UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 29 OCTOBER 2021

Title:	**Update on Emergency Preparedness**
Responsible Director:	**David Burbridge, Chief Legal Officer**
Contact:	**Head of Emergency Preparedness & Business continuity**

Purpose:	To present the 6 monthly update to the Board on progress with Emergency Preparedness and the EPRR 2021 Annual Assurance process.
Confidentiality Level & Reason:	None
Board Assurance Framework Ref: / Strategy Implementation Plan Ref:	SIP - #20 Align emergency preparedness and business continuity planning across our sites
Key Issues Summary:	As a category 1 responder, the Trust has a statutory duty to ensure that it can respond to emergency situations and to provide essential services at times of operational pressure in the event of an internal emergency.
Recommendations:	The Board of Directors is asked to accept this update on Emergency Preparedness and agree to receive a further update in 6 months' time. The Board of Directors is asked to note and accept the declaration of Substantial Compliance against the 2021 National Core Standards.

Signed: David Burbridge	**Date:** October 2021

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 29 OCTOBER 20

UPDATE ON EMERGENCY PREPAREDNESS

PRESENTED BY THE CHIEF LEGAL OFFICER

1. Introduction

1.1 As a category 1 responder, the Trust has a statutory duty under the Civil Contingencies Act 2004 to ensure that it has adequate arrangements in place to ensure it can respond to an emergency, support emergency response partners and continue to provide essential services to the public at times of operational pressure in the event of an internal emergency and as is reasonably practicable in the event of an external emergency.

1.2 Following the launch of the Emergency Preparedness Resilience & Response (EPRR) Core Standards in April 2013, all NHS Trusts, Foundation Trusts and Clinical Commissioning Groups (CCG's) were asked to complete a self-assessment against these Core Standards. Due to the on-going Covid-19 response a reduced National Core Standards assurance has been undertaken this year.

2. Executive Summary

2.1 This paper reports on the progress made over the last 6 months to provide assurance that the Trust is fulfilling its statutory duties and can demonstrate resilience in relation to emergency planning and preparedness. The 2020/2021 EPRR annual report was submitted to board in April and is attached as appendix 1 for reference.

2.2 All existing emergency plans are in the process of being aligned across all 4 sites of the Trust, but some will have to remain site specific e.g., the Major Incident plans. The ongoing Covid response has meant that there a few of the Emergency plans remaining to be aligned. These will be aligned over the next 12 months.

2.3 The 2021 National EPRR Core Standards were issued in July 2021 with a submission required by 31st August 2021.

3. Emergency Preparedness Policy

The Emergency Preparedness Policy is available on the Trust intranet and acts as a framework to support the procedures which set out practical steps to ensure an adequate response by the Trust.

4. Emergency Incident plans and testing

4.1 Alongside the Covid-19 response, the emergency planning team (EPT) have continued to update and align emergency incident plans as required.

4.2 <u>RAMP stakeholder table-top exercise – 2nd June 2021</u>

4.2.1 RCDM ran an external stakeholder tabletop exercise on the 2nd June which was supported by the EPT. No formal report from RCDM received as yet.

4.2.2 The exercise was well-attended considering the ongoing Covid-19 response and the requirement for social distancing for those in attendance.

4.2.3 Scenario ran at 3 escalating levels – business as usual, business as usual plus and at Military major incident. Current processes worked well with no significant gaps identified. Some minor changes to communication pathways to be added into the process.

4.3 Infant Abduction simulation exercises

4.3.1 On 28 June, an exercise on the Heartlands Hospital site was jointly run by the EPT and the maternity practice development team. A number of actions and recommendations were made following the outcome of the exercise – report available on request.

4.3.2 A second exercise was undertaken on 27 September at Good Hope Hospital. Again, a number of actions and recommendations will be made once the debriefs and report are concluded. Some of these will be the same as in the Heartlands report and relate to changes required within the procedure which, due to the short gap between exercises, was not unexpected.

4.4 The Operational Covid-19 Surge Plan

The Covid-19 surge plan (Summer) has been updated to reflect changes since the last review in 2020 and is currently with Operational Management.

4.5 Emergency Incident testing

There is a requirement under the Civil Contingencies act to undertake a communications exercise every 6 months; a table top exercise annually and a live exercise every 3 years. However, the on-going 'live' response, nationally and across the trust, to Covid-19 supersedes the requirement for exercises. Nevertheless, having undertaken both a table-top and a live (simulation) exercise, albeit small scale during this period, the trust has exceeded its statutory requirements for exercising.

5. Emergency Incident Training Programme

5.1 As with many other departments, training has been significantly impacted by the Covid-19 response.

5.2 A prioritised approach to training was developed and has enabled some training to be undertaken. This is far below the normal levels of training for EPRR but proportionate to the Covid-19 response.

5.3 Between April and end of September 2021 a total of 32 sessions and 209 staff have undertaken some form of emergency planning training. This is a combination of face to face, Microsoft teams and training exercises.

5.4 Training sessions in the diary for the rest of the year and into 2022 although, due to historic winter pressures, these are always much lower than throughout the April to October period.

6. Business Continuity planning

6.1 The business continuity programme commenced in April 2021 with new templates and completion guidance. Divisions 1,2,5,6 and 7 have started working on these with divisions 3,4 and corporate areas yet to be approached.

6.2 This programme faces significant challenges due to the on-going significant pressures and conflicting priorities due to Covid, emergency attendance and the elective recovery programme.

7. Incidents & Plan Activation

7.1 Formal response to Covid-19 is still on-going and will be for some time. The national requirement for a Trust Incident Command Centre (ICC) remains and continues to be maintained by the emergency planning team.

7.2 No other formal plans have been activated during this reporting period.

8. Additional Emergency Plans

The brief period of hot weather in July highlighted some changes required within the 2021 Heatwave plan which were quickly completed and the amended plan published.

9. EU exit operational readiness

No operations shortages reported that could be specifically attributed to the EU exit.

10. Annual EPRR NHSE Core Standards submission

10.1 A shorter set of National EPRR Core Standards were issued this year, removal of training section, and were submitted on the 31st August. The CCG review the submission, request any evidence they may require, before submitting their assurance of our compliance to NHSEI in October 2021.

10.2 Against this year's core standards we have self-assessed and against the NHSEI assessment criteria declared Substantial Compliance. The Core Standards submission is attached as appendix 2 for reference.

11. Conclusion and recommendations

11.1 The Trust has maintained its statutory obligations under the Civil Contingencies Act 2004 and the emergency planning annual work programme will continue to ensure on-going compliance with these.

11.2 The Board of Directors is asked to accept the Substantial Compliance declaration for the 2021 NHSE Core Standards assurance process.

11.3 The Board of Directors is asked to accept this update on Emergency Preparedness and agree to receive a further update in 6 months' time.

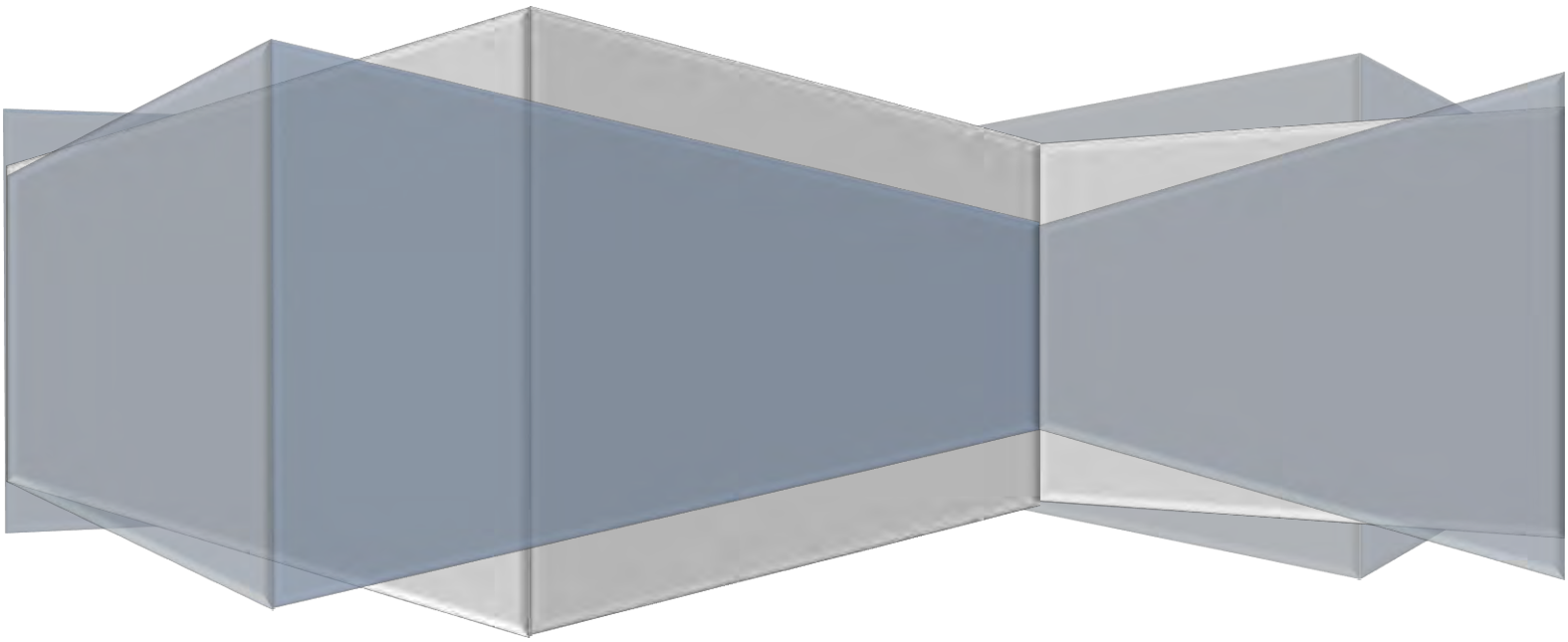
David Burbridge
Chief Legal Officer **October 2021**

University Hospitals Birmingham
NHS Foundation Trust

UHB EPRR Annual Report

1 April 2020 – 31 March 2021

Emergency Planning Team



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1. Position Statement

1.1 This annual report details the work carried by the University Hospital's Birmingham NHS Foundation Trust (UHB) Emergency Planning Team (EPT) to ensure that the Trust is able to meet its Statutory Obligations as an NHS Category 1 Responder and to support the local NHS structures within the NHS England and Improvement West Midlands area (NHSE&I).

1.2 The financial year of April 2020 – March 2021 has seen the EPT focus all of its attention on the Trusts response to COVID-19 and the EU Exit.

1.3 This is the first full year where the EPT has work together as a single team since the merger of the Trust. Appendix 1 demonstrates the EPRR structure within the Trust.

1.4 To ensure that the Trust meets its obligations the EPT has focused on the following work streams.

- 1.4.1 Supporting the Trusts response to COVID-19
- 1.4.2 Specified training program to ensure Trusts ability to respond to an incident
- 1.4.3 EU Exit Operational Readiness Group
- 1.4.4 New Business Continuity & Lockdown Plan process and templates
- 1.4.5 Review of Emergency Incident Plans
- 1.4.6 Support during Incidents

1.5 The following working groups would have been supported by the EPT but have subsequently been suspended during the National response to COVID-19. Membership of the following local & national work groups

- 1.5.1 Local Health Resilience Forum
- 1.5.2 Local Health Resilience Partnership
- 1.5.3 National planning group for implementation of National Occupational Standards
- 1.5.4 National planning group for implementation of Strategic & Tactical training programme for all NHS Trusts

1.6 The following sections cover these work streams in greater detail.

2. 2020 National Core Standards

2.1 Due to the National response to COVID-19, the Core Standards have been suspended for 2020.

2.2 In place of the 2020 Core Standard an alternative assurance process was implemented and the assurance statement submitted to board in October 2020.

3. 2019-20 Emergency Incident Plans Review

Since the acquisition, the EPT have been working on the alignment of the Trusts Incident Response plans to ensure a robust and coordinated response to any incident. These have continued to be reviewed during the 2020-21 period where possible and are split in to two types of plans:

4. Trust Wide Plans

4.1 These plans are available in the following areas and on the Intranet sites:

(a) Command & Control rooms

(b) Emergency Department's

4.1.2 The following plans have been reviewed and approved over the past 12 months:

4.2 Trust Wide

4.2.1 Cold Weather (Aligned)

4.2.2 Fuel (Aligned)

4.2.3 Heatwave (Aligned)

4.2.4 Operation Consort (Aligned)

4.2.5 Operational Pandemic Flu Plan (Aligned)

4.3 Site Specific

4.3.1 Local Emergency Hospital (LEH)

4.3.2 Solihull Response Plan – New document during COVID-19 response

4.3.3 Trauma Unit (TU) & Mass Casualty Plan – BHH

4.4 The incident response plans are submitted to the Trust Emergency Planning Group (EPG) for approval & ratification. A number of these will also require ratification by the Trust Strategic Emergency Preparedness Steering Group.

4.5 The incident response plans listed below have been postponed until 2021 due to the amount of work required to align them within the Trust structure. The current versions of these plans will be used in the response to an incident.

4.5.1 BCM overview

4.5.2 CBRN - now aligned but not yet ratified

4.5.3 Critical Incident Plan – now aligned but not yet ratified

4.5.4 Evacuation & Shelter Plan

4.5.5 Lockdown Plan

4.5.6 Threat Plan

4.6 Following the first wave of Covid-19 the EPT developed a Covid-19 Surge Plan which plans how a second wave of the pandemic will be managed. This planning has taken into account, at divisional level, lessons learned from the

initial response to ensure that the successful actions are embedded and captures the operational changes across UHB at divisional level.

5. Training Programme

5.1 Due to the Trust response to COVID-19 there has been a dramatic reduction in training as staff could not be released for training due to the high demands on services and social distancing. The only training that has continued is either via video conferencing or in relation to new plans in place to respond to incidents.

5.2 For the year April 2020 – March 2021, 21 training sessions have been delivered across the Trust to which 142 staff members attended.

5.3 66 pre-booked training sessions with staff allocated to them have been cancelled over this time period due COVID-19 restrictions.

5.4 These training figures are detailed in Appendix 2

5.5 Due to the Trust's response to COVID-19 since February 2020, all training sessions have been suspended unless deemed response specific.

5.6 With the response to COVID on-going we are currently reviewing how we can adapt our 2021/22 training programme to ensure we continue to meet out statutory obligations under the Civil Contingencies Act 2004.

5.7 All training programmes for 2021-22 will be reviewed and are currently been rewritten to reflect changes to plans, guidance & lessons learnt from COVID-19, actual events and exercises both locally & nationally. The following training sessions will be available once operationally viable.

- 5.7.1 Emergency Department
- 5.7.2 Estates Decon Shelter
- 5.7.3 First On Nurse
- 5.7.4 Initial Operational Response
- 5.7.5 Loggist
- 5.7.6 Major Incident Awareness
- 5.7.7 On Call Manager/Director (Command & Control)

5.8 A full breakdown of the training sessions and numbers across the Trust is available through the EPT.

6. Exercises

6.1 As part of the Trust's statutory obligations within the Civil Contingencies Act 2004, it is a statutory requirement for the Trust to carry out the following exercises:-

- 6.1.1 Live exercise, once every 3 years or activation of the Trusts Emergency Incident Plans to respond to an incident

6.1.2 Desk Top exercise, once a year

6.1.3 Communications exercise, twice yearly

6.2 Any activation of plans supersedes the need for exercise; all requirements for exercising have been superseded by the ongoing Covid-19 response and mean that we are currently fully compliant with our exercising requirements.

7. Incidents

7.1.1 COVID-19

Since February 2020 the Trust has been responding to the National COVID-19 incident. Further details on the Trusts response to this incident is included in section 15 of this document.

7.1.2 FK Calea Parenteral Nutritional feeds

Since August 2019, the EPT continues to be the single point of contact for the Trust in relation to information & data requests from NHS E&I. During the period August 2019 to February 2020, the team coordinated & submitted the weekly Sitreps up the National NHS E&I working group.

7.1.3 Birmingham City centre stabbings

Just after midnight on the 6th September 2020 the QEHB Emergency Department (ED) received a call from West Midlands Ambulance Service (WMAS) trauma desk to inform them of an incident taking place in the Birmingham City centre. The ED received and treated 6 patients over a 5 hour period from this incident.

Following this incident the EPT was tasked to conduct a full incident debrief to identify any lessons learnt. A copy of this report is available through the EPT

8. Business Continuity Management (BCM) & Lockdown Plans

8.1 Project

8.1.1 Over the past 12 months the EPT have been developing a new BCM & Lockdown plan process and template, piloting this with Imaging, Pharmacy and Procurement Departments. The BCM template is a service wide document and will encompass all the aspects and sites each service covers.

8.1.2 Once the BCM plans have been completed by the respective service they will require divisional sign off.

8.2 The EPT is planning to roll out this programme commencing in May with division 1 and then moving through each division.

9. Team Expenditure

9.1 This is the first financial year that the EPT has been under one budget code/holder. The expenditure for this financial year is £10,781.71 with £10,582.72 of that being for response equipment.

9.2 The yearly revalidation programme for the Powered Respirator Protective Suit (PRPS) at BHH, GHH & SH has been the largest expenditure for the team at a total cost of £7,380.04. The QEHB PRPS revalidation programme is currently funded through QEHB Emergency Department.

9.3 Additional EPT funding will need to be reviewed for the period April 2021 – March 2022 due to the additional PRPS cost pressures identified in January 2019 along with the national upload of PRPS to 24 suits per site planned for May 2021.

9.4 A full breakdown list of all items purchased & expenditure by the team is available upon request.

10. Local Health Resilience Partnership (LHRP)

10.1 Due to the National response to COVID-19 the LHRP meetings have been cancelled since the onset of Covid in March 2020. These meetings would beattended by David Burbridge as the AEO for the Trust with Kellie Jervis deputisingin his absence.

10.2 The role of the LHRP is to deliver the National Emergency Planning, Response & Resilience (EPRR) Strategy at a local level and to establish a local Health Risk Register.

11. Local Health Resilience Forum (LHRF)

Due to the National response to COVID-19, the LHRF has been cancelled since March 2020. Normally this working group meets monthly and a member of the EPT would attend the LHRF meetings.

12. Joint Emergency Services Interoperability (JESIP)

12.1 The EPT continues to work with partner agencies to ensure the national JESIP strategy of collaborative working continues. The Trust incorporates the JESIP model through the following.

12.2 Trusts response to COVID-19

12.3 Including JESIP in on-call training

12.4 Sharing plans

12.5 Supporting partners with their training & exercising

13. Risk Assessment

13.1 In line with the National Risk Assessment, the Local Resilience Forum (LRF) and West Midlands Conurbation LHRF the EPT has created a risk assessment document.

13.2 This document details the plans which mitigate the risks to the Trust and scoring is based on the number of incidents. This document is available upon request through the EPT and is reviewed annually.

14. EU Exit

14.1 After confirmation that the UK had left the EU on the 31st January 2020 and entered the transition period the EU Exit group suspended its meeting. These meetings reconvened in October 2020 in readiness for the end of the transition period on the 31st December 2020.

14.2 The EPT has coordinated and supported the response and mitigation in relation to EU Exit by ensuring all Sitreps have been submitted on time; dissemination of new guidance in a timely manner; collating information required for both Sitreps and freedom of information requests as they arrive with the trust; and providing the administrative support to the operational readiness meetings held fortnightly.

14.3 In December 2020 EU Exit data was incorporated into the daily sitreps submitted by the Covid Coordination Centre and continues to form part of these daily submissions.

15. COVID-19

15.1 Since the outbreak of COVID-19 across the UK in February 2020, the EPT have helped support the Trusts response to this pandemic. Initially this was to provide guidance to the Strategic Group during the daily meetings and then the setting up and running of the COVID-19 coordination centre (CCC) in the Wolfson building at QEHB.

15.2 Throughout the Trusts response to COVID-19 the CCC has been running from 08:00-20:00, 7 days a week with the hours covered dropping slightly between the first & second waves. These hours are mandated by NHS E&I nationally and are dependent on what incident response level the country is set at.

15.3 Staff cover the CCC from 07:45 - 20:00 (over two shifts) and the numbers of staff working in the centre during the response phase has been regularly reviewed to match the demand on the service and to meet social distancing guidance. During the first wave staff from Corporate Services and other Divisions supported the CCC.

Since September 2020, the EPT have ensured that the CCC is covered both physically in hours and remotely out of hours. Whilst working in the CCC the staff roles & responsibilities included the follows:

15.3.1 Coordinated & submitted the multiple daily reports to NHS E&I & other NHS partners

15.3.2 Signal point of contact for Q&A's from NHS E&I Regional Coordination Centre

15.3.3 Forward information & guidance received to the appropriate Staff, Department, etc.

15.3.4 Staff advice for non-Occupational Health questions

15.4 One of the main duties of the CCC is to coordinate & submit the numerous of mainly daily returns nationally via various IT based systems as listed below. This requires the support of several departments across the Trust to provide the relevant information daily.

15.4.1 Bed Occupancy – Internal request for BHH, GHH & SH only to Informatics Team. QEHB system reports this directly.

15.4.2 BSOL STP daily figures – Trust wide

15.4.3 Crit Con report – Daily Trust wide report only when the Trust is reporting level 2 and above

15.4.4 Daily discharge figures – Trust wide

15.4.5 Daily Sitrep per hospital site

15.4.6 Maternity – Trust wide bi-weekly

15.4.7 Mortuary figures – Dependant on National level this was either daily or weekly

15.4.8 Shielding Patient numbers – Trust wide

15.5 The following returns where submitted directly throughout the response by the respective departments to help and support the CCC reporting

15.5.1 IIMarch – Daily by Infection Control

15.5.2 NHS E&I Lateral flow testing – Daily by Improvement Team

15.5.3 PHE Lateral flow testing – Daily by Improvement Team

15.5.4 Renal stocks – Weekly by Critical Care Team

15.5.5 Waste management – Daily by Facilities Department

15.5.6 Weekly activity report – Weekly by informatics

15.6 A large number of adhoc returns and reports continue to be requested for NHS E&I both locally and nationally. A majority of the time these have had sufficient response time but there have also been a number that have been between 1and 24 hour

response times .

15.7 Once the incident has stood down and the Trust has returned to normal business a full debrief report will be undertaken and shared with the Trust with the lessons learnt being incorporated into an updated pandemic plan.

16. Work Programme: April 2021 – March 2022

16.1 As previously mentioned the work programme for the forthcoming financial year will be dependent on the continuing Trust response to the on-going COVID-19 outbreak and once the Trust returns to a 'new' normal business the work programme will be reviewed and prioritised.

16.2 The main focus will be on ensuring the plans are now fit for purpose following internal & external debriefs and changes to national plans & the BCM project.

16.3 As the EPT was unable to rollout the Community Initial Operational Response (IOR) boxes (dry decontamination process to be used in the event of a contaminated person) across the remaining Community & Satellite sites, we will endeavour to roll this out this financial year. This will ensure consistency across all Trust sites during a chemical or Hazmat incident.

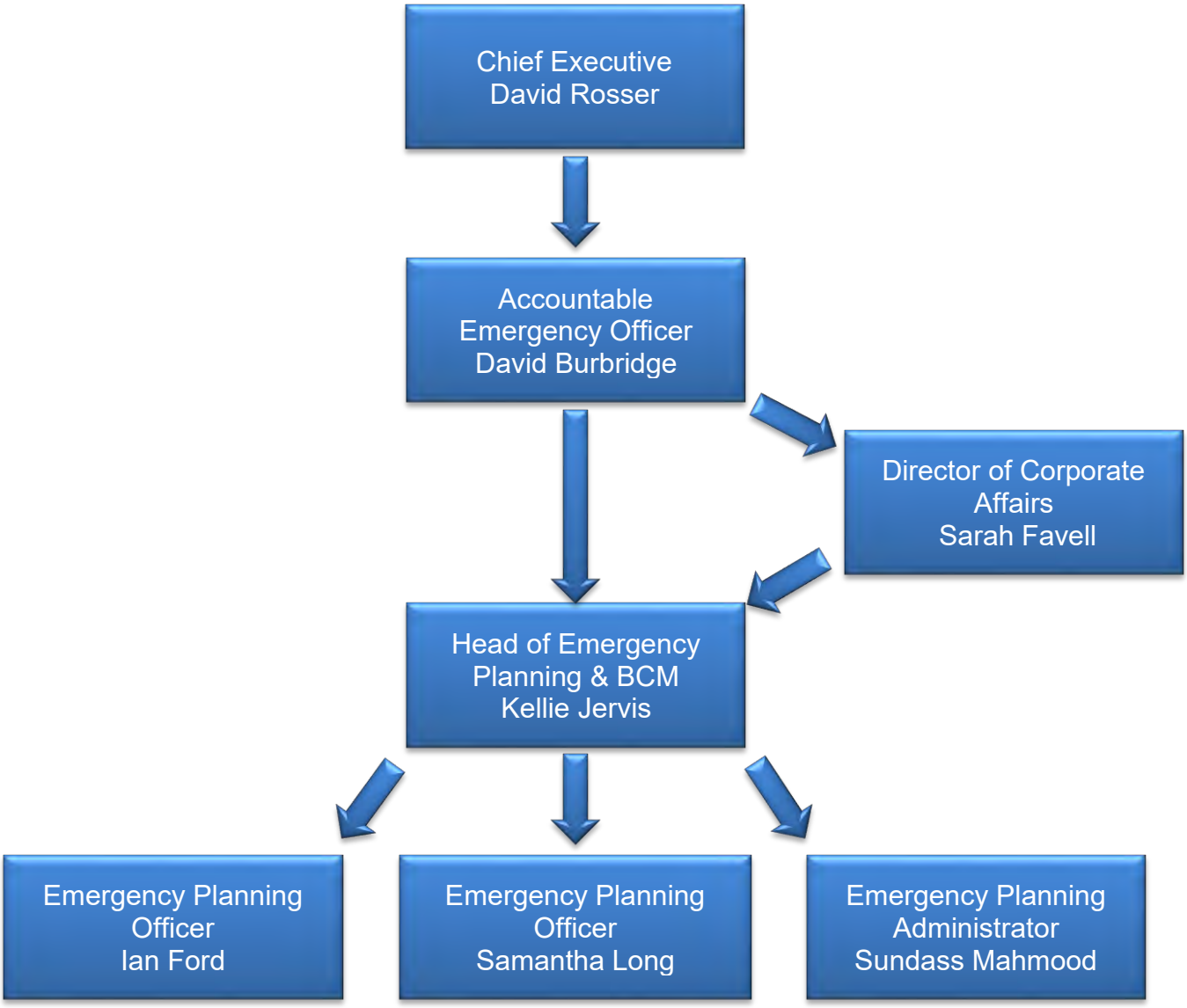
16.3.1 These are designed to support front line staff outside of the four acute hospital sites when dealing with self-presenting contaminated patients.

16.3.2 The EPT will create these IOR kit boxes, deliver & train the staff on how to respond to deal with contaminated patients as well as how to report this to the Trust.

16.4 On Call manager training will recommence as soon as operationally possible with the initial focus on new to rota staff and then moving on to all other on call staff. This will be a Trust wide programme to ensure all staff received the appropriate level training.

16.5 Emergency Department training will recommence as soon as operationally possible again with the priority being new staff.

Appendix 1 – Emergency Planning Team Structure



Appendix 2 – Trust Training Figures

Type of Training		Number of Session	Number of Staff
Command & Control		**20 Cancelled**	**-**
Emergency Department		**22 Cancelled**	**-**
Table Top Training Sessions		**0**	**0**
External Training Sessions		**0**	**0**
Breakdown	Staff attending other organisations exercises	**0**	**0**
	Staff attending Training delivered by other organisations	**0**	**0**
Adhoc Training Sessions		**Number of Session**	**Number of Staff**
Adhoc Training Breakdown	Radio	**0**	**0**
	Major Incident Awareness	**8**	**40**
	ED Reception Staff	**0**	**0**
	Estates Decon Shelter	**0**	**0**
	First On Nurse	**9**	**24**
	Initial Operational Response	**4**	**78**
	Loggist	**0**	**0**
	Corporate Nursing	**0**	**0**
	Control Room	**0**	**0**
	Total Numbers	**21**	**142**

Appendix 3 – Commonly used Acronyms

AEO	Accountable Emergency Officer
BHH	Birmingham Heartlands Hospital
BCM	Business Continuity Management
BSOL STP	Birmingham & Solihull Sustainability and Transformation Partnership
CBRN	Chemical Biological Radiological Nuclear
CCA	Civil Contingencies Act
CCC	COVID-19 Coordination Centre
COBR	Cabinet Office Briefing Rooms
COMAH	Control of Major Accident Hazards
DH	Department of Health
DPH	Director of Public Health
ED	Emergency Department
EPRR	Emergency Preparedness, Resilience and Response (DH)
EPG	Emergency Planning Group
EPO	Emergency Planning Office
EPT	Emergency Planning Team
EU	European Union
GHH	Good Hope Hospital
Hazmat	Hazardous Materials
ICC	Incident Coordination Centre
ID	Identification
IMT	Incident Management Team
IOR	Initial Operational Response (Also known as Remove, Remove, Remove)
JESIP	Joint Emergency Services Interoperability
LEH	Local Emergency Hospital
LHRF	Local Health Resilience Forum
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MIU	Minor Injuries Unit
MTC	Major Trauma Centre
NHS	National Health Service
NHS E&I	NHS England & Improvement
PHE	Public Health England

PRPS	Personal Respiration Protection Suits
QE or QEHB	Queen Elizabeth Hospital
SAGE	Scientific Advice to Government in Emergencies
SCG	Strategic Coordinating Group (Multiagency Strategic Command)
SITREP	Situation Report
Sol or SH	Solihull Hospital
SR	Sub Region - the local presence of the NHS E&I
STAC	Scientific and Technical Advice Cell
Trust	UHB
TU	Trauma Unit
UHB	University Hospitals Birmingham (Trust)
WMAS	West Midlands Ambulance Service
WMFS	West Midlands Fire & Rescue Service
WMP	West Midlands Police

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England and NHS Improvement Region	NHS England and NHS Improvement National	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Name and role of appointed individual		Fully compliant				David Burbridge, Chief Legal Officer is the Trust AEO
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	Y	Y	Y	Y	Y	Y	Y	Y	Y			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.		Fully compliant				UHB policy in placed dated January 2019 review date January 2022
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board		Fully compliant				2020-21 EPRR annual report to April 2021 Board
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group		Fully compliant				All criteria covered within the EPRR Policy
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Process explicitly described within the EPRR policy statement		Fully compliant				Captured within the EPRR policy . Debriefs & formal reports are undertaken following all incidents & exercises with recommendations and associated action plans included. Reports are submitted to the Emergency Planning Group (EPG) for approval & monitoring.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register		Fully compliant				EPRR risk assessment in place and reviewed in line with national & community risk registers. July 2019
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document		Fully compliant				Risks reported to EPG and escalation directly to AEO if required.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	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		Fully compliant				Newly aligned Critical Incident plan
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	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	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		Fully compliant				TU & LEH plans reviewed August 2020 due to COVID organisational changes for COVID response. MTC plan still current
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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		Fully compliant				Heatwave plan in place & ratified May 2021
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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		Fully compliant				Cold weather plan in place & ratified November 2020
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	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	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		Fully compliant				MTC plan ratified 2018 TU & LEH plans ratified August 2020
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Y											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		Fully compliant				Process in place
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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		Partially compliant				Off site evacuation plans in place for 3 out of 4 hospital sites.
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Y	Y	Y			Y					Y	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		Fully compliant				Plans/procedures in place
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals', Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Y	Y	Y			Y					Y	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		Fully compliant				Op Consort in place August 2020 VIP policy in place Jan 2021
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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.		Fully compliant				Automated call out cascades in places for all required responders
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Fully compliant				Pre identified rooms in place with appropriate supporting documentation. E.g. action cards, plans, set up guides, etc.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity Response plans		Fully compliant				Process in place and detailed within BCM plan ratified May 2021
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented processes for completing, signing off and submitting SitReps		Fully compliant				As evidenced in COVID-19 response
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y													• Guidance is available to appropriate staff either electronically or hard copies		Fully compliant				Copies of latest Clinical Guidelines circulated to the Emergency Departments (ED) and uploaded to the ED website
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y													• Guidance is available to appropriate staff either electronically or hard copies		Fully compliant				Electronic versions uploaded to intranet/sharepoint.
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Social Media Policy during 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		Fully compliant				Requirements incorporated in to EPRR policy and within relevant plans as required. Shared information through LHRP as required. Communications and Media Management plans. Includes social media
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing						Communications and Media Management plans. Includes social media
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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		Fully compliant				Media Management & Comms operational plans form part of MI & Mass Cass planning.
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	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate		Fully compliant				Mutual aid arrangements covered in relevant incident plans. Contribution to the up keep of the West Midlands Conurbation Mutual Aid document.* Workforce sharing agreement in place for BSOL July 2021
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.			Y					Y	Y				Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs						Not Applicable
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.									Y					• Detailed documentation on the process for managing the national health aspects of an emergency						Not Applicable
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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'.		Fully compliant				As evidenced in COVID-19 response
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 Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement		Fully compliant				Overarching BCM plan in place and also within the EPRR Policy
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	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						Forms part of the overarching BCM plan
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Statement of compliance		Partiatly comoliant				Work programme in place with compilition due Jan 2022
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	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation		Partially compliant				New aligned process in place and currently being rolled out across the Trust. Previous plans not superseded are still in place although in differing formats
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports		Fully compliant				BCM plans audited by EP Team and reported to EPG
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans		Fully compliant				Post incident reports completed and shared, recommendations & action plans as required are used to inform BCM review.
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	Y	Y	Y	Y	Y	Y	n	Y	Y	Y	Y	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements		Fully compliant				Undertaken by Procurement, new contracts now required to provide their BCM plans. Alternative suppliers in place in the event of shortages. EU Exit planning has ensured up to date supplier plans in place.
Domain 10: CBRN																										
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y		Y			Y					Y		Staff are aware of the number / process to gain access to advice through appropriate planning arrangements		Fully compliant				Available within CBRN plans
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y		Y			Y							Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies						CBRN plan in place
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	Y		Y			Y							• Impact assessment of CBRN decontamination on other key facilities		Fully compliant				Risk assessment in place and incorporated in plan
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y													• Rotas of appropriately trained staff availability 24 /7		Fully comoliant				CBRN training provided to ED & Estates staff
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y		Y			Y							• Completed equipment inventories; including completion date		Fully comoliant				Appropriate equipment held on all sites and forms part of WMAS external audit
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and renobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y													• Record of equipment checks, including date completed and by whom. • Report of any missing equipment		Fully comoliant				Forms part of the monthly equipment audit of all kit or undertaken as part of training schedule Service contracts in place
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 renobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y													• Completed PPM, including date completed, and by whom		Fully comoliant				Annual maintenance contracts in place and PRPS revalidation program ongoing. Ram Gene's recertified annually
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y													• Organisational policy		Fully compliant				Disposed of as per hazardous waste policy
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y													• Maintenance of CPD records		Fully comoliant				PRPS train the trainer completed by relevant leads
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y													• Maintenance of CPD records		Fully comoliant				PRPS train the trainer completed by relevant leads
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y		Y			Y							• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique		Fully comoliant				Incorporated in annual training programme COVID response has had a significant impact on all training programmes
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Y			Y									Fully comoliant				CBRN equipment conforms to FFP3 equivalent protection. As evidenced in COVID response

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						

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		Fully compliant				
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		Fully compliant				
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		Fully compliant				
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		Fully compliant				
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		Fully compliant				
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		Fully compliant				
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		Fully compliant				Reviewed in July 2021

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation 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
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.	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		Partially compliant	Review of plan to include all hospital sites Identify an appropriate offsite location for QEHB	Emergency Planning Team	Aug-22	
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.	Statement of compliance		Partially compliant	Work programme in place with complition due Jan 2022	Information Governance & IT	Jan-22	
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	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation		Partially compliant	Work programme in place to align all plans	Emergency Planning Team	Aug-22	