally within the CCG and also with system partners. Through internal and external system meetings learning is identified and solutions shared. We receive feedback via the LHRP with regard to local incidents so that lessions can be learned eg Mass vaccination due to hospital closure We have developed an action plan following the Wannacry Cyber Attack which was worked up through our IT Service Providers to ensure our IT systems and processes remain robust. We participate in local exercises such as COMAH and ensure that any lessons learned are fed back to the organisation. Our EPRR policy confirms the processes following an EPRR incident in order to ensure lessons are learned. We take repsonsibility for debriefing and providing support to staff where required via individual line managers which is coordinated bia the EAO. De-briefing may also be on a multi-agency footprint.	Fully compliant				
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	CCG has corporate risk registers that it regularly reviews and the EPRR risks are contained within this framework. Furthermore our EPRR risk assessments take account the community risk register as detailed within the LHRP feedback. We participate in local COMAH exercises and wider NHS and local health & social care economy EPRR exercises and embed any identified risks back within our internal processes. Our risk assessment of specific local risks is captured in our Emergency Preparedness, Resilience & Response Policy: Fuel shortage, Flooding, Evacuation & Shelter, Pandemic, Heatwave, Severe Winter Weather, Diverts. The policy is reviewed by the author annually to identify any changes required. Our usual risk management processes allow us to consider if there are any further internal risks that could threaten the performance of the organisation's functions in an emergency - via the Governing Body Assurance Framework and Risk Register.	Fully compliant				
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	CCG has Governance Sub-committee, Health and Safety Group and IPC meetings that all feed into the Senior Management Team for oversight and scrutiny . These are then reflected in the corporate risk register. Our Business Continuity Contingency Plan includes plans and mitigation for the short term (under 72 hours) and the longer term for: - Loss of key staff in the short or long term (Epidemic/pandemic illness, industrial action, Simultaneous resignation of a number of staff (eg lottery syndicate win) , school closures, travel/transport disruption preventing staff getting to base or home). - Loss of operating premises or access to operating premises (contamination of premises or access to premises. Disruption is utility supply to premises, Fire, Flooding, Structural defect/failure. Terrorist or criminal attack, Cordon preventing access to premises) - Loss of Information Technology support structure (Major electronic attacks, Severe disruption to the IT network and systems including loss of data network, major applications, hardware failure, Loss of landline telephones including switchboard, Loss of mobile phone network. - Data loss affecting CCG service/function delivery (electronic data stolen/lost, Destruction of paper files, Failure of back up or failsafe. Temporary loss of data). - Supplier failure, affecting CCG service/function delivery (supplier/provider contract breach, Supplier/provider industrial action, Stock management failure, Supplier does into administration/ Supply chain collapse. Partner CCGs unable to deliver hosted functions)	Fully compliant				
Domain 3 - Duty to maintain plans											
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	Our EPRR Policy supported the CCG to respond to each of these areas. Our poliy covers: -incidents and emergencies (Incident Response Plan) (Major Incident Plan) - Severe weather (heatwave; flooding; snow and cold weather) - Pandemic Influenza - Infectious Diseases Outbreak (also supportd b the Health Protection Agency (HPA) Agreement) - Evacuation Our Business Continuity Policy and Action Plan underpinned by team specific operation plans covers: - Corporate and service level business continuity - Fuel disruption - Utilities - IT and Telecommunications failures Furthermore the CCG has learnt from the last 18months in terms of setting up and running Command and control funtions within the organisation and staffing these appropriately in order to ensure co-ordination and response	Fully compliant				

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	The CCG is designated as a Cat 2 responder and as such our responsibilites are more at a system response and support. However our policy covers: -incidents and emergencies (Incident Response Plan) (Major Incident Plan) - Severe weather (heatwave; flooding; snow and cold weather) - Pandemic Influenza - Infectious Diseases Outbreak (also supportd b the Health Protection Agency (HPA) Agreement) - Evacuation Our Business Continuity Policy and Action Plan underpinned by team specific operation plans covers: - Corporate and service level business continuity - Fuel disruption - Utilities - IT and Telecommunications failures Furthermore the CCG has learnt from the last 18 months in terms of setting up and running Command and control funtions within the organisation and staffing these appropriately in order to ensure co-ordination and response	Fully compliant				
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	Our overarching Business Continuity Policy and Plan and EPRR Policy support the CCG in responding to heatwaves, underpinned by our Inclement Weather Policy . This is low level with duties to CCG staff within the buildings that the CCG rented.	Fully compliant				
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	Our overarching Business Continuity Policy and Plan and EPRR Policy supports the CCG in responding to heatwaves, underpinned by our Inclement Weather Policy . This is low level with duties to CCG staff within the buildings that the CCG rented.	Fully compliant				
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	EPRR Policy The CCG is a partner in a number of specific plans which have been developed across the health community in order to respond to emergencies and escalate actions appropriately. These incluse: NHS England Incident Response Plan Sheffield System Wide Escalation Plan Heatwave Plan Pandemic Flu Plan	Fully compliant				
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.		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	The CCG is a designated Cat 2 responder and as such works with the healthcare providers to assist with issues of mutual aid.	Fully compliant				
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	The CCG's overarching Business Continuity Policy and Plan and EPRR supports our response in this respect Sheffield CCG has in place a Fire Safety Policy which is reviewed every two years. The role of Responsible Person as defined by the Regulatory Reform (Fire Safety) Order 2005 is undertaken by the Assistant Chief Officer as part of the South Yorkshire and Bassetlaw CCGs Health, Safety and Security Shared Service. The Director of Finance is the nominated Officer and is responsible for the implementation of the Fire Safety Policy.	Fully compliant				
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.		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	As above:The CCG's overarching Business Continuity Policy and Plan and EPRR supports our response in this respect Sheffield CCG Fire Safety Policy has in place a Fire Safety Policy which is reviewed every two years. The role of Responsible Person as defined by the Regulatory Reform (Fire Safety) Order 2005 is undertaken by the Assistant Chief Officer as part of the South Yorkshire and Bassetlaw CCGs Health, Safety and Security Shared Service. The Director of Finance is the nominated Officer and is responsible for the implementation of the Fire Safety Policy.	Fully compliant				
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.		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	In the event of VIPs attending the CCG premises clear security measures are enacted. This would be jointly with the landlord of the premises, the police and other related partners. The Governing Body would be notified. and clear procedure would be dictated by the police	Fully compliant				
Domain 4 - Command and control												
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.	The CCG has both an internal on call system and is a partner in the SYB OOH Oncall arrangements. This is enacted through the Rotherham Hospital switchboard who have access to the rota. The procedure is also outlined in the Business Continuity policy and the EPRR policy	Fully compliant				
Domain 5 - Training and exercising												
Domain 6 - Response												

30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		The CCG has identifed key rooms with its HQ for an incident room (s). These are also identified in both the Business Continuity policy and the EPRR policy. This has been used in the early part of the Pandemic, however, with remote working Teams calls have enabled a virtual centre to be introduced with good effect	Fully compliant				
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	The Business Continuity policy has agreed templates for directorates to use to identify key critical staff, capacity and specialised resources. Each team is responsible for its completion. These are overseen by the Governance Sub committee. The Policies are kept on the local CCG intranet for ease of access.	Fully compliant				
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	The CCG has set up an EPRR inbox specifically to receive and send the SITREPs, receive updated guidance and- cascade urgent updates. This one portal ensures that the CCG has a single reservoir of information that can be viewed by nominated EPRR and BC leads in the organisation	Fully compliant				
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.			N/A	Fully compliant				
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.		• Guidance is available to appropriate staff either electronically or hard copies	N/A	Fully compliant				
Domain 7 - Warning and informing											
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	Sheffield CCG set up and runs the Sheffield System Partnership Gold meetings on behalf of all health and social care partners in its city. Throughout the Pandemic the Health and Care Gold cell met 2 weekly and when required to ensure a place based response to incidents, co-ordination of calls for mutual aid and to plan andrespond to surge and pressures in the system. This group is still meeting and can be invoked by any Executive Director from any of the health and social care partners in Sheffied. This group also recently underwent a system debrief to explore lessond learnt and develop new contingencies	Fully compliant				
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	Communication Strategy included in the Business Continuity Policy and Plan. The CCG has a Deputy Director of Communications that would be responsible for communicating to the partners and our providers during a business continuity incident. An Action Card for the Communications Lead is included in our EPRR procedure. The majority of communications will be via providers or via Category 1 responders who will support as required. The initial communication of an LRF/LHRP cross-footprint incident alert is to the first on-call officer of the Yorkshire and Humber Area Team.	Fully compliant				
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	Communication Strategy included in the Business Continuity Policy and Plan. Cascade Tests undertaken to inform all staff. These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They include testing telephone, email, paging and other communications methods in use. The communications exercise is conducted both during the in-hours period and the out-of-hours period on a rotational basis and is unannounced. Accountable Officer and senior team have all received media training.	Fully compliant				
Domain 8 - Cooperation											
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	The CCG has agreed with its ICS partners and local place based health and social care partners mutual aid where possible. There is an agreement between the Sheffield City Council and the CCG regarding the funding of outbreaks and responsibility	Fully compliant				
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	We are represented at the Health Resilience Partnership meeting by Sheffield CCG EPRR lead and NHS Rotherham CCG as part of the hosted Health and Safety and Security Shared Service for South Yorkshire and Bassetlaw CCGs Post-meeting feedback is provided to the CCG AEO and operational EPRR Leads. The Y&H EPRR lead chairs these meetings and s out conduit to LRFs both in and out of region.The request for multi region action and support would be intiaited by the Regional LHRP/Y&H EPRR Regional Lead	Fully compliant				
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	This is led by NHSE Regional Leads, Y&H EPRR Lead and Local Authority/City Council attendance at LRFs. Information is then cascaded down to the Health system by these identified leads	Fully compliant				

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'.	As Category 2 Responders, we have a duty to share information and cooperate. In the event of an incident, we will use our generic email addresses used for EPRR as the main route of communication and the Incident Control Centre number as the main telephone number (if back in office). The Communications Leads will coordinate communications. We share information via the Local Health Resilience Partnership and via local Emergency Planning Meetings. We have local Information Sharing Agreements (ISA) / Policies for "business as normal" across our local strategic partnerships which also support EPRR. We have a mutual aid agreement for premises with our partner CCGs. SY LRF information sharing protocol for Cat 1 &2 Responders - Approved 2018	Fully compliant				
Domain 9 - Business Continuity											
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	The CCG has a specific Business Continuity Policy and Plan that clearly identifies our Business Continuity Management Statement of Intent. Full details of the plan can be found on our website at: http://www.intranet.sheffieldccg.nhs.uk/policies.htm	Fully compliant				
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	The CCG has a specific Business Continuity Policy and Plan that clearly identifies our Business Continuity Management Statement of Intent. BC reports directly to our Governance Sub-committee which in turn then reports directly to our Audit and Integrated Governance Committee and ultimately to Governing Body. The CCG also has a Risk Management Strategy and action plan in place that sets out the process for overseeing risk management within the organisation. The strategy and plan are reviewed by the Governance Sub-committee and approved by the Audit and Integrated Governance Committee annually. This process provides Board to floor oversight and scrutiny of risks, assurances and actions.	Fully compliant				
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	Compliance of our internal IT provision assured through Information Governance Group and Governance Sub-committee.	Fully compliant	*Wording is based on IT provider being Embed - Gershon to advise on revised wording. I think it may just be deleting "received through our IT provider and" and replacing it with "of our internal IT provision" - does that make sense Gershon?*			
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	The CCG has an over arching Business Continuity Policy and Plan overseen by the Deputy Accountable Officer and supported by the Corporate Services Risk and Governance Manager. The BCP supports the overall CCG whilst each directorate has its own localised BCP. Each plan details business critical functions and there minimum tolerable periods of disruption.	Fully compliant				
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	This is through our internal audit programme, our EPRR and BC polices, minutes of BC/GSC/GB	Fully compliant	*This should be replaced with Brian's new Job Title* F			
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	The BCPs are regularly evaluated and updated when required and when the BC policy is reviewed.This is usually conducted through the CCG Business Continuity meeting whereby all BCP leads are responsible for addressing any changes to their individual team plans.	Fully compliant				
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 are required to provide this information as part of the core standard NHS Contract. Assurance is received by contract monitoring group meetings	Fully compliant				
Domain 10: CBRN								This shoud be deleted!			
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	EPRR lead and SRO would gain access to this via the Y&H EPRR lead, Health Protection lead for SYB via Leeds and Yorkshire Ambulance Service	Fully compliant				
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.		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	N/A	Fully compliant			
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.		• Impact assessment of CBRN decontamination on other key facilities	N/A	Fully compliant				

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.		• Rotas of appropriately trained staff availability 24 /7	N/A	Fully compliant				
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/		• Completed equipment inventories; including completion date	N/A	Fully compliant				
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		• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	N/A	Fully compliant				
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		• Completed PPM, including date completed, and by whom	N/A	Fully compliant				
64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.		• Organisational policy	N/A	Fully compliant				
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		• Maintenance of CPD records	N/A	Fully compliant				
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.		• Maintenance of CPD records	N/A	Fully compliant				
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.		• 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	N/A	Fully compliant				
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.			The CCG arranged for training of all staff who may have patient contact during the Pandemic to receive FIT testing . The CCG also trained staff to become FIT testers and trainers themselves . The CCG has access to IPC training and IPC specialists to advise and support in the determination of correct PPE and the required training associated with the differing levels of PPE	Fully compliant				

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. 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.	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						

DEEP DIVE

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service 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	If applicable	If applicable						
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	If applicable	If applicable						
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	If applicable	If applicable						
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	If applicable	If applicable						
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	If applicable	If applicable						
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	If applicable	If applicable						
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	If applicable	If applicable						

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

NHS Sheffield CCG: STATEMENT OF COMPLIANCE

NHS Sheffield CCG has undertaken a self-assessment against required areas of the EPRR Amended Core standards self-assessment tool v1.0

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Full (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.

_____

Signed by the organisation's Accountable Emergency Officer

02/09/2021

Date signed

02/09/2021	02/09/2021	_____
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report