Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

13 June 2024

The Boardroom, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS and via MS Teams at 1.30 p.m.

AGENDA

NOTE: there will be a confidential session at 1.00pm for the Board of Directors to receive a patient/staff story.

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	1.30pm
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the last meeting held on 11 April 2024	Chair	
5	Board Action Log	Chair	
6	Chair's report	Chair	
7	Questions raised by Governors in relation to matters on the agenda (verbal) *(to be received by 1pm on 11 June 2024)*	Board	

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	1.45pm
9	Chief Executive's Report	CEO	1.55pm
10	Integrated Performance Report	Asst CEO	2.00pm
11	Our Journey to Change Quarter 4 2023/24	Asst CEO	2.35pm

BREAK (2.50pm – 3.00pm)

12	Our Journey to Change Delivery Plan 2024/25	Asst CEO	3.00pm

BAF RISK 1: Safe Staffing

13	Report of the Chair of People, Culture and Diversity Committee	EDfP&C	3.10pm
14	Guardian of Safe Working Annual Report	Int. GoSW D Burke	3.20pm
15	Freedom to Speak Up Report	FTSUG D Williams	3.35pm

BAF RISK 2: Demand
BAF RISK 3: Cocreation
BAF RISK 4: Quality of Care
BAF RISK 8: Quality Governance

16	Report of the Chair of Quality Assurance Committee	Cmt Chair	3.55pm
17	Learning from Deaths Report [restricted document in line with the recommended code of practice during a pre-election period]	EMD	4.05pm

BAF RISK 10: Regulatory Compliance

18	Report of the Chair of Mental Health Legislation Committee	Cmt Chair	4.15pm
19	Compliance against the NHS core standards for emergency preparedness, resilience and response	MD NYY CG	4.25pm

Governance

20	Board of Directors Register of Interests	Co Sec	4.35pm
21	Board Assurance Framework (verbal)	Chair	4.40pm

Matters for information

22	Leadership Walkabouts [restricted document in line with the recommended code of practice during a pre-election period]	EDoCA&I	-
23	Use of the Trust's Seal	Co Sec	-

Exclusion of the Public:

24	Exclusion of the public - the Chair to move: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely*	Chair	4.50pm

	disclosure of confidential information as defined in Annex 9 to the Constitution as explained below: *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit –* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*		

BREAK (4.50pm-5.00pm)

Standard Items

25	Confidential minutes of the last meeting held on 11 April 2024	Chair	5.00pm
26	Confidential Action Log	Chair	

Strategic Items

27	Chief Executive's Confidential report	CEO	5.05pm
28	Reportable Issues Log	ECN	5.25pm
29	Report of the Chair of Audit & Risk Committee	Cmt Chair	5.35pm

BAF RISK 5: Digital
BAF RISK 6: Estate/Physical Infrastructure
BAF Risk 7: Cyber Security
BAF RISK 9: Partnerships and System Working
BAF Risk 12: Financial Sustainability

30	Report of the Chair of Strategy & Resources Committee	Cmt Chair	5.45pm
31	Finance Reports: a) 2024/25 Financial Plan b) Month 1 2024/25 Finance report	DoFE&F	5.55pm

Governance

32	Board Assurance Framework	Co Sec	6.15pm
33	Board committee terms of reference and appointments	Co Sec	6.25pm

Evaluation

34	Meeting evaluation *In particular, have we, as a board of directors:* • *Via the agenda, papers and our discussions, fulfilled our objectives of supporting our communities, staff and stakeholders?* • *Fulfilled our statutory roles?* • *Held the organisation to account for the delivery of the strategy and services we provide?*	Chair	6.30pm

Matters for information

35	Minutes of meetings of board committees a. Audit & Risk Committee, 6 February 2024 b. Strategy & Resources Committee, 13 February 2024 c. People, Culture and Diversity Committee, 20 February 2024 d. Mental Health Legislation Committee, 27 February 2024 e. Quality Assurance Committee, 4 April 2024 f. Audit & Risk Committee, 8 April 2024 g. Quality Assurance Committee, 2 May 2024	Co Sec	-

David Jennings
Chair
7 June 2024

Contact: Karen Christon, Deputy Company Secretary
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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 11 APRIL 2024 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MS TEAMS

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
C Carpenter, Non-Executive Director
J Murray, Non-Executive Director
K Kale, Executive Medical Director
J Maddison, Non-Executive Director
B Murphy, Executive Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
B Reilly, Non-Executive Director and Deputy Chair
L Romaniak, Executive Director of Finance, Estates and Facilities
P Scott, Executive Managing Director, Durham, Tees Valley and Forensic Care Group and Deputy Chief Executive
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Executive Director of Therapies (non-voting)
S Dexter-Smith, Executive Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)
M Liebenberg, Head of Therapies, NYYS Care Group (on behalf of Z Campbell)
C Morton, Lived Experience Director, Durham, Tees Valley and Forensic Care Group
C Nosiri, Lived Experience Director, North Yorkshire, York & Selby Care Group
S Paxton, Head of Communications (on behalf of A Bridges)

Observers:
S Double, Alder
H Griffiths, Governor
J Kirkbride, Governor
K North, Deputy Director for People and Culture
S Theobald, Associate Director of Performance
E Thomas, Involvement & Engagement Member
J Welsh, Involvement & Engagement member

24-25/01 CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and commented on the powerful staff story that the board had the opportunity to hear prior to the meeting.

24-25/02 APOLOGIES FOR ABSENCE

Apologies for absence were received from A Bridges, Executive Director of Corporate Affairs and Involvement and Z Campbell, Executive Managing Director, North Yorkshire, York & Selby Care Group.

24-25/03 DECLARATIONS OF INTEREST

During the meeting B Kilmurray declared an interest in relation to his appointment as a participant member of the Humber and North Yorkshire ICB Board, following his appointment as Chair of the provider collaborative.

24-25/04 MINUTES OF THE LAST MEETING HELD ON 14 MARCH 2024

The minutes were agreed as an accurate record of the meeting subject to the following amendment:

'J Murray welcomed the proposal and proposed that reference be made to the *principles of inclusive leadership'* [Para 23-24/174, bullet 4 refers].

24-25/05 BOARD ACTION LOG

The following points were noted:

1. The board seminar programme 2024/25 had been finalised and circulated to Executive Directors for final comments.
2. Work had been completed to map the activities of Commissioning Committee to other committees and a report proposing changes to committee terms of reference would be discussed at the next meeting. The action was closed [23-24/135].
3. It was agreed that the board was well sighted on all financial issues and the action be closed [23-24/11].
4. It was noted that P Scott would provide the update on the Autism Adult Neurodevelopmental Service as the action had been led by Durham, Tees Valley and Forensic Care Group [23-24/151].
5. A concern was expressed that the board seminar on patient outcomes had been deferred to July and the board was advised that the date provided an opportunity for all relevant members of staff to attend [23/24-136].

24-25/06 CHAIR'S REPORT

The Chair presented the report and drew attention to the discussion at the Mental Health Chairs' Network and the meeting with Co Durham and Darlington, North Tees and South Tees Trust Chairs and Chief Executives, on areas of common purpose.

24-25/07 QUESTIONS RAISED BY GOVERNORS

P Bellas advised that a question had been raised in respect of the use of acronyms throughout the board papers and the Chair proposed that report authors provide explanatory information in future reports.

24-25/08 BOARD ASSURANCE FRAMEWORK

P Bellas presented the report, which provided information on strategic risks to support the board's discussions at the meeting and advised that work that would be undertaken to review all risk profiles prior to the next board meeting in June.

The Chair noted the positive assurance provided in relation to safe staffing, demand, cocreation and quality of care and negative assurance in relation to out of area placements, where the board was aware of the strategic challenge and risk.

B Reilly advised that Quality Assurance Committee had approved the reduction in risk score from high to medium for Cocreation. The Chair welcomed the focus the Board Assurance Framework had given to this and noted that the records of Quality Assurance Committee would evidence why the change in risk score had been approved.

24-25/09 CHIEF EXECUTIVE'S REPORT

B Kilmurray presented the report, which provided a briefing on important topical issues of concern to the Chief Executive.

Commenting on the 2024/25 Financial Plan, L Romaniak noted the board was invited to attend the next meeting of Strategy and Resources Committee, where the Trust's financial plan would be approved prior to submission. Once submitted, the aggregate position of North East North Cumbria Integrated Care System (ICS) would then be considered. This process followed a series of ICS peer reviews to consider how the draft aggregate position at March 2024, would be improved.

B Kilmurray went on to highlight the position in respect of the Gender Identity Service, following the closure of the Tavistock and Portman NHS Foundation Trust, and advised that individuals would remain on a waiting list until regional hubs were established late 2024/25. The Trust had offered to provide keep in touch support in the interim.

24-25/10 INTEGRATED PERFORMANCE REPORT

M Brierley presented the report, which proposed there was reasonable assurance regarding the oversight of the quality of services delivered and actions undertaken to improve performance in required areas.

P Scott reported from Durham, Tees Valley and Forensic Care Group and noted:

- The development of performance improvement plans (PIPs) in all required areas, with detailed trajectories for improvement, and improvements that had been noted in relation to children and young people (CYP) eating disorders waiting times and adult and mental health services for older people (MHSOP) outcomes.
- The stabilisation in use of independent sector beds, improvement in bed occupancy in MHSOP, and implementation of PIPs that would support a 50% reduction in patients with a length of stay over 60 days and address challenges in relation to delayed transfers of care.
- Work undertaken to assess the needs and identify modifications in practice and the environment, for those with autism.
- Challenge provided through the Getting in Right First Time Programme in relation to inpatient services and support by the Integrated Care Board, which included potential for increased case management capacity.
- Improved crisis line call pick up rates, where call screening had reached 90-95%, and the introduction of a call back option to reduce missed calls.
- Progression of a second phase of international recruitment to reduce reliance on agency costs for medical staff, and challenges related to agency expenditure in adult inpatient services.
- Recruitment within Secure Inpatient Services that had stabilised the workforce and reduced vacancies from 92 in April 2023 to 8 in March 2024.

M Liebenberg reported from North Yorkshire, York and Selby Care Group and noted:

- Arrangements in place to support and monitor four services in business continuity, where the majority of challenges related to staff pressures and options to support recruitment had been explored with People and Culture Directorate.
- Work that would be undertaken to finalise the PIP for CYP Services caseloads, meanwhile improvement work would continue to take place.
- The impact of high waiting times for young people on neurodevelopment caseloads, and work that would be undertaken to review the trajectory of referrals to understand

the level of workforce required to meet the nine month waiters target and to identify those patients that could be transferred under shared care arrangements.

- Work that had commenced to understand the metric for children and young people showing measurable improvement following treatment.
- The spike in restrictive intervention that had occurred in relation to two patients in older people services, and he acknowledged the work of the team to achieve a successful outcome for both patients.
- The inclusion of negative assurance in the Board Assurance Framework (BAF) in relation to demand, where there was concern that Service Development Funding may be withheld.
- The appointment of a trainee psychologist for community learning disability teams.
- Acquisition of a bladder scanner at Foss Park, which had prevented admissions to the acute Trust, improved patient experience and reduced transfer costs.

In discussion the following points where raised:

1. Assurance was provided on daily work undertaken by bed managers to consider all options to avoid the transfer of patients to independent sector beds.

2. There had been increased interest by Registered Nurses to work in Secure Inpatient Services.

3. B Murphy noted concerns that Service Development Funding may be withheld and proposed to escalate this to the Quality Board.

   L Romaniak commented on the challenging financial position and noted that final financial plans for 2024/25 had not been agreed. She proposed that mental health investment standards audits would identify where funding had not flowed appropriately and noted she had raised a concern with NHS England regional colleagues and the North East North Cumbria Integrated Care Board.

   B Reilly welcomed the information provided in the report and noted a governance concern raised by Quality Assurance Committee, that funding previously withheld had not been used for its intended purpose.

   The Chair acknowledged the views expressed and commented on the exceptional work undertaken by the Trust and national recognition received in relation to the transformation of community services, and the importance of the Service Development Fund to continue this work.

   L Romaniak advised that in 2023/24 the ringfence on the fund had been removed to allow the NHS to achieve a balanced position.

4. Assurance was provided that the absence of data in the IPR to support patient measures, did not reflect a loss of data, but related to the inability to map data into the Integrated Information Centre to produce high quality reports.

5. J Maddison queried the trend of inappropriate out of area bed days for adults, despite good work undertaken – noting the impact on patients, families and resources - and work that may need to be undertaken with system partners in mitigation.
   In response, L Romaniak commented on the impact of delayed transfers on adult bed occupancy, staffing and out of area placements and noted a similar challenge in respect of older people beds, although this was a more stable position.

B Murphy proposed that data be triangulated with quality data to understand the full impact.

6. J Murray sought assurance on the number of patient safety incident investigations reported, following transition to the national Patient Safety Incident Framework (PSIRF).
B Murphy advised that the framework, implemented in January 2024, provided 10 days to undertake a multi-disciplinary after action review, the outcome of which may not result in notification of a patient safety incident. The ICS had reviewed the Trust's implementation plan and was satisfied that it could evidence the system operated appropriately.

   The Chair noted the assurance provided, that differences in data following transition to the new system, were understood.

7. The Chair sought assurance on issues related to InPhase and proposed timescales by which they would be resolved.
B Murphy advised that the Head of Risk Management had worked closely with care groups to close the gap, support was in place and there continued to be oversight in order to identify areas of risk. Teams had different levels of competency and a definitive timescale was difficult to identify. She proposed to report any change in trajectory to Quality Assurance Committee.

8. In respect of actions taken to improve unique caseloads, P Scott provided assurance that community transformation activity had led to an improvement in adult and children caseloads and proposed that progress would be reported in June 2024. M Liebenberg also advised that the care group was sighted on current challenges, and actions taken had resulted in a slow but positive improvement.

9. The Chair commented on the link between staffing and teams in business continuity and the national focus on productivity and sought assurance that actions proposed would address Trust vacancies.
S Dexter-Smith advised that there was a focus on areas where workforce levels had reduced and noted that the Trust had seen a reduction in leavers and improvement in staff sickness. K Kale also noted the positive position of medical staff recruitment through international recruitment activity.

10. In respect of the metric feeling safe, P Scott noted that 82% of patients in Durham, Tees Valley and Forensic Care Group felt safe most of the time. He expressed confidence in actions led by Lived Experience Directors to engage service users and noted transformation work underway in inpatient services, alongside other activity.
B Reilly agreed with the assessment and advised that Quality Assurance Committee had reviewed the actions and detail which supported that. She also noted the positive experience at Hartlepool Borough Council scrutiny committee, which spoke to the value of the Lived Experience Directors.

11. In respect of Talking Therapies, M Brierley acknowledged there were challenges related to waiting times between first and second appointment, and the Trust had established a risk based approach to keep in touch arrangements and provided self-support through an online tool. Challenges had been driven by demand, workforce capacity and commissioning levels. A national review of the service would be undertaken.
B Kilmurray noted the Trust would report on recovery from April 2024.

24-25/11 CORPORATE RISK REGISTER

B Murphy presented the report, which proposed there was good assurance over risk management processes in place, the consideration of risks for addition to the Corporate Risk Register and the ongoing management of these risks. She noted the inclusion of additional information, at the request of the board, which showed the movement of risks over time and advised that the Head of Risk Management had begun work with risk owners to confirm target dates for delivery of ratings.

Committee Chairs' provided assurance that committees had been sighted on the justification for changes to risk scores.

In discussion the following points were raised:

1. J Murray welcomed the inclusion of information on the movement of risks and proposed to review those that were relevant to People, Culture and Diversity Committee.

2. B Murphy provided assurance that risk scores were adjusted retrospectively based on evidence provided and changes would be reported into the relevant committee.

3. B Murphy proposed that board committees consider those corporate risks that had remained static for 12 months. C Carpenter also suggested this work included a review of target dates. **Action: Committee Chairs**

4. J Maddison advised that Audit and Risk Committee had taken good assurance from its review of the risk management framework, how embedded it was in the organisation and the involvement of committees. He welcomed progress made to date and information provided on justification for changes to risk scores and target dates. He proposed that committee Chairs would continue to provide assurance to the board.

24-25/12 STAFF SURVEY

S Dexter-Smith presented the report, which provided an overview of the results of the staff survey undertaken in Autumn 2023, and proposed that, overall, the results gave good assurance of continued progress following the significant improvement in 2022.

In discussion the following points were raised:

1. B Kilmurray welcomed the increase in staff participation in the survey and improvement in key areas and he supported the proposed areas of focus for 2024/25.

2. B Reilly sought assurance that information had been cascaded and there was ownership of actions at the right level.
   In response, S Dexter-Smith advised that information had been proactively shared with teams and care groups and there was clarity on actions that would be undertaken by them and Trust wide. She went on to note the national timeline, with the survey completed in September/ October 2023 and advised that work had started as soon as initial results were known.
   Commenting further, B Murphy and K Kale confirmed that they had discussed the results with their team and information would be cascaded to, and actions undertaken by teams.

3. R Barker noted themes in relation to openness, transparency, leadership and teams and proposed there was assurance, through work undertaken, that there was a focus on the right topics.

4. J Murray welcomed the steady improvement across a range of indicators and noted that the bottom five scores were marginally below average.

5. Summing up the discussion, the Chair proposed that there was assurance that data would be used to focus on those areas where support was needed, and that feedback would be used to identify if actions had made a difference.

Agreed: *the proposed areas of focus for 2024/25 be supported.*

[M Brierley left the meeting]

24-25/13 UPDATE FROM LIVED EXPERIENCE DIRECTORS

C Nosiri and C Morton provided a verbal update and noted:

- The Trust's commitment to embed lived experience and the establishment of groups and networks to ensure the voices of service users were heard and to support cocreation activity across the Trust.
- The establishment of Co-creation Boards in care groups, which had transformed governance arrangements.
- Support provided by senior leaders throughout the organisation.
- The development of new opportunities to listen to service users and carers, particularly seldom heard groups.
- Their involvement in strategic level activity, which included the development of personalised care and co-production of the policy.
- Achievements, which included the engagement and involvement of community groups to support the Durham and Darlington Crisis Service and policy development across a range of areas.
- Feedback from Peer Support Workers, which suggested that whilst there was a range of useful intelligence and activity, there was inconsistency and some resistance to their involvement.
- Opportunities to focus on tangible initiatives to support the clinical offer and inpatient and community transformation, and to grow lived experience roles within the workforce.
- Consideration that needed to be given to the support available to individuals to ensure they were able to contribute effectively, and how co-creation boards were reflected in the accountability framework.

In discussion the following points were raised:

1. B Murphy noted the co-production of quality priorities as a positive example of the impact of cocreation.

2. B Murphy commented on the importance of the role of Peer Support Workers in delivery of Our Journey to Change and queried what support could be made available to enable them to be a helpful disruptor.

3. B Kilmurray acknowledged the positive work undertaken and welcomed the opportunity for a two year review to understand the impact on patient experience, outcomes and Trust priorities.

4. P Scott proposed the Trust had a tradition of coproduction and should be proud of what had been achieved. He welcomed the support of Lived Experience Directors to embed lived experience in the Trust's governance arrangements and their contribution to community transformation activity.

5. H Crawford recognised the difficulties that might be faced by Lived Experience Directors and how far the Trust had come compared to other organisations. She offered to support the development of qualitative and quantitative impact data.

6. L Romaniak welcomed the opportunity for a two year review and reflected on an impactful presentation at the Trust's AGM and how the Trust might build on the skills and experience of Lived Experience Directors and peer networks.

7. S Dexter-Smith noted the shift that cocreation was more automatically weaved into everything the Trust did and commented on the contribution of Lived Experience Directors to the development of the Leadership and Management Academy and the Trust's Welcome, with information provided to new staff about the power of cocreation.

8. The Chair welcomed the opportunity for transparency about the Cocreation Boards and information on how they would inform and challenge the Trust board.
He proposed that cocreation be a headline message in the annual report and that Lived Experience Directors use the opportunity of the AGM to showcase what they had achieved.

24-25/14 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report which outlined matters arising from the meeting held on 11 April 2024. In addition to that reported, she alerted the board to:

- The Durham and Darlington Crisis Team, which would enter short term business continuity.
- A request from the North East North Cumbria Integrated Care Board to attend the next committee meeting.
- The delay to finalise board committee terms of reference.

In discussion the following points were raised:

1. B Kilmurray welcomed the opportunity for Executive Directors Group to have oversight of progress to manage section 17 leave and time away from the ward, and for the board to fully consider the outcome of learning from the Edenfield Review. He also noted the external governance review had been included on the agenda and would be completed by May 2024.

2. B Murphy confirmed that: Martha's Rule and learning from the Edenfield Review would be considered by Fundamental Standards Group and Executive Clinical Leaders Group; there had been no breaches of mixed sex accommodation; Roseberry Park Hospital would come out of business continuity due to improved staffing levels and regional leaders had confirmed that TEWV was the most successful trust in the region for international recruitment.

3. In response to a query, B Murphy advised that proposals to improve the environment on Cedar Ward would be revisited as the Trust sought to be more ambitious in how it protected the privacy and dignity of service users. Final proposals would be considered by the Environmental Risk Group and progressed quickly.

24-25/15 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

K Kale, Executive Medical Director, presented the report which outlined matters arising from the meeting held on 14 March 2024. In addition to that reported, he noted:

- A correction to the report to reflect that Section 136 related to the powers of the police to detain and take an individual to a place of safety; Section 15 related to scrutiny of documentation; and Section 5 related to the ability to detain an individual.
- Concerns related to communications between wards and carers had been reflected in the CQC inspection. This contrasted with the Integrated Performance Report, which indicated that 72% of carers said they were actively involved in decisions about the care and treatment of the person they care for.

In discussion the following points were raised:

1. B Murphy noted her attendance at a conference on health inequalities and expressed interest in understanding the demographic mix of communities that accessed Trust services, in order to understand if the Trust reached minority groups.

   K Kale noted work that would be undertaken by the Consultant in Public Health and a challenge to Trust services/teams that they considered inequality. H Crawford advised that a multi-disciplinary team had been established to understand the background to data and how it could be used.

2. The Chair noted the Gypsy, Roma and Traveller community as a significant minority group within the Trust area and potential area of focus. In response, H Crawford advised there was limited information and low levels of engagement with the community and proposed that the board may wish to receive further information.

Bringing the discussion to a close the Chair thanked R Barker who had stepped in as Interim Chair of the committee.

24-25/16 RESERVATION OF POWERS TO THE BOARD AND SCHEME OF DELEGATION

P Bellas introduced the report, which sought agreement on the approval of the Reservation of Powers to the Board and the Scheme of Delegation, following its removal from the revised Constitution.

Agreed: *the Reservation of Powers to the Board and the Scheme of Delegation be approved.*

24-25/17 BOARD ASSURANCE FRAMEWORK

The Chair returned to the Board Assurance Framework and invited the board to consider if matters discussed on the agenda had changed their view on progress.

B Murphy noted financial risks related to mental health transformation work.

24-25/18 EXCLUSION OF THE PUBLIC

Agreed: *that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution.*

Following consideration of confidential matters, the meeting concluded at 6.20pm

Board of Directors
Public Action Log

RAG Ratings:	
	Action on track
Completed	Action completed
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
14/03/2024	23-24/166	BAF	Historical information to be removed.	Co Sec	Apr-24	**Completed**	
14/03/2024	23-24/166	BAF	BAF to be updated to provide assurance in respect of highlighted pressures in AMH and PICU, and to comment on the overall level of assurance related to digital and cyber security	Co Sec MD DTVF MD NYYS Asst CEO	Apr-24	**Completed**	
11/01/24	23-24/136	Patient outcomes	Timescales to be provided for completion of current work to improve the reporting of patient outcomes.	EMD	Jul-24		Linked to board seminar session to be held on 11 July 2024
11/01/24	23-24/138	Charitable Funds	LR to consider how governance arrangements could reflect independent assurance provided by Non-Executive Directors	EDoFI&E	Apr-24	**See agenda item 33**	Discussing establishment of a new Charitables Committee formed from Audit & Risk Committee Non-Executive Director membership supplemented by other colleagues, e.g. potentially staff wellbeing council / Lived Experience with SRC and ARC chair / Trust secretariat. Propose might meet 6-monthly (for example for 30 minutes following ARC). Trust secretary considering alongside scheduling of 2024/25 Board and Committee Meetings
08/02/24	23-24/151	Our Journey to Change	Update on delivery of the Autism Adult Neurodevelopmental Service to be provided at the next meeting	MD DTVF (as action led by DTVF Care Group)	Mar-24	**see attached paper**	Mar24: Proposed for discussion in April 2024 - in order that a more meaningful report can be provided (delay in IIC waiters report due to migration to Cito) Apr24: report delayed to June 2024
14/03/24	23-24/174	Leadership & Management Academy	Council of Governors to be briefed on proposals, at a future meeting	EDfP&C	Jun-24	**Completed**	**Report provided to Council of Governors 3 June 2024**
11/04/24	**24-25/11**	**Corporate Risk Register**	**Committees to consider corporate risks that had remained static for 12 months and review target dates**	**Committee Chairs**			

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For General Release

Meeting of:	**Board of Directors**
Date:	**13th June 2024**
Title:	**Autism and ADHD waiting times**
Executive Sponsor(s):	**Patrick Scott, Managing Director DTVF & Deputy Chief Executive**
Author(s):	**Shaun Mayo, General Manager AMH Planned Care**

Report for:				
	Assurance	**x**	***Decision***	
	Consultation		***Information***	**x**

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	**X**
2: To co-create a great experience for our colleagues	**x**
3: To be a great partner	**x**

Executive Summary:

Purpose:

Provide a summary of the current autism and ADHD assessment waiting times in Durham Tees Valley & Forensics (DTVF) including a summary of ongoing work programmes to address the current waiting times issues.

Overview:

The regional and national picture for autism and ADHD diagnostic assessments is reflective of our position, with demand outstripping capacity leading to an increase in numbers of waiters and length of wait increasing year on year.

Despite a number of quality improvement initiatives made to both the autism and ADHD pathways, we are still seeing an increase in demand and an inability to address the current waiting list with current waits above 3 years for both autism and ADHD assessments.

Current waiters:

- ADHD – 3748
- Autism– 3302

The key challenges facing services include high caseloads, predominantly linked to autism and ADHD, with over 40% of the current caseload attributed to people awaiting autism and/or ADHD assessments. In order to address safety concerns in relation to effective waiting list monitoring the service has introduced a keeping in touch process to ensure any changes in need are identified and responded to.

In addition to this the service is also in the process of reviewing their waiting times dashboards, which require additional validation following the introduction of CITO.

Although the service has a number of significant challenges in relation to current waiting times for autism and ADHD assessment, we have over the last six months began three significant focus areas which include:

1. Following an improvement initiative in relation to the introduction of a whole team assessment process for ADHD, we have been able to demonstrate a significant improvement in waiting times in one of the pilot areas (Durham East and Durham West CMHT), with waiting times for ADHD assessments now at 56 days. However, the improvement initiative in our second pilot site (Middlesbrough) has not led to a notable reduction in waiting times. We are now in the process of investigating reasons for the variation in impact, prior to considering role out of this model. Initial indications are that the difference in impact has been linked to differing resources, staff availability and caseloads between the two teams.
2. When considering demand and capacity in relation to the completion of autism and ADHD assessments it has become apparent that in order to make any meaningful reductions in waiting times it is likely that we will have to consider prioritisation of assessments within our Neuro pathways. The service is currently in the process of undertaking an extensive review of our autism assessment model, which includes recommendation for DTVF Care Group and Integrated Care Board (ICB) – paper to be presented to June 2024 DTVF Care Group Board.
3. Development of a streamlined waiting list and keeping in touch monitoring process. Development event alongside information and performance colleagues planned for 5th June 2024.

Prior Consideration and Feedback N/A

Implications: Our current position demonstrates:

- Minimal level of assurance for the Care Group Board in relation to current waiting times.
- Moderate level of assurance in relation to ongoing management of safety risks via the keeping in touch process.

Recommendations: For information at this stage, with a further submission to be considered following autism assessment model review, which will be submitted to the DTVF Care Group Board in June 2024.

Chair's Report: 11th April – 13th June 2024.

Headlines:

External:

- Mental Health Annual Conference NHS Confederation
- North East North Cumbria & PWC Chair and Chief Executive meeting – finances
- Tour of Roseberry Park with Teesside University psychology lead
- Provider Collaborative Chair & Chief Executive meeting
- Stockton Council Social Care & Health portfolio and Director of Adult Services meeting
- Stockton Council Social Care & Health Scrutiny Committee meeting
- (Mini) Board to Board with Humber & North Yorks ICB
- Meeting with Carers Group
- Durham Central ICP quarterly meeting
- Teesside University : Installation of their new Chancellor.
- Regular catch-up with Cumbria, Northumberland, Tyne & Wear Chair
- Strategic discussion with Chair and Chief Executive of Humber Foundation Trust.

Council of Governors (CoG)

- Council of Governors June meeting
- Meeting Harrogate Governor

Internal

- Various Living The Values Awards (Polly Brewster / Carly Baker)
- Our Journey to Change Delivery Plan Conference
- Developing Communications Strategy for the next 12 months discussions
- Ridgeway Visit : 'Ridgeway Writes'
- Leadership Walkabouts : Teesside Crisis Team, and also Newtondale Ward
- Discussions over Humber & North Yorkshire 2024/25 financial plans
- Our developing Voluntary Sector Strategy
- Accounts Briefing & Board seminar on Programme Management etc
- Monthly catch-up with Director of Finance & Estates : 2024/5 likely NHS financial plan, and TEWV 2023/4 likely outturn
- Non-Executive Director (NED) appraisals
- NED recruitment
- Visit to Research & Development Team Flatts Lane

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 June 2024**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:

Assurance		***Decision***	
Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: The purpose of this report is to support discussions at the meeting by providing information on the risks included in the Board Assurance Framework (BAF).

Proposal: Board Members are asked to take the strategic risks, included in the BAF, into account during discussions at the meeting.

Overview: The BAF brings together all relevant information about risks to the delivery of the Trust's strategic goals.

A summary of the BAF is attached. It seeks to provide information on the strategic risks together with positive and negative assurances relating to key controls which have been identified since the last board meeting.

The board will recognise that it receives a number of reports to each meeting that are pertinent to the BAF risks, including:

- Integrated Performance Report
- Chief Executive's Report
- Board Committee Reports
- Monthly Finance Report (confidential)
- Reportable Issues Log (confidential)

Prior Consideration and Feedback	None relating to this report.
Implications:	None relating to this report.
Recommendations:	The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
1	✓	✓		**Safe Staffing** **There is a risk** that some teams are unable to safely and consistently staff their services **caused by** factors affecting both number and skill profile of the team. **This could result** in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.	**DoP&C**	**PCDC**	**High 20** (C5 xL4)	**Moderate 10** (C5 x L2) **Q3, 25/26**	**Q1, 25/26** Workforce plans in place for all services (-1L)	**Good**	Knowing which staff we need and where	▪ Daily operational processes in care groups ▪ Monthly e-roster reviews re fill rates etc ▪ Safe staffing reports re shifts over 13 hours, missing RN, missed breaks	**Positive** **IPR:** Staff in post with a current appraisal (metric 21) - *improved performance and controls assurance* **PCDC:** ▪ Good assurance, from deep dives, on the decision making relating to the changes in risk scores and mitigating actions being taken ▪ Good assurance that the BAF risk "safe staffing" is being managed effectively ▪ Good assurance that a robust process is being followed for running the staff networks for colleagues from protected groups ▪ Good assurance that the right actions are being taken to maintain the Trust's apprenticeship workforce ▪ The TEWV Leadership and Management Academy was launched in May **F2SUG**: Good assurance that this control is operating effectively **Negative** **PCDC:** Emerging risk about violence and aggression towards staff, the severity, and numbers of incidents.	**Public Agenda Item 10 –** Integrated Performance Report **Public Agenda Item 11 –** OJTC Delivery Plan **Public Agenda Item 13 –** People, Culture & Diversity Committee Report **Public Agenda Item 14 -** Annual Report by Interim Guardian of Safe Working **Public Agenda Item 15 –** Freedom to Speak up Guardian Report
											Ensuring that staff are recruited to and safely deployed to the right places	▪ Rosters for inpatient services ▪ Daily management huddles/ staffing calls ▪ Daily safety huddles on wards		
											Staff are appropriately trained to support people using our services	▪ Daily safety huddles on wards ▪ Increasing number of development JDs in place to ensure people are safely developed into more senior roles ▪ Individual and manager compliance reports available weekly		
											Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here.	▪ Quarterly reviews and annual appraisals support staff ▪ Supervision – managerial and clinical ▪ OH provision ▪ Multiple H&W interventions including comprehensive support and psychological services – all with outcome measures		
											Ensuring that local leaders and managers are equipped to lead and maintain safe staffing	▪ Recruitment processes inc LE panel members ▪ 3 year leadership programme and quarterly leadership events for service management level and above		
											Early understanding of when things go wrong	▪ Operational escalation processes ▪ Links from services to ePCD increasingly strengthening ▪ Thinking about leaving interviews ▪ 'Working in TEWV' monthly online meetings		
2	✓			**Demand** **There is a risk** that people will experience unacceptable waits to access services in the community and for an inpatient bed **caused by** increasing demand for	**Mng Dir**	**QuAC**	**High 16** (C4 xL4)	**Moderate 12** (C4 xL3) **31/3/24**	**31/3/24** (-1L)	**Good**	Partnership Arrangements	▪ Weekly operational interface meetings with Local Authority partners to support flow within inpatient services	**Positive** **IPR:** Inappropriate OAP bed days for adults that are 'external' to the	**Public Agenda Item 10 –** Integrated Performance Report
											Demand Modelling	▪ Associate Director of Strategic Planning and Programmes – Lead		

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	1	2	3											
				services, commissioning issues and a lack of flow through services **resulting in** a poor experience and potential avoidable harm.								for demand modelling in the Trust	sending provider (metric 9) - *improved performance and controls assurance* **Negative -**	
											Operational Escalation Arrangements	▪ Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls ▪ Bed Management Team – Responsible for the oversight and management of the use of beds ▪ On-call arrangements – Agreement of actions in response escalation ▪ Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand ▪ Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services		
											Integrated Performance Reporting	▪ Operational delivery of performance standards by wards and teams ▪ Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure		
											Establishment Reviews	▪ Safe Nursing Workforce Staffing Standards Team – Responsible for managing and delivering the establishment review process. This is based on: ▪ Acuity dependency assessments for each ward using the MHOST tool and professional judgements ▪ General Management reviews, including discussions with Matrons, on the ward assessments ▪ Assessments of a range of data including benchmarking, patient outcomes, staffing information e.g. use of temp staff and overtime ▪ Care Group Boards – Review the outcomes of the establishment reviews and development of proposals (included in the Establishment Review reports to the BoD) ▪ Finance Department – Reviews of affordability of the outcome of establishment reviews *(Reports to the FSB/EDG)*		
											Strengthen voice of Lived Experience	▪ Role of peer workers. ▪ Expanding opportunities of lived experience roles, including lived experience facilitators and senior lived experience roles/peers ▪ Service level service user and carer user groups ▪ Triangle of care ▪ Patient Experience reporting ▪ Understanding our complaints themes and impact on services ▪ Patient Safety Partners - PSIRF ▪ Partnership with clinicals networks – cocreation of clinical care initiatives and models ▪ Commissioning VCS lived in core services to meet identified needs		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
3	✓			**Co-creation** **There is a risk** that if we do not fully embed co-creation **caused by** issues related to structure, time, approaches to co-creation and power **resulting in** fragmented approaches to involvement and a missed opportunity to fully achieve OJTC	**DoCAI**	**QuAC**	**Moderate 12** (C4xL3) ↓	**Low 4** (C4 x L1) **Q2/Q3 2024/25** ↓	**Q2/Q3 2024/25** ▪ Co-creation Framework: final chapters to completed and rolled out trust-wide (-1L) ▪ Review to provide assurance on patient experience data (-1L)	**Good**	Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers	-	**Public Agenda Item 11 –** OJTC Delivery Plan
											Friends and Family / Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)		
											Complaints Policy	▪ Chief Executive – Overall accountability for ensuring that the Complaints Policy meets the statutory requirements ▪ Director of Corporate Affairs and Involvement – Responsible for the development, implementation and monitoring of the complaints policy ▪ Head of Patient Experience - Responsible for facilitating the effective reporting, investigation, and communication of all complaint activity ▪ Complaints Team Manager – Responsible for managing the complaints' function including the central database for complaints and producing statistical data ▪ Trust Organisational Learning Group – triangulation between all sources of intelligence to identify and act on service improvements. ▪ General Managers/Service Managers ▪ Ward/Team Managers/Modern Matrons ▪ Complaints Team		
4	✓	✓	✓	**Quality of Care** **There is a risk** that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; **caused** by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions **resulting** in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.	**CN**	**QuAC**	**High 16** (C4 x L4)	**Moderate 9** (C3 x L3) **1/4/25**	A number of actions will cumulatively achieve target score: ▪ Achieve safer staffing across all services – to within tolerable levels (1/4/25) ▪ Reduce occupancy on inpatient wards to 85% (TBC) ▪ Complete inpatient safety estates works	**Good**	Friends and Family/Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)	**Positive** **IPR:** ▪ Inpatients reporting that they feel safe whilst in our care (metric 3) - *improved performance assurance* ▪ Adults and Older Persons showing measurable improvement following treatment - clinician reported (metric 6) -	**Public Agenda Item 10 –** Integrated Performance Report **Public Agenda Item 11 –** OJTC Delivery Plan **Public Agenda Item 16 –** Quality Assurance Committee Reports
											Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3						(1/4/25) ▪ Transform community services and reduce waits for services (TBC) ▪ Achieve a minimum of 85% compliance across all services with mandatory training, supervision and appraisal (TBC) ▪ Demonstrate robust floor to board quality governance (1/9/25)			(OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers	*improved controls assurance* ▪ Compliance with ALL mandatory and statutory training (metric 20) - *improved performance assurance* **QuAC (June)PR:** ▪ Good assurance from manual data to indicate reduction in restrictive interventions in ALD ▪ Good level of assurance on progress made in adult learning disabilities (DTVF) ▪ Good assurance for rating of 'about the same' from the Community Mental Health Survey 2023 when compared to 53 other mental health trusts in England ▪ Good assurance on work undertaken to develop 'Carers Trust Triangle of Care' over the last 12 months. ▪ Good assurance on progress with medicines optimisation **Negative -**	
											Our Quality and Safety Strategic Journey	▪ Chief Nurse – Responsible for the development of Our Quality and Safety Journey ▪ Workstreams and key performance indicators have been developed for each of the Journey's four priorities ▪ The professional structure with the care groups have day to day oversight of the quality and safety of care ▪ Integrated Performance Dashboard is utilised to identify variance in care delivery ▪ Learning from serious incidents and near misses		
											Incident management policies and procedures	▪ Chief Nurse ▪ Responsible for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place ▪ Clinical and operational Managers medical Staff, modern matrons responsible for the operational implementation of the policy and associated guidelines. ▪ MDT in teams ensure effective after action reviews.		
											Governance arrangements at corporate, directorate and specialty levels	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolios including: ▪ ERQ (CN) – Responsibilities include oversight of Serious Untoward Incident/Never Event management processes and receive lessons learnt for sharing across the Trust as appropriate ▪ CGBs (Mgt Dirs) – Responsibilities include Oversight of the day to day management of an effective system of integrated governance, risk management and internal control across the whole Care Group's activities		
											Performance Management of Serious Incident Review	▪ Patient Safety Team - ▪ Responsible for ensuring all reportable serious incidents are reviewed within the agreed timescales following an internal governance process ▪ Daily patient safety huddles to review incidents of moderate harm and above to identify areas of immediate action and learning and support timely dissemination of information to mitigate risks ▪ Implementation of PSIRF Jan 24		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								Organisational Learning Group	▪ PSIRF Policy ▪ PSIRF Implementation plan		
5	✓	✓	✓	**Digital** **There is a risk that** failure to implement appropriate, cost effective and innovative approaches to digital infrastructure, **caused by** lack of resources, infrastructure challenges and digital expertise **resulting in** limited delivery of OJTC goals today and for the future.	**ACE**	**SRC**	-	-	-	-	-	-	-	**Public Agenda Item 11 –** OJTC Delivery Plan
6	✓	✓	✓	**Estate / Physical Infrastructure** **There is a risk** of delayed or reduced essential investment **caused by** constrained capital resources **resulting in** an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.	**DoFE**	**SRC**	**Medium 12** **(C4 x L3)**	**Low 6** **(C3 x L2)** **2028/29**	**2028/29** Estates Master Plan delivery achieves proposed rationalisation of estate to reduce call for capital and revenue funding on non-core assets (-1C & -1L) *(Note: Two other actions have been identified which may reduce or increase likelihood score but this will not be clear until the outcomes are known:* ▪ *NENC ICB CDEL funding methodology – March 2025* ▪ *Confirmation of national capital allocations - 2025/26 to 2027/28)*	**Good**	NENC Infrastructure board	▪ Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC meetings	-	**Public Agenda Item 11 –** OJTC Delivery Plan
											Estates Master Plan	▪ EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework ▪ Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval		
											CIG & CPSG	▪ Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements		
											Estates, Facilities & Capital Directorate Management Team Meeting	▪ All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital		
											ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring 🡻	▪ EFM Directorate responsible for: ▪ **PLACE** ▪ Organising (with CA&I) the PLACE assessment visits ▪ Compiling the information ▪ Submission of the information to NHSE ▪ Preparation of the Action Plan ▪ **ERIC** Compiling and submitting ERIC submission to NHSE ▪ **PAM** Self-assessment against the questions included in the PAM and on the delivery of resultant action plans, processes in train to ensure timely submission		
											Green Plan submission and monitoring	▪ EFM Directorate responsible for compiling and submitting Green Plan submission to NHSE / ensuring progress to deliver milestones		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
											Environmental Risk Group	▪ Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs ▪ Directors of Operations / Operational teams support identification of environmental issues ▪ Service desk tracks levels of maintenance issues		
7	✓	✓	✓	**Cyber Security** **There is a risk** of a successful cyber-attack or breach, **caused by** global threats, digital and data security and literacy, **resulting in** compromised patient safety, business continuity, systems and information integrity and loss of confidence in the organisation.	**ACE**	**SRC**	-	-	-	-	-	▪	-	-
8	✓	✓	✓	**Quality Governance** **There is a risk** that our floor to Board quality governance does not provide thorough insights into quality risks **caused by** the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information **resulting in** inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	**CN**	**QuAC**	**Moderate 12** (C4 x L3)	**Moderate 9** (C3 x L3) **01/01/25**	A number of actions will cumulatively achieve target score: ▪ Implement the Quality Dashboard ▪ Embed the Executive Review of Quality and supporting forums as an enabler to identifying and managing risks to quality of care ▪ Develop the role of the Associate Director of Nursing and Quality to increase curiosity into the Fundamental Standards of Care ▪ Review and relaunch the Quality and Safety priorities	**Good**	Open and transparent culture working to organisational values steered by Our Journey to Change	▪ Cohesive Board ▪ Engaged and visible Executive ▪ High Quality Care Group Directors ▪ Substantive recruitment of service leadership and clinical teams	**Positive** **QuAC (May):** ▪ Good assurance on the evidence of recent reductions in the number of incidents that have needed to be escalated to a full patient safety incident investigation (PSII) ▪ Good assurance demonstrated on progress with the Quality Assurance and Improvement Programme and NICE implementation ▪ Good assurance evidenced from the annual requirement to assess all emergency	**Public Agenda Item 10 –** Integrated Performance Report **Public Agenda Item 11 –** OJTC Delivery Plan **Public Agenda Item 16 –** Quality Assurance Committee Reports **Public Agenda Item 17 –** Learning From Deaths Report **Confidential Agenda Item 29 –** Audit and Risk Committee Report
											Executive and Operational Organisational Leadership and Governance Structure	▪ Chief Executive – Responsible for the Operational Leadership and Governance Structure ▪ Executive Directors – Responsible for the delivery of key elements of the Leadership and Governance Structure within their portfolios ▪ Co Sec – Responsible for the provision of secretariat services within the governance structure ▪ Care group clinical leaders responsible for the oversight of care delivery		
											Quality Management System	▪ The QI team is well established and embedded into services. ▪ There is an operational, clinical and professional leadership structure. ▪ There are Improvement plans for incidents, complaints and inspections. ▪ The IPD tracks performance monthly. ▪ The Care Group Board oversees delivery of services.		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3						within Our Journey to Change ▪ TEWV Leadership Academy will help all leaders enact their role to safeguard and improve quality		Oversight / Insight / Foresight	▪ Performance team are responsible for measuring and reporting performance ▪ Chief Nurse leads the nursing and quality directorate who have responsibility to measure and report out on - patient safety - quality governance -audit - infection, prevention and control - safeguarding - risk -Use of Force ▪ Chief Nurse lead the executive review of quality reporting to QuAC ▪ Medical Director leads on a number of patient safety priorities including Mortality review and Sexual Safety ▪ Care groups have dedicated clinical leaders at director delivery levels with a role to assess delivery of care standards	equipment against the Trust Resuscitation policy ▪ Good assurance that the Trust is meeting its obligations under law to produce and publish the Patient Publication of Information for 2024 ▪ Good assurance on reporting and learning from deaths. ▪ Good assurance on the progress to develop a Trust strategy for physical health care ▪ Good assurance on the process in place for oversight of suicide prevention assessments (identification of environmental ligature anchor point risks) ▪ Good assurance on the process through daily huddles to review any incidents of moderate harm and the after-action reviews **Learning from deaths:** Good assurance of reporting and learning in line with national guidance **ARC Report:** Substantial assurance linked to progress with the Quality Assurance & Improvement Programme **QuAC (June):** Good assurance on progress with recommendations following four independent investigations undertaken by NICHE	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3										**Negative** **QuAC (May):** ▪ Reasonable assurance for the final CQUIN position ▪ Limited assurance about the historical management of medical device assets, however there is now a system and process in place and specialist skill has been appointed to ensure we have robust management in place **QuAC (June):** Reasonable assurance on progress with implementation of Duty of Candour and ongoing implementation of actions	
9			✓	**Partnerships and System Working** **There is a risk that** failure to take a proactive role and engage effectively with partners **caused by** capacity challenges including spanning 2 ICSs and multiple local authorities **limits** our ability to influence service transformation and improve the health of the communities we serve.	**ACE**	**SRC**	**Moderate 12** (C4 x L3)	**Low 6** (C3 x L2) **Q3 – 31st September 2024**	-	**Good**	Membership of Partnership boards, provider collaboratives and Commissioning Groups in both ICB	▪ Care Group Board members and Associate Directors within ACE team all core members	-	-
											Place-based commissioning and partnership leads working for TEWV	▪ Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures ▪ Joint work / operational processes with local authorities and other partners including PCNs ▪ Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future		
											Supporting North East and North Cumbria Mental Health and Learning Disabilities Specialised Services Partnership	▪ Operational service leads from DTVF Care Group are members of the different groups in the Partnership		
											Placing AD Strategy into NENC ICB MHLDA Transformation Team	▪ AD Strategic Planning and Programs placed into NENC ICB MHLDA Transformation Team for one day per week. Asked to lead on Inpatient Quality Transformation (including bed census)		
											Attending HNY ICB Operations Group	▪ AD Strategic Planning and Programs and Finance Business Partner attend		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
10			✓	**Regulatory compliance** **There is a risk** that failure to comply with our regulatory duties and obligations, at all times, could **result** in enforcement action and financial penalties and damage our reputation	**CEO**	**Board**	**Moderate 12** (C4 x L3)	**Moderate 8** (C4 x L2) **31/03/25**	**31/3/25** Delivery of CQC Improvement Plan (-1L)	**Good**	Statutory Reporting	▪ Reporting requirements and timetables developed by the Company Secretary ▪ Information provided by designated leads ▪ Reports produced by Corporate Affairs and Communications based on submissions received. ▪ Annual Accounts timetable drafted by Head of Accounting and Governance ▪ Annual Accounts (and related TAC submissions) undertaken by the Finance Staff ▪ Head of Financial Accounting and Governance considers and coordinates annual training needs for annual accounts team ▪ Accounting ledger and accounts payable entries reviewed including to ensure accurate coding to support reporting as well as VAT recovery	**Positive** **QuAC (May):** ▪ Good assurance on the timeline for stakeholder consultation, internal review, approval and publication of the Quality Account **MHLC:** ▪ Good assurance regarding the oversight of CQC MHA monitoring inspection activity and completion of actions ▪ Substantial assurance that the number of times detained patients are discharged by the tribunal or hospital mangers is within normal range ▪ Good assurance that the legislative requirements for patients held in the Trust on a s136 are being met in all areas ▪ Substantial assurance that there is a robust escalation process in place for any patients who have not had their rights within three days of detention **ARC:** ▪ Good assurance with Counter Fraud progress ▪ Substantial assurance with the accuracy, completeness and compliance of the Trust's accounts being prepared in line with accounting standards and accuracy to reflect the year's transactions	**Public Agenda Item 10 –** Integrated Performance Report **Public Agenda Item 16 –** Quality Assurance Committee Reports **Public Agenda Item 18** – Mental Health Legislation Committee Report **Confidential Agenda Item 29 –** Audit and Risk Committee Report
											Provider Licence	▪ Board certification processes undertaken by the Company Secretary ▪ Delivery of related by policies by operational and corporate departments ▪ Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec ▪ Delivery of improvement plans by designated leads		
											Environmental Sustainability	▪ The Estates, Facilities and Capital Team are maintaining day to day BAU ▪ Estates & Facilities DMT maintain routine operational oversight		
											Statutory Financial Duties	▪ Processes overseen by the Head of Financial Management including annual budget holder sign off of budgets / establishments following agreement of annual budget setting processes ▪ Annual budget prepared by DoFEF ▪ Monthly financial reports and refreshed forecast outturn positions prepared by Finance Department to support agreement with Care Groups / Directorates and returns for submission to NHSE ▪ Budget holder management of individual budgets ▪ Accountability Framework sets out responsibilities for financial management		
											Compliance with the CQCs Fundamental Standards of Quality and Safety	▪ Day to day delivery of the fundamental standards by ward and team staff ▪ Responsibility for delivery of each element of the CQC Action Plan designated to lead Directors ▪ Chief Nurse is the lead Executive for relationship management with the CQC		
											Compliance with Mental Health Legislation (MHL)	▪ Delivery of the requirements of MHL by ward and team staff		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								Equality, Diversity, Inclusion and Human Rights	▪ The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery ▪ EDIHR Lead and officers: ▪ Provision of support for inclusion networks ▪ Compilation of Equality Act 2010 data ▪ Compilation of evidence and consultation on the EDS ▪ Support for the development of the Trust's equality objectives ▪ Designated managers/leads: ▪ Completion of equality analyses ▪ Delivery of actions under the EDS ▪ All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision ▪ Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities	**SRC:** Good assurance in respect of the risk management processes that are in place **Negative** **IPR:** ▪ Uses of the Mental Health Act (metric 15) - reduced performance assurance **MHLC:** ▪ Reasonable assurance on the implementation of the Positive and Safe Improvement Plan ▪ Reasonable assurance that the Trust is meeting its requirements under the Mental Capacity Act ▪ Reasonable assurance that the use and reporting of DoLS is being carried out as required **ARC**: ▪ Significant improvement progress to update Board Assurance Framework risk profiles, links with the corporate risk register and controls and mitigations and demonstrate reasonable assurance. ▪ Reasonable assurance was evidenced on the operation and controls relating to the registration of conflicts of interest **PDCD**: A request for a review of the level of assurance provided in the Corporate Risk register (CRR) is still ongoing with limited	
											Risk Management Arrangements	▪ Care Group Managing Directors, General Management Tier and Service Management Tier – ▪ Consider capture and maintain risks raised by staff in local risk registers ▪ Develop and implement action plans to ensure risks identified are appropriately treated ▪ Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the risks within their work environment ▪ Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate ▪ Head of Risk Management – Day to day management of the Trust Risk Register		
											Health Safety and Security (HSS)	▪ The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts ▪ Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR) ▪ Provision of HSS information for new employees at Trust induction. ▪ HSS awareness training forming part of all staff mandatory package. ▪ HSS online tool kit available for all services, wards and departments across the trust. ▪ Regular workplace audits undertaken by the HSS team. ▪ Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any		

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
												remedial actions	assurance	
											Executive and Care Group Leadership, management and governance arrangements	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolio ▪ Individual staff compliance with the range of policies relating to regulatory compliance e.g. health and safety		
											Inquests and Coroners	▪ Inquest Team - Management of the Inquest process from a Trust perspective including: ▪ Arranging and compiling witness statements and submission to Coroner ▪ Instruction of Solicitors ▪ Co-ordination and compilation of information ▪ Provision of support for staff ▪ Preparation of responses to Regulation 28 Reports by staff nominated by the CEO		
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park and impacted by limited access to capital funding **could adversely affect** our service quality, safety, financial, and regulatory standing.	**DoFE**	**Board**	**High 16 (C4xL4)** ↓	**Moderate (12) (-1L)**	Two actions have been identified to support achievement of the risk score; however, delivery dates are uncertain: ▪ Roseberry Park Rectification Works complete ▪ Medium Term NHS and ICB Capital allocations confirmed nationally	**Good**	Roseberry Park Rectification Programme	▪ Programme Director and Programme Manager – Responsible for managing the RPRP including key risks and issues log (Assurance to weekly huddle)	-	
											Capital Programme	▪ Trust CPSG overseeing agreement of priorities for capital investment / impact assessment ▪ DMT overseeing detailed milestone capital project planning ▪ NENC Infrastructure Board (ICS Estates & Finance Directors)		
											External Audit			
12	✓	✓	✓	**Financial Sustainability** **There is a risk that** constraints in real terms funding growth **caused by** government budget constraints and underlying financial pressures **could adversely impact** on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	**DoFE**	**SRC**	**High 20** (C5 x L4)	**High 20** (C5 x L4) **2028/29** ↑	**2028/29** A number of actions have been identified which might cumulatively reduce the risk score; however, the target score is being maintained at the present level given national and regional uncertainty	**Good**	ICB Financial Governance including Mental Health LDA Sub Committee and CEO and DoF financial planning groups and sub groups	▪ DoFE member of ICS DoF/CFO group ▪ DoFE member of ICS Resource Allocation Steering Group ▪ CEO member of NENC CEO provider collaborative group ▪ CEO leading HNY provider collaborative work for MHLDA ▪ COOs leading Provider collaborative work to assess implications for beds / pathways and clinical models	**Positive** **IPR:** Cash balances (actual compared to plan) (metric 30) - *improved performance and controls assurance* **Negative** **IPR:** Use of Resources Rating - overall score (metric 26) - *reduced controls assurance*	**Public Agenda Item 10 –** Integrated Performance Report **Confidential Agenda Item 29 –** Audit and Risk Committee Report **Confidential Agenda Item 30 –** Strategy and Resources Committee Report **Confidential Agenda Item 31 –** Finance Report
											Financial Sustainability Board	▪ Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position		
											Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	▪ ACE -Responsible for the delivery of the Business Planning Framework ▪ DoFE and ESRG – Responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers ▪ Managing Directors (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. *(Reporting into FSB and ESRG*		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
												into EDG with assurances into S&RC and Board)		
13	✓	✓	✓	**Public confidence** **There is a risk that** ongoing external scrutiny and adverse publicity **could lead to** low public and stakeholder perception and confidence in the services we provide	DoCAI	Board	**High 20** (C5 x L4)	**Moderate 10** (C5 x L2) **June 24**	**Q1 2024/25** (-2L) Refreshed trust-wide communications strategy	Reasonable	Communications Strategy	▪ Director of Corporate Affairs and Involvement ▪ Head of Communications ▪ Communications team	-	
											Stakeholder Communications and Engagement Strategy	▪ Trust Board ▪ Director of Corporate Affairs and Involvement ▪ Care Group Board Directors ▪ Head of communications ▪ Corporate Affairs and Stakeholder Engagement Lead ▪ Communications team		
											Social Media Policy	▪ Director of Corporate Affairs and Involvement – responsible for the development, implementation and monitoring of the social media policy ▪ Head of communications ▪ Comms team – responsible for ongoing monitoring of social media ▪ General Managers/Service Managers – ▪ Ward/Team Managers/Modern Matrons – as above ▪ Complaints team ▪ Patient experience team ▪ Clinical leaders ▪ Service managers ▪ People and Culture		

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 June 2024**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Brent Kilmurray**

Report for:				
	Assurance		***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***

Executive Summary:

Purpose:	A briefing to the Board of important topical issues that are of concern to the Chief Executive.
Proposal:	To receive and note the contents of this report.
Overview:	Pre-Election Guidance
Prior Consideration and Feedback	n/a
Implications:	No additional implications.
Recommendations:	The Board is invited to receive and note the contents of this report.

Pre-Election Guidance

As you are aware the Prime Minister has announced that there will be a general election on 4th July 2024. As a consequence, NHS England has issued pre-election guidance that provides advice on the key considerations for NHS organisations and their employees during this important period.

One of the important points of advice is that: “Board meetings should be confined to discussing matters that need a board decision or require board oversight. Matters of future strategy should be deferred”.

We have previously issued the full document to Board members for your advice and guidance.

Due to the guidance, I will leave my report at that and will provide some verbal updates.

Communications Dashboard

April-May 2024

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

These months we...

- Celebrated big wins at the Positive Practice in Mental Health Awards
- Raised awareness for Perinatal services in Durham and Tees Valley for Maternal Mental Health Week
- Provided training sessions over teams for Local Issue Resolution
- Searched for co-creation champions within TEWV
- Supported Mental Health Awareness Week and Equality, Diversity and Humans right week
- Connected our Crisis Service to NHS 111
- Launched our first ever TEWV 10k

Highlights

Our first running event, the TEWV 10k was a success, selling out with 500 participants

We secured five awards and several highly commended accolades at the Positive Practice in Mental Health Awards

The MELISSA Bus visited Darlington, with our Perinatal team raising awareness for Maternal Mental Health Week

Lee Obridge, a senior clinician, ran the Leeds Half Marathon for 'Recovery Runners' a charity to support those with alcohol addiction

Xani Bryne, a trainee clinical psychologist completed his second challenge for Tandem Against Suicide, with Brent Kilmurray

The Young Carers Team from Carers Plus Yorkshire visited our CAMHS service at Lake House for Young Carers Action Day

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

17
Media enquiries handled by the team

3
Media releases issued

124
Total pieces of coverage across online news, TV, and radio

News stories

- **New emergency number issued to get mental health help** - *Richmondshire Today*
- **Bereaved families call on Prime Minister for public inquiry into mental health trust -** *Northern Echo online*
- **TEWV NHS organises first trust 10K fundraiser race in York** - *The Press York (online)*
- **NHS trust fined £200,000 after teenage girl took her own life -** *Yahoo! News online*

Our website

121,269
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

2,535,850
page views

Top staff intranet news stories

1. Right Care Right Person
2. CBT recruit to train initiative expands access
3. Celebrating our wins at the Positive Practice in Mental Health awards
4. New mental health hub planned for North Yorkshire
5. TEWV 10k gets York running
6. ID badges and plans for improvement

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

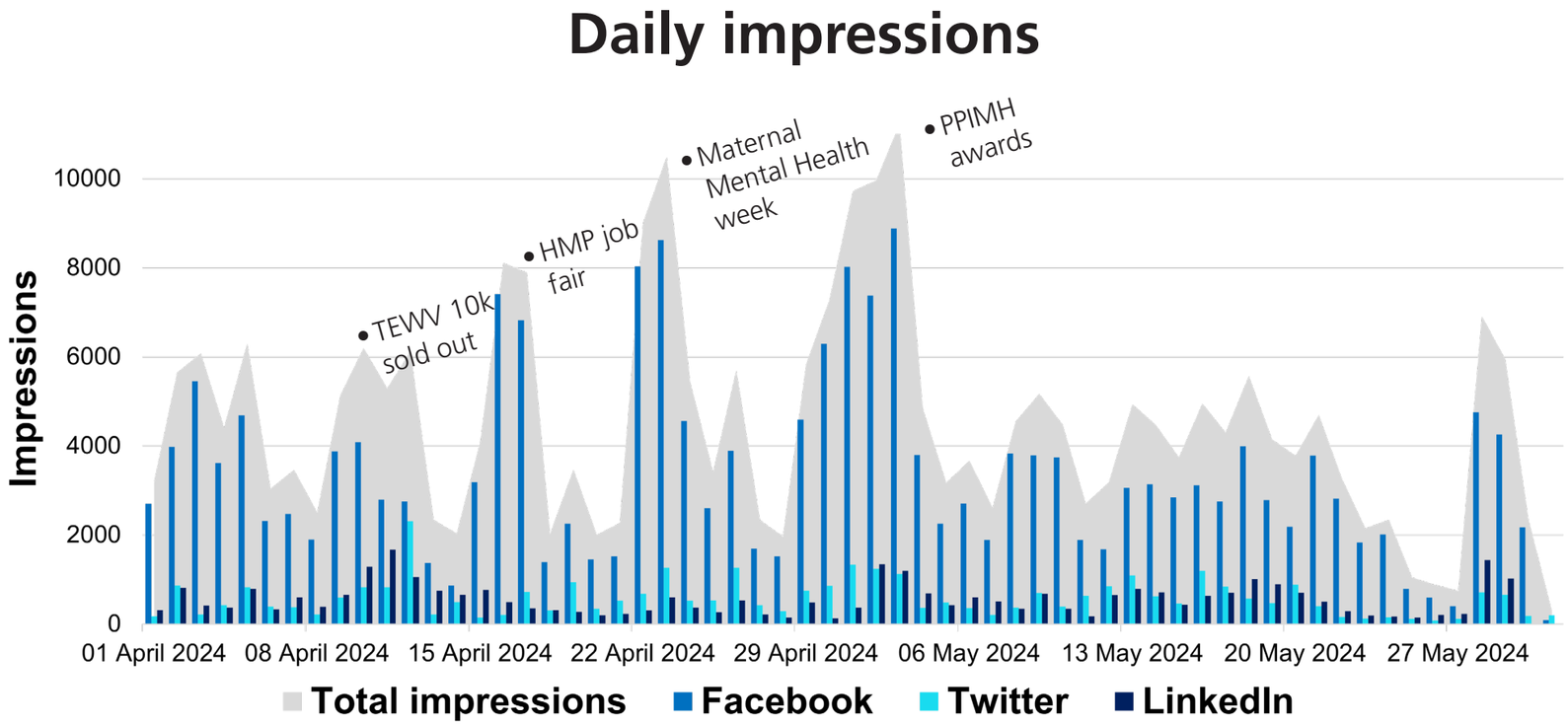
Our audience

26,710
Total followers

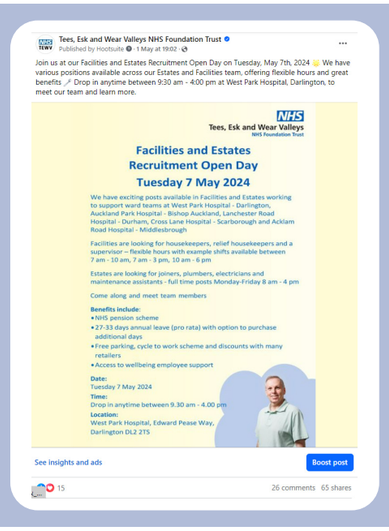
365
New followers

255,464
People who saw our content - impressions

20,651
Engagements



Top posts



Impressions 15,682 - Engagement 703

Impressions 1,495 - Engagement 46

Impressions 4,576 - Engagement 134

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13th June 2024**
Title:	**Board Integrated Performance Report as 30th April 2024**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Ashleigh Lyons, Head of Performance**

Report for:				
	Assurance	✓	***Decision***	
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1.	Safe Staffing	The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.
2.	Demand	
3.	Co-Creation	
4.	Quality of Care	
5.	Digital	
6.	Estates & Infrastructure	
7.	Cyber Security	
8.	Quality Governance	
9.	Partnerships & System Working	
10.	Regulatory Compliance	
11.	Roseberry Park	
12.	Financial Sustainability	
13.	Public Confidence	

Executive Summary:

Purpose: The Board Integrated Performance Report (IPR) aims to provide oversight of the quality of services being delivered and to provide assurance to the Board of Directors) on the actions being taken to improve performance in the required areas.

Proposal: It is proposed that the Board of Directors receives this report with **good** assurance regarding the oversight of the quality of services being delivered. There are three areas within the Integrated Performance Dashboard (IPD) with **limited performance assurance** and **negative controls assurance;** in addition, there are **several areas of concern** within the National Quality Standards/Mental Health Priorities. There are mitigations within each of the Headlines which summarise the improvement actions and the impact expected.

Overview: There are some key points to note in this month's IPR which are as follows:

- **CITO:** On the 5th February 2024, we went live with our new mental health and learning disability electronic patient record (CITO). We are now able to report the patient-based measures in our Integrated

Performance Reports (IPR); however, there are some data quality/timeliness issues, which is to be expected as staff learn the new system and adapt ways of working (these are noted against the relevant measures). We have identified issues relating to the recording of activity/contacts/referral sources and the duplication of referrals which are impacting some of our measures.

- **InPhase**: We are continuing to progress several actions to support improvement in the quality of the incident data recorded on InPhase. Whilst we know the incident data recorded in InPhase is accurately reported through IIC, there are areas where data quality can be improved not just as a result of the transfer to a new recording system, but also new processes and the increased visibility of historic issues.
- **Staff Survey:** We continue to validate some of the data following concerns over consistency. If we find anything pertinent following investigation the detail will be updated in next month's report.

The overall **good** level of assurance has been determined based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD), improved performance and/or controls assurance for 6 measures with the majority of our measures now reporting good performance assurance, and progress against the National Quality Standards/Mental Health Priorities.

There are "Headlines" for each of the sections: the Integrated Performance Dashboard (page 6) and the National Quality Standards/Mental Health Priorities (page 49). These headlines include mitigations which describe how we intend to improve performance, the impact of the actions and when we expected to see the impact. We are continuing to use the Performance Improvement Plans (PIPs) as a tool to support improvement; however, the improvement actions are within the IPR (where completed). The key changes for the IPD are shown in italics on page 12 within the Performance & Controls Assurance Overview.

The Integrated Performance Report (IPR) is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks (see page 48 alignment of measures to the Board Assurance Framework).

Prior Consideration and Feedback

The Integrated Performance Report was discussed by Executive Directors Group and the Care Group individual IPRs by the Care Group Boards in April 2024.

Implications:

There are no identified implications in relation to receipt of this report to the Board of Directors.

Recommendations:

The Board of Directors is asked to:

1. Note the information contained within the report.
2. Note the actions in place to manage any areas where performance is not where we would want it to be.
3. Confirm it is assured on the actions being taken to improve performance in the required areas.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 30th April 2024

Report produced by: Amy Walford, Performance Lead (Corporate) and Ashleigh Lyons, Head of Performance
Date the report was produced: 22/05/2024

For any queries on the content of this report please contact: Ashleigh Lyons, Head of Performance
Contact Details: ashleigh.lyons@nhs.net

journey to change

CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS Foundation Trust

Within our Board Integrated Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. SPC is an analytical tool that plots data over time; it helps understand variation in data and in doing so guides when and where it is appropriate to take action.

Variation: natural (common cause) or real change (special cause)?

Special Cause Improvement Low is good	We're aiming to have low performance and we're moving in the right direction.
Special Cause Improvement High is good	We're aiming to have high performance and we're moving in the right direction.
Common Cause – no significant change	No significant change in the data during the reporting period shown
Special Cause Concern Low is good	We're aiming to have low performance and we're moving in the wrong direction.
Special Cause Concern High is good	We're aiming to have high performance and we're moving in the wrong direction.
Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	We're currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.
Special cause variation of a decreasing nature where DOWN is not necessarily improving nor concerning.	We're currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.

Assurance: is the standard achievable?

Target Pass	We will consistently achieve the target/standard
Target Pass / Fail	Our performance is not consistent and we regularly achieve or miss the target/standard
Target Fail	We will consistently fail the target/standard

Please note assurance on whether the standard/plan is achievable is now included for a number of measures. Standards for the remaining ones will be progressed, where required.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

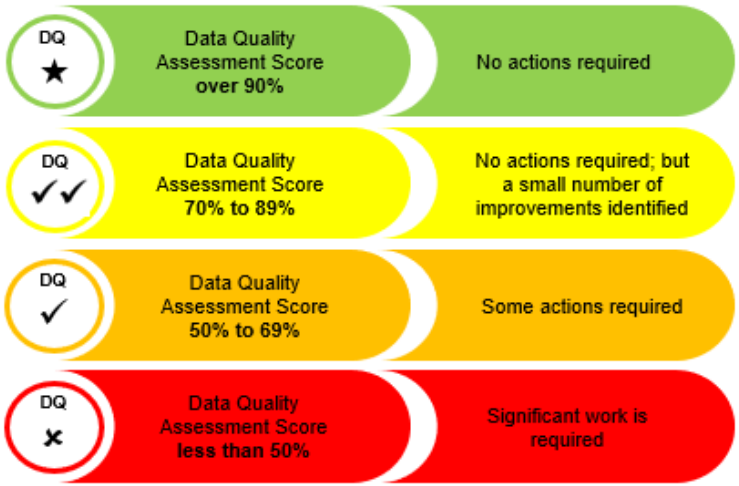
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit.

The last full assessment was completed during September 2023. We have now updated the assessment for the measures that were impacted following the transfer to InPhase in October 2024. The next bi-annual assessment will be completed in Quarter 1 2024/25 which will include all measures.

Note: The development of the local audit/assurance framework to support the assessment has been delayed due to capacity issues within Business Intelligence who have been supporting the implementation of CITO. This will now be completed in quarter 1 2024/25 with the first assessment of this element in quarter 2 2024/25.

Action Status
Our action status is informed by a combination of current performance, performance over time (including trends) and general intelligence.

When we interpret a Statistical Process Control chart we look at the current variation depicted within the chart, how our performance is compared to what we are trying to achieve, whether we have assurance that we will achieve the standard (if applicable) and whether our performance over time is improving.



Glossary of Terms

A&T	Assessment & Treatment
ADHD	Attention deficit hyperactivity disorder
AMH	Adult Mental Health
ASD	Autism Spectrum Disorder
BME	Black and Minority Ethnic
CED	Child Eating Disorders
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CYP	Children & Young People
CYPS	Children and Young People Services
DTOC	Delayed transfers of care
DTVFCG	Durham Tees Valley and Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
HNYICB	Humber & North Yorkshire Integrated Care Board
ICB	Integrated Care Board
IPD	Integrated Performance Dashboard
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NENC ICB	North East & North Cumbria Care Board
NYYSCG	North Yorkshire, York & Selby Care Group
Neuro	Neurodevelopmental services
OAP	Out of Area Placement
PIP	Performance Improvement Plan
PIpA	Purposeful Inpatient Admission
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
SMART	Specific, measurable, achievable, relevant, time-bound
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
UoRR	Use of Resources Rating
VoY	Vale of York

Board Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience:** no significant change in any of the measures; however, achieving standard in April for patients rating their experience as very good or good. There is also special cause improvement (an increase) in the number of carer responses.
- **Outcomes:** CYP special cause concern and below standard for the PROM; however, special cause improvement for the CROM although also below standard. AMH/MHSOP special cause concern and below standard for the PROM; however, no significant change and below standard for the CROM.
- **Bed Pressures:** no significant change in bed occupancy; however, special cause improvement visible for the inappropriate out of area bed days.
- **Patient Safety:** no significant change in any of the measures. There was one (1) unexpected Inpatient unnatural deaths reported on STEIS during April.
- **Uses of Mental Health Act** no significant change.
- **Staff** We have special cause improvement for leaver rate and appraisal, and no significant change for sickness and mandatory training. However, we are achieving standard in April for mandatory training.
- **Demand** no significant change in referrals however, special cause concern continues for caseload.
- **Finance** The Trust has submitted a breakeven plan for 24/25 and will report actuals against this to determine whether the final position is in line with expectations. At time of report, although agreed and signed off at Care Group level, the 2024/25 plan including detailed CRES targets had not been uploaded to the finance ledger. Work to achieve this is ongoing in line with the timeline set out by the Director of Finance to all budget holders in February. Performance against plan to the end of May will be reported in June.

Risks / Issues

Of most concern:
- Adults and Older Persons PROM
- Unique Caseload
- Agency price cap compliance

Of concern:
- Children and Young Persons PROM

Positive Assurance

Significant improvement seen in:
- Children and Young Persons CROM
- OAP bed days (inappropriate)
- Staff Leaver Rate
- Appraisals

Positive assurance for:
- Capital Expenditure (Capital Allocation)
- Cash balances (actual compared to plan)

Board Integrated Performance Dashboard Headlines

Mitigations

AMH/MHSOP PROM and CROM
DTVFCG have a PIP and the actions are for AMH services (specifically EIP and treatment & intervention teams) to focus greater discussion and challenge utilising the team and service level dashboards; for Older Persons services to add this measure to the team and service level governance dashboards, and for both Adult and Older Persons services clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It was anticipated that the impact of these improvement actions would be seen in May 2024 (April data) with a 5% increase in Adults and Older Persons showing measurable improvement, however these actions have not yet been completed. The Care Group have requested an extension to the PIP with a revised date of the end of June 2024. NYYSCG have a PIP for AMH services which focuses on completion rates within caseload supervision and monitoring of outcomes within service leadership huddles. It is anticipated that the impact of these improvement actions will be seen in June 2024 (May data) with a 5% increase in Adults. Within MHSOP a deep dive to understand the root cause and support the development of a PIP was completed in April 2024. This work was completed and identified that outcomes are not being collected routinely by medical staff. A meeting has been arranged to discuss proposed mitigating actions in June. Following discussion at EDG it has been agreed to focus efforts to ensure the agreed outcome measures are recorded at the start and end of the patient's journey and for services to review a sample of patients not achieving measurable improvement to understand the reason(s) why. It is anticipated we will see improved collection of outcome measures from August (July data).

Caseload
DTVFCG have a PIP and have identified several actions to address the backlog of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of quarter 1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues. It is anticipated this action will increase assessments and reduce 80% of referrals coming into intervention teams by June 2024. NYYSCG CYPS have identified two specific pieces of work that are required before being able to identify SMART actions, these actions will be completed by the end of June 2024, which will then inform their PIP. The Task & Finish Group within Corporate Services have shared a core data set with both Care Groups to support improved understanding of our caseload levels.

CYP PROM
Durham Tees Valley & Forensic Care Group revised their Performance Improvement Plan (PIP) as the original actions did not have the desired impact. They will now undertake a patient level deep dive into patients discharged with a paired outcome measure that are not demonstrating an improvement. This will be completed by the end of May 2024. The service will also focus efforts to ensure the agreed outcome measures are recorded at the start and end of the patient's journey and for services to review a sample of patients not achieving measurable improvement to understand the reason(s) why. It is anticipated we will see improved collection of outcome measures from August (July data). The measure will be revised to include Parent Rated outcomes and the new assessment tools by the end of June 2024 (visible in the July report).

Finance To support improved compliance, the Executive Workforce and Resources Group are overseeing a Performance Improvement Plan to ensure optimal rosters and the Trust is progressing a second phase of International Recruitment to aim to recruit a more sustainable medical and nursing workforce and reduce reliance on agency costs.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

Durham Tees Valley & Forensic Care Group IPD Headlines

Headlines

CITO: On the 5th February 2024, we went live with our new mental health and learning disability electronic patient record (CITO). We are aware there are some data quality/timeliness issues relating to the recording of activity/contacts/referral sources and the duplication of referrals that are impacting some of our measures, which is to be expected as staff learn the new system and adapt ways of working. Our Digital and Data colleagues are working with clinical services to support improvements in the quality of patient data recorded on CITO.

- **Patient and Carer Experience** no significant change with patient and carer experience
- **Inpatients Feeling Safe** no significant change and we see special cause improvement (an increase) in the number of responses . Discussions are ongoing in relation to a revised standard
- **CYP Outcomes** special cause concern in PROM, however, special cause improvement for CROM, but both remain below standard
- **AMH / MHSOP Outcomes** special cause concern for PROM but special cause improvement in CROM
- **Bed Pressures –**no significant change in bed occupancy or in the number of inappropriate out of area bed days.
- **Patient Safety / Incidents / Mental Health Act** no significant change across all measures
- **Staff.** For recommending the Trust as a place to work we achieved 48.83% and for staff feeling able to make improvements we achieved 53.91%; both of which are the lowest positions to date. Special cause Improvement in appraisal and no significant change in mandatory and statutory training or sickness however a downward trend in sickness is noticed.
- **Demand** no significant change in referrals; however special cause concern in caseload driven by AMH and CYPS.
- **Finance** The Care Group, expected to spend £21.7m in April, and actually spent £21.4m, which is £0.3m less than planned. The improvement is as a result of reduced levels of Independent sectors beds, this position is potentially subject to further allocation of £2m unidentified CRES

Risks / Issues*

Of most concern:
- AMH/MHSOP PROM
- Unique Caseload
- Financial Plan: Surplus/Deficit

Of concern:
- CYP PROM
- Agency price cap compliance
- Agency Spend

Positive Assurance

Significant improvement seen in:
- CYP CROM
- Staff Leaver Rate.
- Appraisal

Durham Tees Valley & Forensic Care Group IPD Headlines

Mitigations

CYPS Patient reported Outcome Measure We have a PIP and the actions were to add this measure to the team and service level governance dashboards and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It was anticipated that the impact of these improvement actions should be a 5% increase in CYP showing measurable improvement by April 2024 (March data); however, whilst the actions were completed, they have not had the desired impact. A new action has been identified for the General Manager to undertake a patient level deep dive into patients discharged with a paired outcome measure that are not demonstrating an improvement. This will be completed by the end of May 2024. In addition, Management Group have approved the updates to the measure to include Parent Rated outcomes and the new assessment tools. This will be actioned by the Business Intelligence Team post CITO.

AMH/MHSOP Patient reported Outcome Measure and Clinician Reported Outcome Measure
A PIP is in place and the actions are for Adult services (specifically EIP and Treatment and intervention teams) to focus greater discussion and challenge utilising the team and service level dashboards; for Older Persons services to add this measure to the team and service level governance dashboards and for both Adult and Older Persons services clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It was anticipated that the impact of these improvement actions should be seen in May 2024 (April Data) with a 5% increase in Adults and Older Persons showing measurable improvement. Whilst these actions have not been completed some improvements have been seen and some additional actions have been added by AMH inorder to improve numbers of timely paired outcomes. These will be monitored over the coming months.

Inappropriate Out of Area Placements
A PIP is in place and the remaining actions are to review the discharge policy in line with best practice, this was due to be implement by end of April 2024 but has been delayed in order for some Quality Improvement events to take place to support this work. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days. To identify patients that are clinically ready for discharge and offer support to address the barriers; to ensure standard approach is taken across Local Authority Meetings to address delays; to identify patients they require additional support from senior leadership team and arrange stop the line meeting; and to review/update Stop the line processes and share with clinical teams. It is anticipated that the impact of these actions has been seen with a 50% reduction in the number of patients clinically ready for discharge (reduced to 14 at end of March) .

Caseload
A PIP is in place with several actions to address the back log of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of Q1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues.

Finance
24/25 Financial Planning, budget setting and contracting has commenced and will be ongoing to identify pressures and priority areas, which will be updated and reviewed now the planning guidance has been issued.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Headlines

- **CITO:** On the 5th February 2024, we went live with our new mental health and learning disability electronic patient record (CITO). We are aware there are some data quality/timeliness issues relating to the recording of activity/contacts/referral sources and the duplication of referrals that are impacting some of our measures, which is to be expected as staff learn the new system and adapt ways of working. Our Digital and Data colleagues are working with clinical services to support improvements in the quality of patient data recorded on CITO.
- **Patient and Carer Experience** no significant change, however ALD are reporting special cause concern low and CYP are reporting special cause improvement. There is no significant change in the number of carer responses.
- **Inpatients Feeling Safe** no significant change and in the number of responses to this measure.
- **Outcomes:** CYP PROM are reporting special cause improvement, CYP CROM are reporting no significant change AMH/MHSOP PROM are reporting no significant change, AMH/MHSOP CROM are reporting special cause concern

  Bed Pressures special cause improvement in Care Group and MHSOP for bed occupancy and below the mean; inappropriate out of area beds days continues to report special cause improvement
- **Patient Safety / Incidents** no significant change across all measures
- **Uses of MHA:** no significant change
- **Staff:** For recommending the Trust as a place to work we achieved 48.61% and for staff feeling able to make improvements we achieved 57.64. **Staff leaver** is special cause improvement. **Sickness** no significant change and continues to improve**, Mandatory Training** no significant change however and is improving. **Appraisals** has changed from special cause concern to no significant change.
- **Demand** no significant change in referrals however, special cause concern continues for caseload
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:
- Adults and Older Persons Clinician reported Outcome Measure
- Unique Caseload
- Financial Plan: Agency expenditure

Of concern:
- Financial Plan: Surplus/Deficit
- Agency price cap compliance

Positive Assurance

Improvement seen in:
- Children and Young Persons Patient Reported Outcome Measures
- Bed occupancy
- Inappropriate OAP
- Number of unexpected inpatient unnatural deaths reported on STEIS
- Staff Leaver Rate

Mitigations

AMH/MHSOP PROM and CROM
AMH Services has a PIP in place which focuses on the completion rates within caseload supervision and monitoring outcomes within the service leadership huddles. It is anticipated that the impact of these improvement actions will be seen in June 2024 with a 5% increase.
MHSOP has undertaken their deep dive and is now working with the Head of Research and Statistics to review their data in greater detail. Agreed actions are to ensure staff complete the agreed outcome measures at the start and the end of the patient's journey to ensure they are timely and paired with a timescale of 31st August 2024, but it must be noted that this will not show improvement in the denominator until September 2024.
To review a sample of patients who are not achieving measurable improvement to understand the reasons why which will allow for specific issues to be identified and align new actions with a timescale of 31st August 2024.

Unique Caseload
CYP have identified two specific pieces of work that are required before being able to identify SMART actions, these actions will be completed by the end of June 2024, which will then inform their PIP.

Finance
Improved performance relative to control totals set in year to support financial recovery provide increased assurance that the Trust will deliver our 2023/24 breakeven plan, based on a mid-case scenario. A small number of external factors have potential to impact the financial outturn however these are currently projected as being manageable within the overall position.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

Performance & Controls Assurance Overview

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive		• CYP showing measurable improvement following treatment - clinician reported • Inappropriate OAP bed days for adults that are 'external' to the sending provider ***improved performance and controls assurance*** • Staff Leaver Rate • Staff in post with a current appraisal ***improved performance and controls assurance*** • Capital Expenditure (Capital Allocation) • Cash balances (actual compared to plan) ***improved performance and controls assurance***		
Neutral		• Patients surveyed reporting their recent experience as very good or good • Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for • Inpatients reporting that they feel safe whilst in our care ***improved performance assurance*** • PSII reported on STEIS • Incidents of moderate or severe harm • Medication Errors with a severity of moderate harm and above • Compliance with ALL mandatory and statutory training ***improved performance assurance*** • New unique patients referred	• Adults and Older Persons showing measurable improvement following treatment - clinician reported ***improved controls assurance*** • Bed Occupancy (AMH & MHSOP A & T Wards) • Restrictive Intervention Incidents Used • Unexpected Inpatient unnatural deaths reported on STEIS • Uses of the Mental Health Act ***reduced performance assurance*** • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work • Percentage Sickness Absence Rate	
Negative		• Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Financial Plan: Agency expenditure compared to agency target • Use of Resources Rating - overall score ***reduced controls assurance***	• CYP showing measurable improvement following treatment - patient reported	• Adults and Older Persons showing measurable improvement following treatment - patient reported • Unique Caseload • Agency price cap compliance

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	92.44%	92.00%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC		?	75.00%	73.85%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	80.12%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	23.47%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	43.15%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	48.60%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC		F	30.00%	20.02%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				99.15%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			478	
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				4	
11)	The number of Incidents of moderate or severe harm	QAC				66	
12)	The number of Restrictive Interventions Used	QAC				1,061	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				1	
15)	The number of uses of the Mental Health Act	MHLC				345	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				54.80% (Jan - 2024)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				60.05% (Jan - 2024)	
18)	Staff Leaver Rate	PC&D	L			11.32%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	5.73%	5.50%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	87.33%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	F	85.00%	84.87%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				7,675	
23)	Unique Caseload (snapshot)	S&RC	H			66,999	

Rep Ref	Our Financial and activity measures	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - Surplus/Deficit	293,000	353,345
25a)	Financial Plan: Agency expenditure compared to agency target	1,091,000	918,194
25b)	Agency price cap compliance	100%	62.78%
26)	Use of Resources Rating - overall score	2	2
29)	Capital Expenditure (CDEL)	318	630,910
30)	Cash balances (actual compared to plan)	56,642	59,506,401

Note: The Trust does not report on CRES achievement in month 1; therefore. the data for CRES Performance – Recurrent and Non-recurrent is not provided.

01) Percentage of Patients surveyed reporting their recent experience as very good or good

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / Standard description:
We are aiming for 92% of patients surveyed, reporting their recent experience as very good or good

What does the chart show/context:
During April **833** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **770 (92.44%)** scored "very good" or "good".

There is no significant change at Trust in the reporting period and whilst we are also showing no significant change in the number of patients who have responded to this question, a decreasing position is seen. There is no significant change at Care Group level; however, special cause concern is seen for ALD within North Yorkshire, York & Selby Care Group. To note, special cause improvement is seen for Secure Inpatient Services.

The latest National Benchmarking data (February 2024) shows the England average (including Independent Sector Providers) was **87**% and we were ranked **17** (1 being the best with the highest ratings) . We were also ranked highest for the total number of responses received.

Underlying issues:
There are no underlying issues to report.

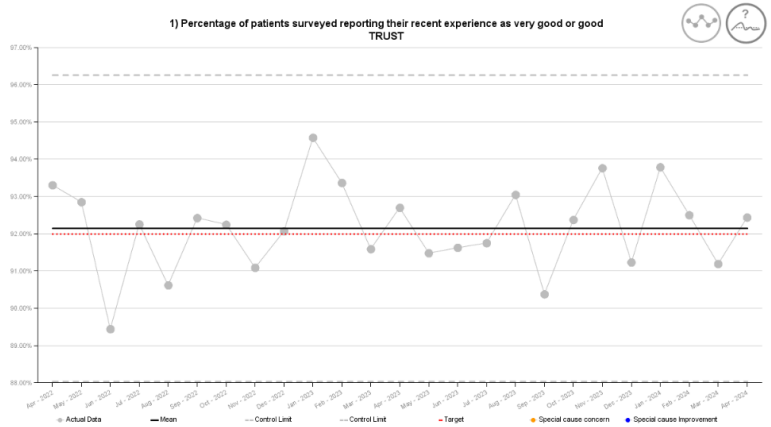
Actions:
- The Patient & Carer Experience Group are going to consider how a patient or carer could understand the performance of each individual team and what key 5 things they might look for (by end of April 2024). **(Not yet completed)** Awaiting revised timescale.
- Quality Improvement Team to undertake some focused work with the top 10 and bottom 10 teams regarding response rates, to learn from and share best practice. This work will be completed by the end August 2024.

No significant change in the data during the reporting period shown

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 93%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for

Tees, Esk and Wear Valleys NHS Foundation Trust

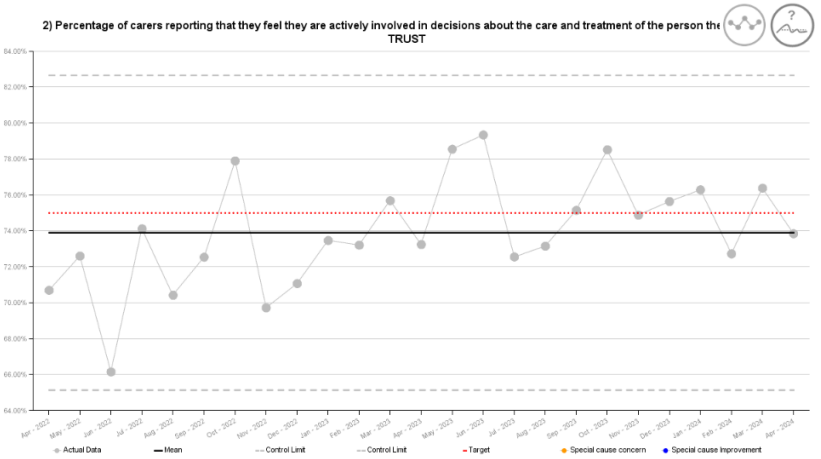
Background / standard description:
We are aiming for 75% of carers reporting, they feel they are actively involved in decisions about the care and treatment of the person they care for

What does the chart show/context:
During April, **325** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **240 (73.85%)** scored "yes, always".

There is no significant change at Trust level in the reporting period; however, we are continuing to show special cause improvement in the number of carers who have responded to the question. There is no significant change at Care Group level; however, to note that special cause improvement is seen for ALD and CYP in Durham, Tees Valley & Forensic Care Group.

Underlying issues:
- Engagement with various patient groups
- Barriers to collecting feedback include:
  - Access to and up to date surveys through the various mechanisms
  - Up to date carer and team information
  - Lack of feedback including display of feedback

Actions:
- The Patient & Carer Experience Team are continuing to work with the Recovery College to develop an e-learning package to deliver the Carer Awareness training and are continuing to deliver face to face training with an increased number of sessions.



03) Percentage of inpatients reporting that they feel safe whilst in our care

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 75%* of inpatients reporting, they feel safe whilst in our care
*(*standard being reviewed – see actions below)*

What does the chart show/context:
During April 171 patients responded to the overall experience question in the patient survey: Question: "During your stay, did you feel safe?". Of those, 137 **(80.12%)** scored "yes, always" and "quite a lot".

There is no significant change at Trust level in the reporting period and this is also seen in the number of inpatients who have responded to the question. There is no significant change at Care Group level.

Underlying issues:
- There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients, environment.
- Self-Harm in inpatient settings can cause other patients to feel unsafe

Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Actions are for Peer Workers and Patients to create their own Leaflets outlining, what would they want other patients to know when they arrive, what would help them feel safe; Suggestion boxes on wards to support people to raise questions or concerns about feeling safe in an anonymous/less intrusive way and a monthly checklist to explore how many patients attended the Mutual Help, Activities, and psycho-social sessions etc so activities can be tailored to suit the cohort of patients. It is anticipated that the impact of these improvement actions should be seen by May 2024 (June report) with a 5% increase in inpatients reporting they feel safe.
- The Patient & Carer Experience Team in collaboration with the Lived Experience Directors will review the "standard" for this measure following the expansion to include "quite a lot". A proposal will go to the Executive Review of Quality in April 2024. **(Not yet completed)** Awaiting revised timescale.

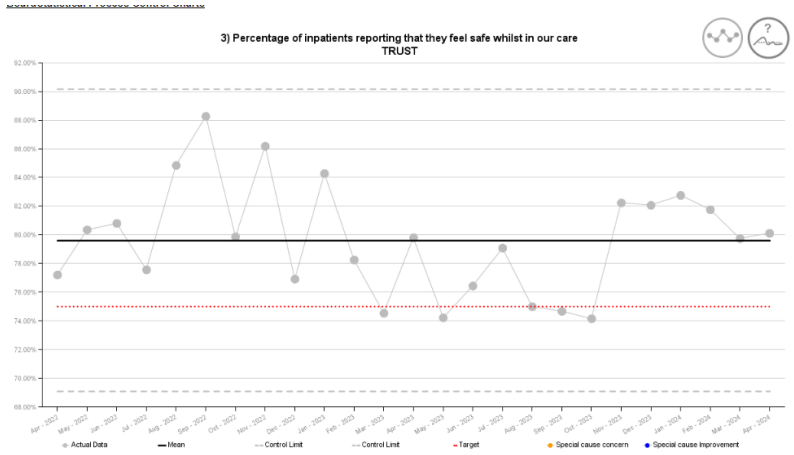
No significant change in the data during the reporting period shown

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ

87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



04) Percentage of CYP showing measurable improvement following treatment - patient reported

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

What does the chart show/context:
For the 3-month rolling period ending April **605** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 142 (23.47%)** made a measurable improvement.

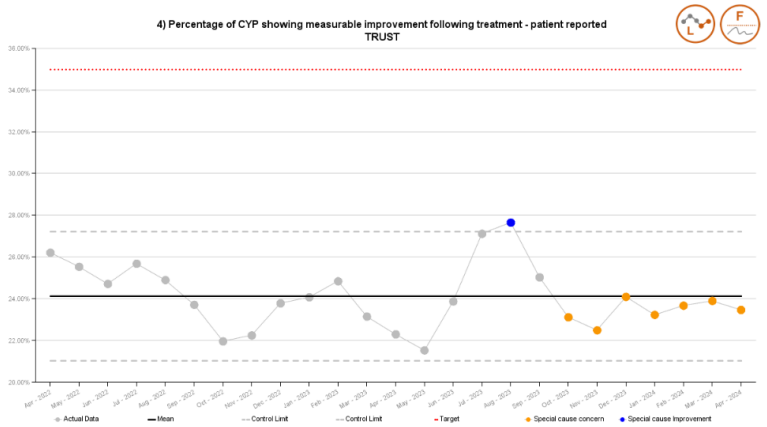
The issue identified last month that impacted Care Group level data has been rectified and all data is now correctly allocated to the relevant Care group.

There is special cause concern at Trust level and for Durham Tees Valley & Forensic Care Group in the reporting period. It should be noted there continues to be special cause improvement in North Yorkshire, York & Selby Care Group; however, there is visible deterioration.

The accepted Patient Rated Outcome Measures are CORS / ORS / GBO (goal-based outcomes) / RCADS / SDQ / SCORE-15 / PHQ-9 / GAD-7 / CORE-10.

Underlying issues:
- This measure currently doesn't include Parent Rated outcomes (which is valid) and the full suite of patient-related outcomes.

Actions:
- Management Group have now approved the updates to the measure to include Parent Rated outcomes and the new assessment tools. This will be actioned by the Business Intelligence Team by the end of June 2024 (July report).
- Durham Tees Valley & Forensic Care Group revised their Performance Improvement Plan (PIP) as the original actions did not have the desired impact. They will now undertake a patient level deep dive into patients discharged with a paired outcome measure that are not demonstrating an improvement. This will be completed by the end of May 2024 (and monthly thereafter). The service will also focus efforts to ensure the agreed outcome measures are recorded at the start and end of the patient's journey. It is anticipated we will see improved collection of outcome measures from August (July data).



05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Background / standard description:
We are aiming for 55% of Adults and Older Persons showing measurable improvement following treatment - patient reported

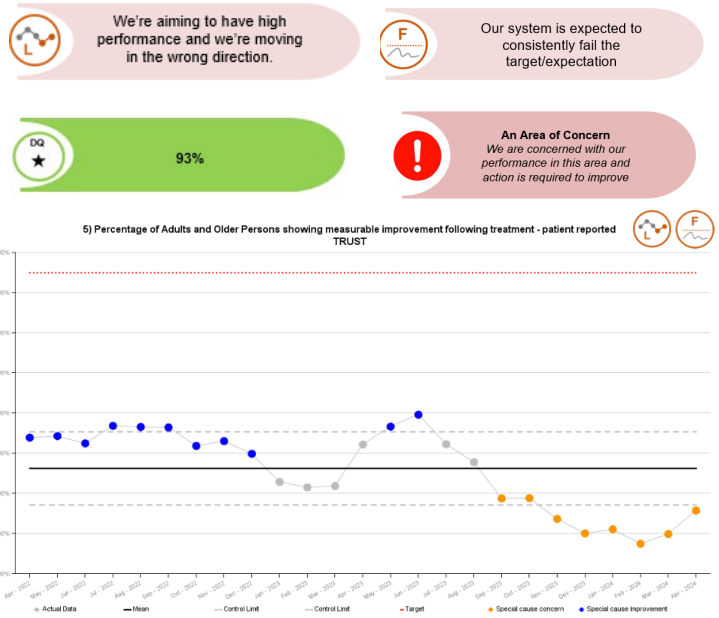
What does the chart show/context:
For the 3-month rolling period ending April **1409** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 608 (43.15%)** made a measurable improvement.

The issue identified last month that impacted Care Group level data has been rectified and all data is now correctly allocated to the relevant Care group.
There is special cause concern at Trust level and for Durham & Tees Valley Care Group, with special cause concern seen for AMH. Whilst there is no significant change for North Yorkshire, York & Selby Care Group, there is a visible deterioration in AMH.

The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

Underlying issues:
- Timeliness and frequency of completing outcomes is impacting
- Within NYYSCG outcomes are not being collected routinely by medical staff within MHSOP.

Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP):
  - Actions are for Adult services (specifically EIP and Treatment and intervention teams) to focus greater discussion and challenge by utilising the team and service level dashboards including details of discharges and paired numbers, and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement.
  - For Older Persons services actions are to add this measure to the team and service level governance dashboards and begin reporting against this measure, and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement.



Actions continued:
It was anticipated that the impact of these improvement actions would be seen in May 2024 (April data) with a 5% increase in Adults and Older Persons showing measurable improvement, however these actions have not yet been completed. The Care Group have requested an extension to the PIP to the end of June 2024.
- North Yorkshire, York & Selby Care Group (NYYSCG) have developed a PIP for AMH services which focuses on completion rates within caseload supervision and monitoring of outcomes within service leadership huddles. It is anticipated that the impact of these improvement actions will be seen in June 2024 (May data) with a 5% increase in Adults showing measurable improvement. Within MHSOP a deep dive is needed to understand the root cause to support the development of a PIP. This work is expected to be completed by the end of April 2024. **(Completed)**. A PIP will now be developed to support improvement by the end of June 2024.

06) Percentage of CYP showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 50% of CYP showing measurable improvement following treatment - clinician reported

What does the chart show/context:
For the 3-month rolling period ending April **605** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 294 (48.60%)** made a measurable improvement.

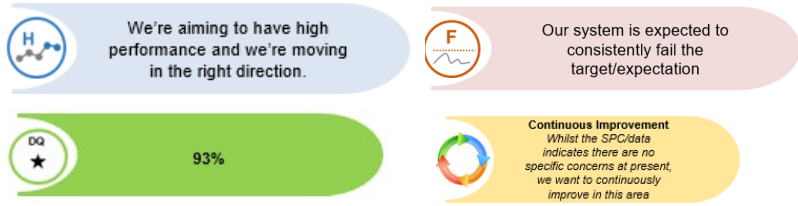
The issue identified last month that impacted Care Group level data has been rectified and all data is now correctly allocated to the relevant Care group.

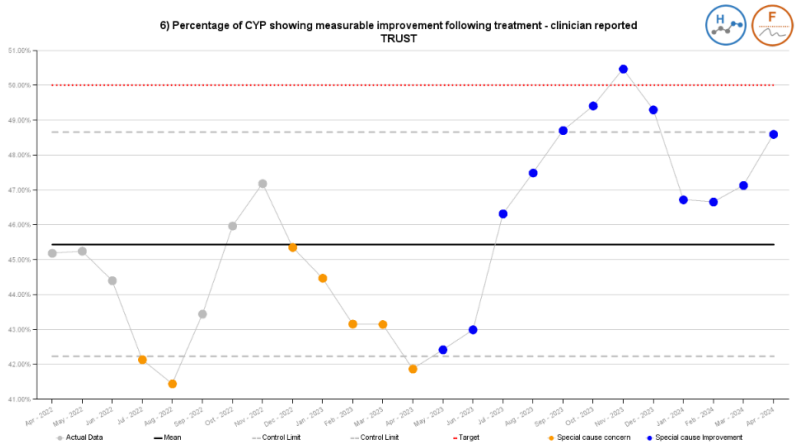
There is special cause improvement at Trust level and for Durham Tees Valley & Forensic Care Group in the reporting period. There is no significant change in North Yorkshire, York & Selby Care Group.

The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

Underlying issues:
- North Yorkshire, York & Selby Care Group - A number of teams are showing as concern; Harrogate Community, York Mental Health Support Team, Selby ADHD, Selby Community Team and York East and Central ADHD Assessment.
- There is inconsistency in the completion of measures between clinicians.
- Data quality issues have been identified in the correct recording of outcomes on Paris.

Actions:
- Durham Tees Valley & Forensic teams are undertaking a patient level review of a sample of patients from each of the teams about who did not show measurable improvement to understand in more detail reasons for this. This was to be completed by the end of April 24. **(Not yet completed)** This will be completed by the end of May 2024.





Actions continued:
- North Yorkshire teams are undertaking a deeper investigation to understand the root cause of the decline which will be completed by the end of April 2024 **(Completed).** Two underlying issues have been identified (see latter two issues) and next steps are being considered, which include a meeting with the Section Head of Research & Statistics to review the findings.

07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 30% of Adults and Older Persons showing measurable improvement following treatment - clinician reported

What does the chart show/context:
For the 3-month rolling period ending April **1728** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 346 (20.02%)** made a measurable improvement.

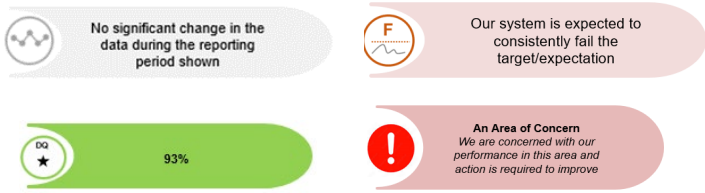
The issue identified last month that impacted Care Group level data has been rectified and all data is now correctly allocated to the relevant Care group.

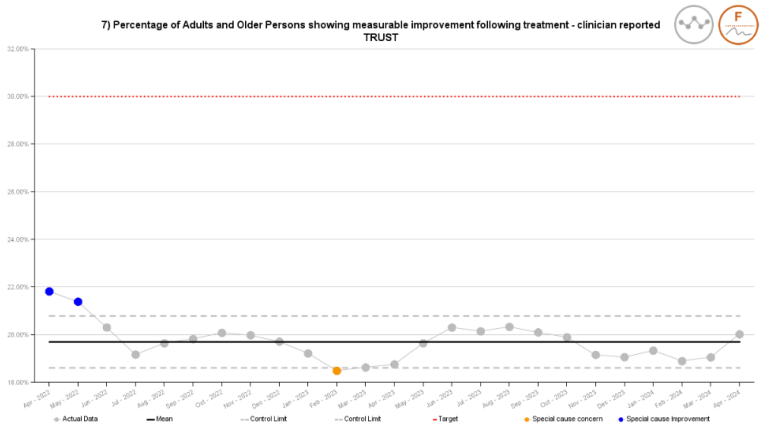
There is no significant change at Trust level in the reporting period. Special cause concern is seen for North Yorkshire, York & Selby, which is reporting special cause concern for AMH. It should be noted, however, that special cause improvement is seen for Durham, Tees Valley & Forensic Care Group. MHSOP services in both Care Groups continues to be a concern (around 10-12% improvement) despite showing no significant change.

The accepted Patient Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).

Underlying issues:
Please see issues against measure 5) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

Actions:
Please see actions against measure 5) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported





08) Bed Occupancy (AMH & MHSOP A & T Wards)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
During April, **10,500** daily beds were available for patients; of those, **10,411 (99.15%)** were occupied. Overall occupancy <u>including</u> independent sector beds was **99.65%**

There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; however, there is special cause concern for Adult Mental Health Services within the Care Group. It should be noted there is special cause improvement in both Mental Health Services for Older People and North Yorkshire, York & Selby Care Group as a whole.

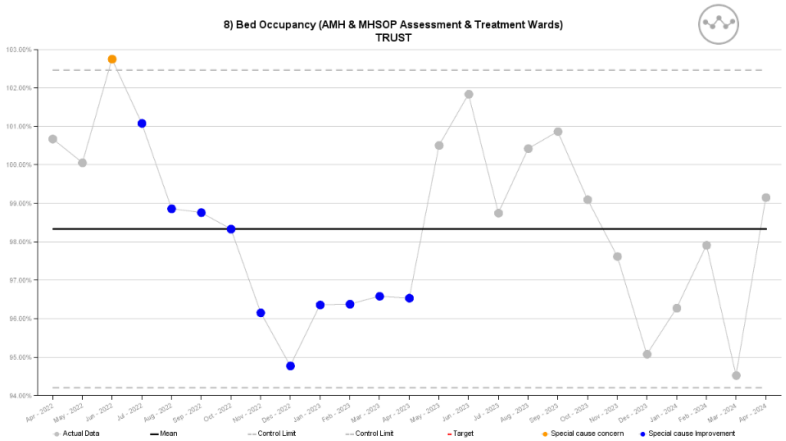
Underlying issues:
- Clinically Ready for Discharge – specifically around accommodation. There is special cause concern in relation to delayed transfers of care (DTOC) for AMH services within Durham, Tees Valley & Forensic Care Group (12.6% DTOC during April). ***At Trust level (both Care Groups) patients classified as clinically read for discharge equated to an average of 34.1 Adult and 16.8 Older Adult beds in April 2024, at an equivalent cost of c £417k (including £118k independent sector bed costs) and £154k respectively for each speciality.**
- Patient flow and adherence to PIPA process
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

Actions:
Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Remaining actions are to:
- Identify best practice across other NHS trusts to support the review of our discharge policy. The policy was expected to be implemented by end of April 2024. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days. **(Not yet completed)** The Care Group have requested an extension to the PIP with a revised date of the end of May 2024.
- Define the purpose of admission and how this is used to support discharge. It is anticipated that 100% of patients will have a defined purpose of admission to hospital. This will be completed by end of June 2024.

No significant change in the data during the reporting period shown

DQ 87%

An Area of Concern
We are concerned with our performance in this area and action is required to improve



09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming to have no out of area bed days by the end of March 2024.

What does the chart show/context:
For the 3-month rolling period ending April **478 days** were spent by patients in beds away from their closest hospital.

Special cause improvement is seen at Trust level and for North Yorkshire, York & Selby in the reporting period. No significant change is seen for Durham, Tees Valley & Forensics Care Group (AMH services). This correlates with bed occupancy in AMH services for this Care Group.

Update:
Previously the inappropriate OAPs metric used in planning was the number of inappropriate OAP bed days; in 2024/25 this was replaced by the total number of active inappropriate OAPs, to focus more on the number of patients subject to inappropriate OAPs.

There was 1 active OAP placement as at 30th April 2024 (North Yorkshire SICBL).

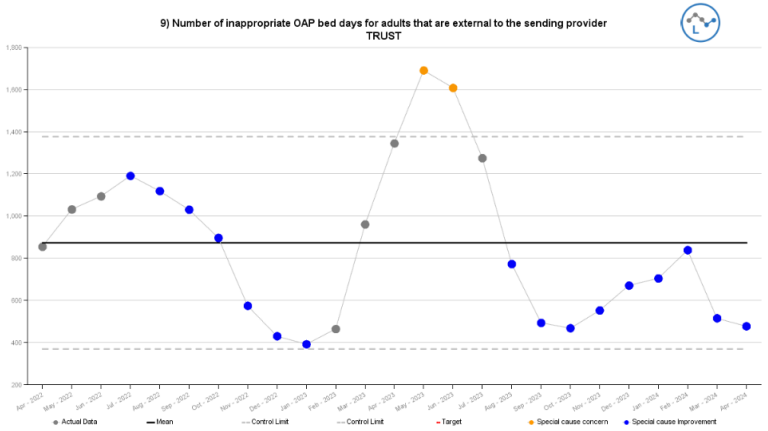
Underlying issues:
Bed Occupancy is impacting on our ability to admit patients to our beds

Actions:
See measure 8) Bed Occupancy

We're aiming to have low performance and we're moving in the right direction.

DQ 73%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



ICB Trajectories versus actual performance for Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)

Active inappropriate adult acute mental health out of areas placements (OAPs)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust	**Ambition**	**10**	**10**	**8**	**7**	**6**	**4**	**4**	**4**	**2**	**2**	**1**	**0**
	Actual	**1**											
North East & North Cumbria ICB	**Ambition**	7	7	6	5	4	3	3	3	2	2	1	0
	Actual	**0**											
Humber & North Yorkshire ICB	**Ambition**	3	3	2	2	2	1	1	1	0	0	0	0
	Actual	**1**											

10) The number of Patient Safety Incident Investigations reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
4 patient Safety Incident Investigations (PSII) were reported on the Strategic Executive Information System (STEIS) during April.

There is no significant change at Trust level and for both Care Groups in the reporting period. Whilst special cause improvement is visible for CYP and SIS in Durham, Tees Valley & Forensic Care Group and MHSOP in North Yorkshire, York & Selby Care Group, this is not necessarily an actual improvement, as there was a change in process late January 2024, when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.

NB. The full investigations (closest equivalent to Serious Incidents previously reported) are now referred to as Patient Safety Incident Investigations (PSII).

Each incident is now subject to a multi-disciplinary after-action review by services and then reviewed within the Patient Safety huddle.

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required.

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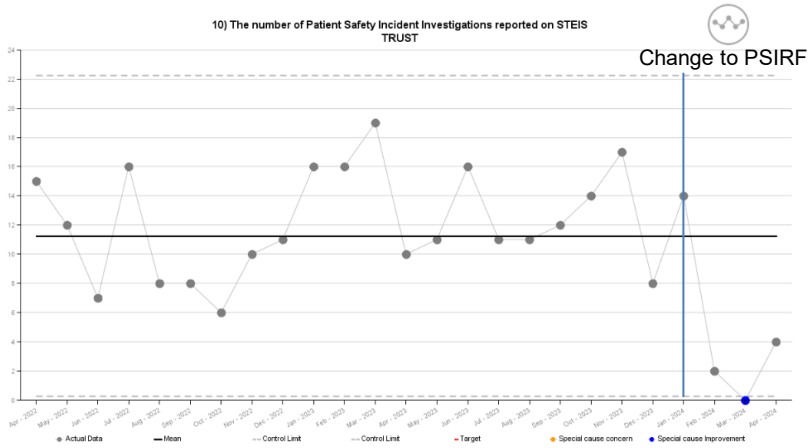
No significant change in the data during the reporting period shown

DQ 87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
66 incidents of moderate or severe harm were reported during April.

There is no significant change at Trust level and for both Care Groups in the reporting period. It should be noted that special cause improvement is visible for ALD and CYP in North Yorkshire, York & Selby Care Group.

Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

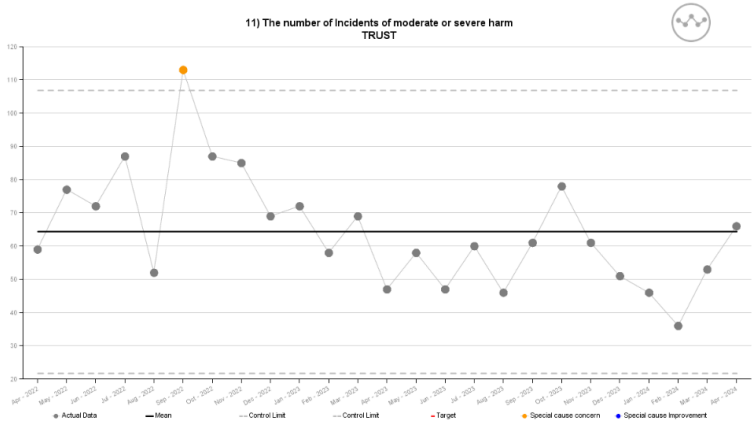
Underlying issues:
- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).

Actions:
- The learning from incidents will be collated and themed by the Patient Safety Team and shared monthly with the Organisational Learning Group.

No significant change in the data during the reporting period shown

DQ 87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



12) The number of Restrictive Intervention Used

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
We have concluded the investigation and refreshed all the data shown for this measure. We are now confident that this is now an accurate reflection of our performance.

What does the chart show/context:

1,061 types of Restrictive Interventions were used during April.

There is no significant change at Trust level and for both Care Groups in the reporting period. Whilst there is special cause improvement for ALD and CYP in Durham, Tees Valley & Forensic Care Group, special cause concern remains visible for AMH. Special cause improvement remains for ALD and CYP in North Yorkshire, York & Selby Care Group.

Underlying issues:

- Concerns remain in Elm and Overdale (latter small number of complex female patients) and high number on Cedar (PICU) within AMH services in Durham Tees Valley & Forensic Care Group

Actions

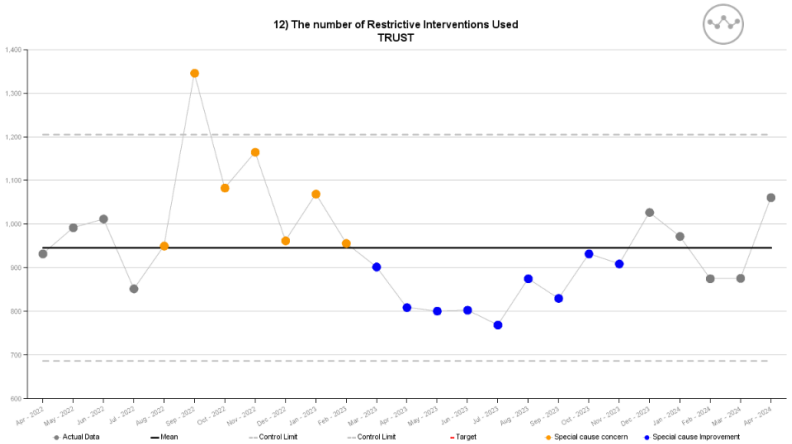
- There are several actions to support improvement to the wards identified above, which include:
  - the Inpatient Lead Psychologist and additional leadership supporting Elm Ward as part of a wider action plan, which includes clinically appropriate discharge.
  - Specialist Practitioner for Positive & Safe working with the teams to review the use of restrictive interventions and to provide education.
  - due to the nature of the patient group, the Trust-wide Autism Team providing additional support into Elm and Cedar wards
- Within DTVF AMH, where required, all female patients have plans in place to ensure that where interventions are required, they are the least restrictive and most appropriate for that individuals care.

No significant change in the data during the reporting period shown

DQ

87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



13) The number of Medication Errors with a severity of moderate harm and above

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:

1 medication error was recorded with a severity of moderate harm, severe or death during April.

There is no significant change at Trust/Care Group level in the reporting period.

Underlying issues:

- EPMA (electronic prescribing & medicines administration) will enable more timely prescribing and administration of medication to patients and will reduce the risk of some errors once embedded.
- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).

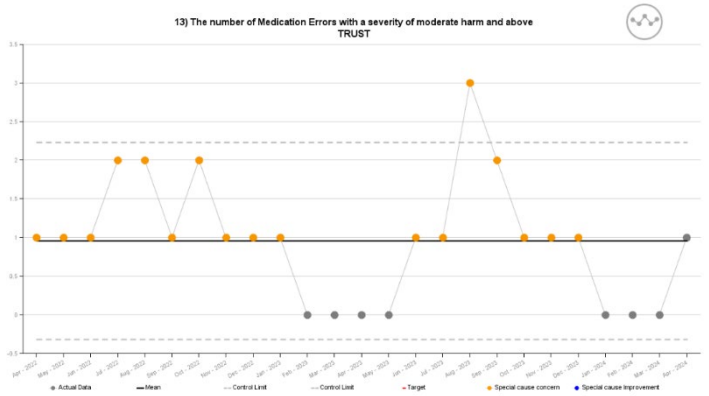
Actions:

- Rollout of EMPA to community services to be completed by the end of November 2024.

No significant change in the data during the reporting period shown

DQ 87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



14) The number of unexpected Inpatient unnatural deaths reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1 unexpected Inpatient unnatural death was reported on the Strategic Executive Information System (STEIS) during April.

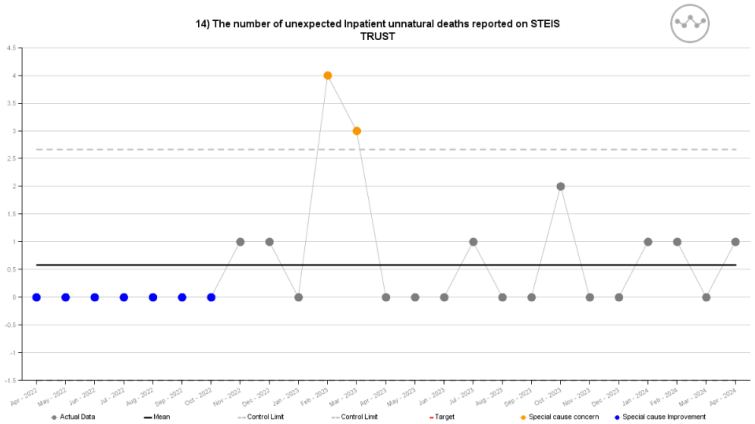
Underlying issues:
There are no underlying issues to report

Actions:
A comprehensive multi-disciplinary after-action review has been completed and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed.

No significant change in the data during the reporting period shown

DQ

87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **345** uses of the Mental Health Act during April .

There is no significant change at Trust/Care Group level in the reporting period; however, special cause concern is visible for ALD and SIS in Durham, Tees Valley & Forensic Care Group and ALD and MHSOP in North Yorkshire, York & Selby Care Group.

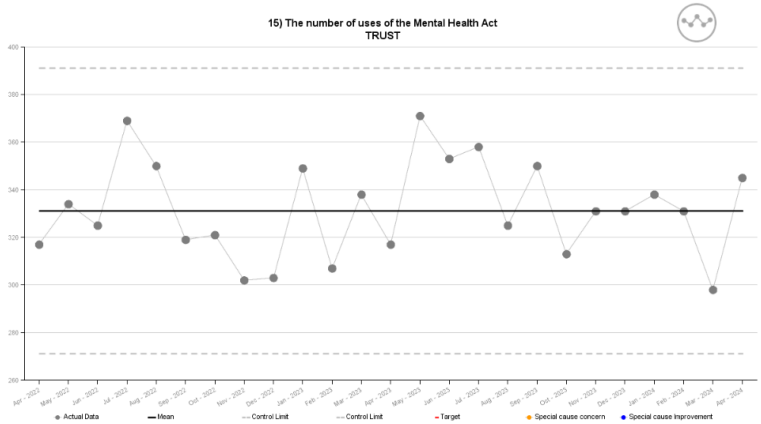
Underlying issues:
Whilst statistical concern is visible for a small number of areas, the Care Groups have confirmed there are no underlying issues to report.

Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ ✓✓ 73%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



16) Percentage of staff recommending the Trust as a place to work

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 60% of staff to recommend the Trust as a place to work (agreed March 2024)

What does the chart show/context:

We have identified that the number of responses being used in the calculation is not consistent therefore we are working with the external providers of the surveys to provide the data required for those data points impacted.

799 staff responded to the January 2024 Staff Survey. In relation to the question "I would recommend my organisation as a place to work", **370 (46.31%)** responded either "Strongly Agree" or "Agree". We recognise this is the lowest data point to date and will continue to monitor this as part of the actions outlined below.

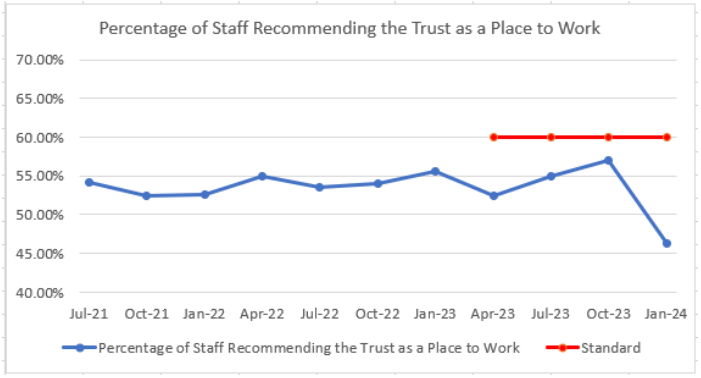
The NHS Staff Survey Benchmarking report 2023, shows the "best result" was 75.43% and the "average result" was 65.59% for similar organisations.

Underlying issues:
We currently have limited data on the percentage of staff recommending the Trust as a place to work therefore we are unable to deploy a Statistical Process Control Chart for analysis of real change.

Actions:
- We have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews/focus groups and a wide range of career development opportunities including development posts.
- In addition to the programme of work, People and Culture triangulate various data sources including staff survey, Organisational Development interventions, Freedom to Speak Up, to identify key themes for targeted action plans.

DQ ✓✓ 87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

Actions continued:
- The National Staff Survey results will be shared with Care Groups and Corporate Services to both disseminate information to staff and to identify key themes and trends. **(Completed)** The Organisational Development Team and People Partners will support the Services to develop targeted action plans over the next 6 months (Sept 24) and report into Executive People Culture and Diversity and People Culture and Diversity Committee. Engagement events will then take place over Sept/Oct 24 to update staff on what we have heard and what action is being taken.
- Responses to the NHS Staff Survey recorded as free text fields have been sourced by the Trust and are to be shared with the Care Groups by the end of June 2024.

17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 65% of staff to feel they are able to make improvements happen in their area of work (agreed March 2024)

What does the chart show/context:

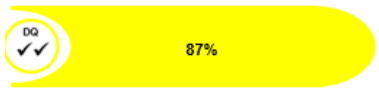
We have identified that the number of responses being used in the calculation is not consistent therefore we are working with the external providers of the surveys to provide the data required for those data points impacted.

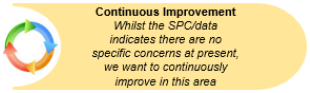
799 staff responded to the January 2024 Staff Survey. In relation to the question "I am able to make improvements happen in my area of work", **419 (52.44%)** responded either "Strongly Agree" or "Agree". We recognise this is the lowest data point to date and will continue to monitor this as part of the actions outlined below.

The NHS Staff Survey Benchmarking report 2023, shows the "best result" as 67.81% and the "average result" as 61.37% for similar organisations.

Underlying issues:
We currently have limited data on the percentage of staff feeling they are able to make improvements happen in their area of work therefore we are unable to deploy a Statistical Process Control Chart for analysis of real change .

Actions:
- The Trust has embarked on a 5-year (November 2027) stepped approach to Quality Improvement (QI) Training support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.
- Our Journey To Change focuses on our cultural development through a wide range of engagement, communication and learning opportunities to enable and empower our staff to make changes in their area of work.





** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

Actions continued:
- The National Staff Survey results will be shared with Care Groups and Corporate Services to both disseminate information to staff and to identify key themes and trends. **(Completed)** The Organisational Development Team and People Partners will support the Services to develop targeted action plans over the next 6 months (Sept 24) and report into Executive People Culture and Diversity and People Culture and Diversity Committee. Engagement events will then take place over Sept/Oct 24 to update staff on what we have heard and what action is being taken.
- Responses to the NHS Staff Survey recorded as free text fields have been sourced by the Trust and are to be shared with the Care Groups by the end of June 2024.

18) Staff Leaver Rate

What does the chart show/context:
From a total of **7,263.49** staff in post, **822.30 (11.32%)** had left the Trust in the 12-month period ending April 2024.

There is special cause improvement at Trust level and for most areas in the reporting period. However, there is special cause concern for the ACE Directorate, Health & Justice and MHSOP within Durham Tees Valley and Forensic Care Group and Management within North Yorkshire, York & Selby Care Group.

The latest (January 2024) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 11 (previously ranked 10) of 71 Trusts Mental Health & Learning Disability Trusts (1 being the best with the lowest leaver rate) and are placed in the highest performing quartile range.

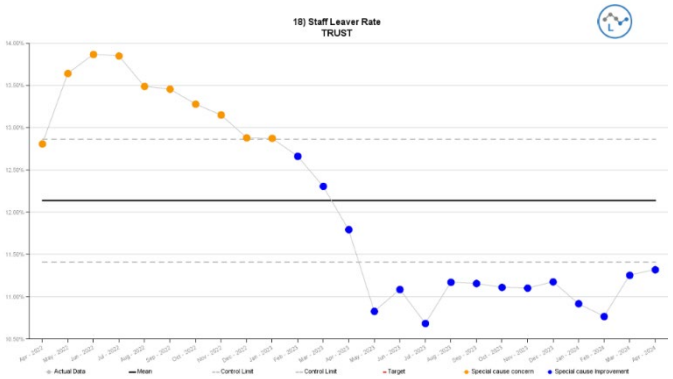
Underlying issues (*for those who do leave and tell us why):
- Staff wanting a new challenge
- Promotion
- Role not being as expected
- Work-life balance

Actions:
- We have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews and a wide range of career development opportunities.
- Following discussion at EDG we have revised the PIP for E Roster effectiveness which includes the original actions; however, with more stretching targets. It is anticipated we will have 80% of rotas published in line with the Trust target and 80% of teams achieving target for annual leave level loading by the 1st July 2024.
- A cross-referencing exercise is to be undertaken against our Intention to Leave data and ESR data to identify trends and ensure that exit interviews are being undertaken in a timely manner. Findings will be shared with services by the end of June 2024.

We're aiming to have low performance and we're moving in the right direction.

DQ 80%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for sickness absence to be no more than 5.5% (agreed March 2024)

What does the chart show/context:
There were **232,377.56** working days available for all staff during March (reported month behind); of those, **13,324.51 (5. 73%)** days were lost due to sickness.

There is no significant change at Trust and Directorate level in the reporting period. The areas showing special cause concern are Mental Health Services for Older People and Management within Durham, Tees Valley & Forensic Care Group and Adult Mental Health within North Yorkshire, York & Selby Care Group.

National Benchmarking for NHS Sickness Absence Rates published 25th April 2024 (data ending December 2023) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.58% compared to the Trust mean of **6.13%**, with the Trust ranked 40 of 48 Mental Health Trusts (1 being the best with the lowest sickness rate).

Underlying issues:
- Anxiety/stress/depression is the main reason of sickness absence
- Impact of organisational processes on sickness (eg disciplinary process)

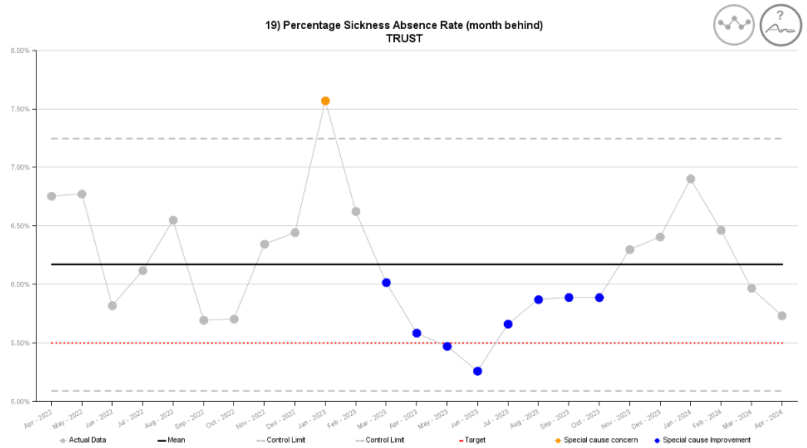
Actions:
- People & Culture are focusing on the health, wellbeing and resilience of our staff. This includes flexible working opportunities, Employee Support Services, Employee Psychological services and Health & Wellbeing Champions. There is also an engagement programme including monthly health and wellbeing meetings, guest speakers and newsletters for staff.
- A rolling programme of sickness audits in both Care Groups will be undertaken from May 2024 by People & Culture colleagues to understand whether sickness absence is being managed in line with procedures. Findings from the DTVF audits were shared with Care Group in April 2024. Audits in NYYS will commence in May 2024, with initial findings available by the end of July 2024.

No significant change in the data during the reporting period shown

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ✓✓ 87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



Actions continued:
- DTVF People Partners to work with the services in each of their areas to develop sickness action plans by the end of June 2024.
- Principle People Partners to monitor causes of long-term sickness to identify the impact of organisational processes. Initial investigations will be completed by the end of June 2024.

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:
179,282 training courses were due to be completed for all staff in post by the end of April. Of those, **156,569** (87.33**%**) were completed.

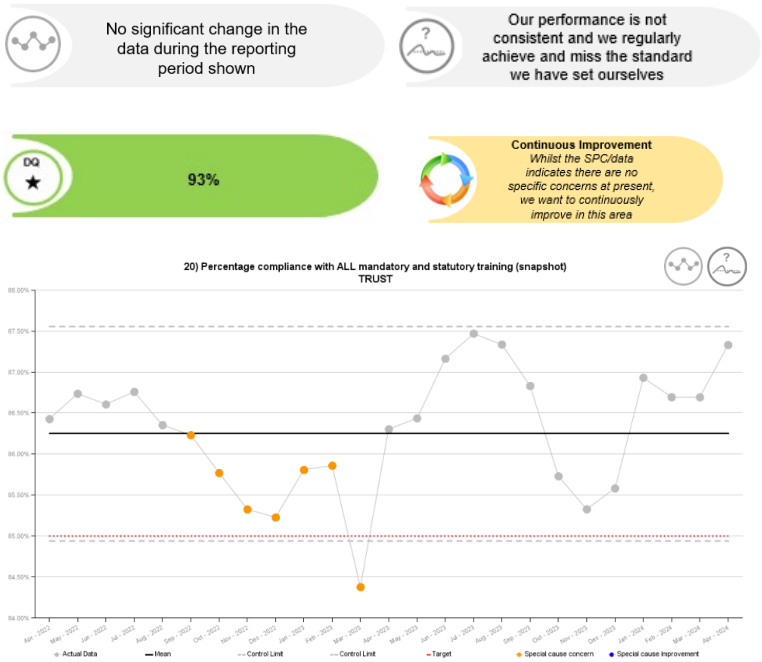
There is no significant change at Trust level and for most areas in the reporting period, with several areas showing special cause improvement: Digital & Data Services, Finance, Nursing & Governance and People & Culture, ALD and MHSOP in Durham, Tees Valley & Forensic Care Group and ALD, CYP and MHSOP in North Yorkshire, York & Selby Care Group. However, there remains special cause concern for AMH in North Yorkshire, York & Selby Care Group.

As at the 30th April 2024, by exception compliance levels below 85% are as follows:

	Number Compliant	Total Number	% Compliant
1) TRUST BOARD	71	92	77.17%
2) NURSING AND GOVERNANCE	1652	1974	83.69%

Underlying issues:
- Staff unable to be released to attend training (high DNA rate)
- Lack of capacity for Positive & Safe training courses
- Lack of suitable training rooms
- Misalignment of competencies and staff on ESR

Actions:
- Training Department are actively following up all staff who DNA
- The training portfolio for Positive & Safe has been reviewed in line with capacity and demand and the Trust Welcome. Implementation date end of September 2024.
- We are constantly reviewing the availability of training rooms across trust premises.
- Workstreams have been agreed following the Quality Improvement Event to review Mandatory Training requirements – implementation date end of September 2024.



20) Percentage compliance with ALL mandatory and statutory training – Supporting Information

Tees, Esk and Wear Valleys NHS Foundation Trust

Mandatory and statutory training

As at the 30th April 2024, by exception compliance levels below 85% are as follows for the following courses sorted by lowest performance:

	Number Compliant	Total Number	% Compliant
1) Positive and Safe Care Level 2 Update*	1048	1651	63.48%
2) Resuscitation - Level 1 - 1 Year*	1637	2537	64.53%
3) Positive & Safe Care Level 1*	2817	4335	64.98%
4) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	192	295	65.08%
5) Rapid Tranquilisation 1	193	284	67.96%
6) Face to Face Medication Assessment	1583	2251	70.32%
7) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1827	2567	71.17%
8) Medicines Management Annual Module	443	606	73.10%
9) Moving and Handling - Level 2 - 2 Years*	704	923	76.27%
10) [illegible]e Safety - 2 Years**	6035	7891	76.48%
11) [illegible]atient Safety Level 2	4533	5785	78.36%
12) [illegible]nnual Medicines Optimisation Module	1727	2171	79.55%
13) [illegible]ollow Up	16	20	80.00%
14) Safe Prescribing	209	261	80.08%
15) [illegible]CA - MCA and Young People Aged 16/17	715	891	80.25%
16) [illegible]afeguarding Level 3**	3106	3859	80.49%
17) Infection Prevention and Control - Level 2 - 1 Year	4936	6113	80.75%
18) Rapid Tranquilisation 2	456	554	82.31%
19) Mental Health Act Level 2	3188	3804	83.81%
20) MCA - Restraint	3431	4044	84.84%

*Indicates face to face learning ** face or face via MST*

Page 2

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 85% of staff in post with a current appraisal

What does the chart show/context:
Of the **6786** eligible staff in post at the end of April; **5,759 (84.87%)** had an up-to-date appraisal.

There is special cause improvement at Trust level and for several areas in the reporting period: Company Secretary, Digital & Date Services, Durham, Tees Valley & Forensic Care Group, Finance, People & Culture, ALD, CYP and SIS within DTVF, and MHSOP within NYYS. However, there is special cause concern for AMH in North Yorkshire, York & Selby Care Group.

As at the 30th April 2024, by exception compliance levels below 85% are as follows:

	Number Compliant	Total Number	% Compliant
1) THERAPIES	30	41	73.17%
2) NORTH YORKSHIRE, YORK AND SELBY	1297	1577	82.24%
3) NURSING AND GOVERNANCE	82	99	82.83%
4) CORPORATE AFFAIRS AND INVOLVEMENT	30	36	83.33%
5) DURHAM, TEES VALLEY AND FORENSIC	3412	4027	84.73%

Underlying issues:
- Some supervisors are not correctly recording appraisals on ESR
- Staff Sickness of both staff and managers
- Staff not being aligned correctly on ESR
- Lack of monitoring process by services

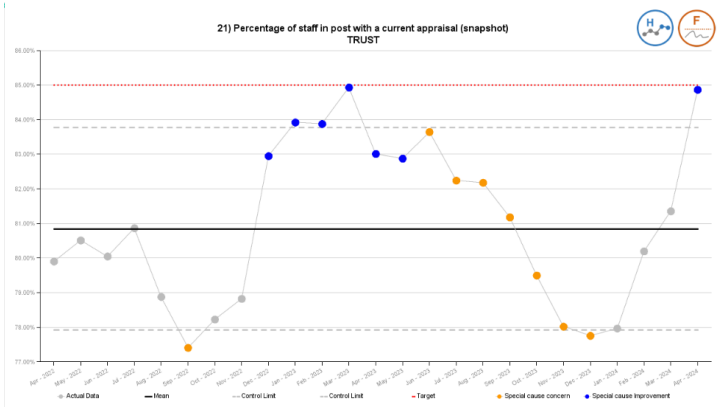
Actions:
- Appraisal training is currently planned from March 2024 (post CITO) until July 2024 for both managers and staff (appraiser and appraisee).
- Communications email to be sent to all staff on how/where to record appraisals by the Organisational Development Lead by the end 30 April 2024. (**Completed**) Communication has been circulated via the All staff briefing by the Team responsible for our appraisal system, TEWVision.

We're aiming to have low performance and we're moving in the right direction.

Our system is expected to consistently fail the target/expectation

87%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



Actions continued:
- Following discussion at EDG we agreed to review and revise the PIP. This has been undertaken by the Performance team in conjunction with the relevant services and will be presented to EDG for approval by the end of May 2023.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
7,675 patients referred in April that are not currently open to an existing Trust service.

There is no significant change at Trust/Care Group level in the reporting period; however, we are showing an unexpected level of variation – a continued shift of high referrals for Secure Inpatient Services within Durham Tees Valley & Forensic Care Group and CYP services within North Yorkshire, York & Selby Care Group.

Underlying issues:
There are no underlying issues to report

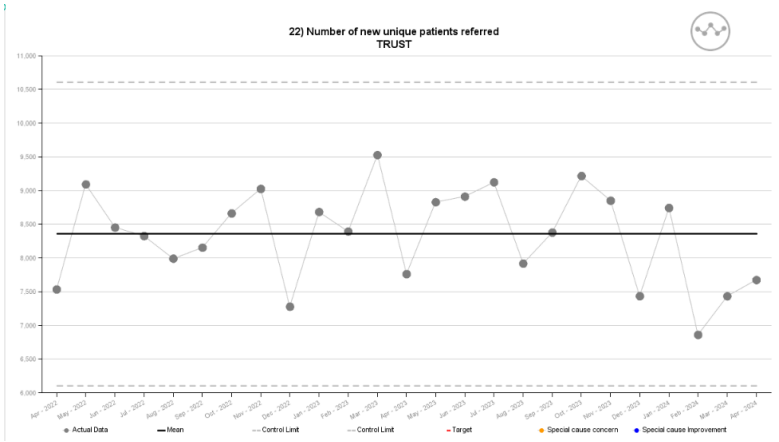
Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ

93%

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area



23) Unique Caseload (snapshot)

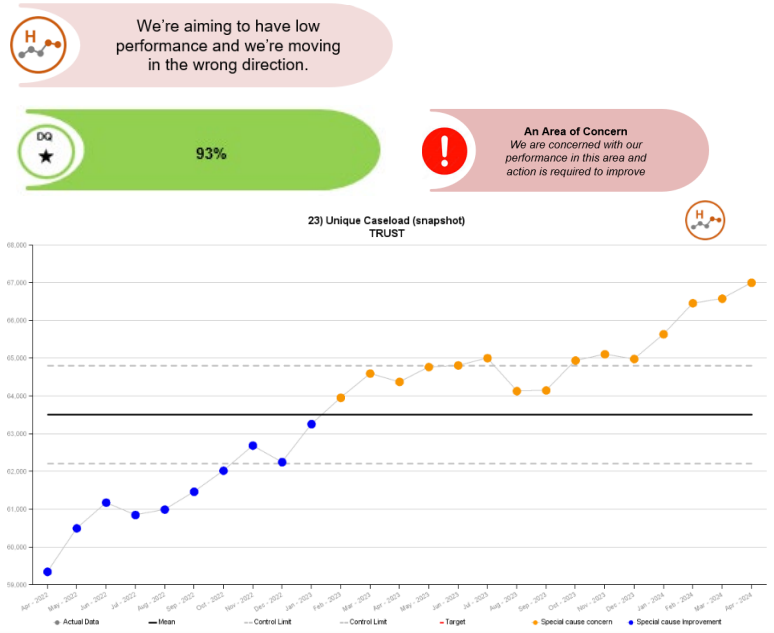
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
66,999 cases were open, including those waiting to be seen, as at the end of April 2024.

There is special cause concern at Trust and Care Group level in the reporting period. Special cause concern is in ALD, AMH, CYP and SIS within Durham, Tees Valley & Forensic Care Group and in MHSOP within North Yorkshire, York & Selby Care Group. It should be noted there is special cause improvement in H&J and MHSOP within Durham, Tees Valley & Forensic Care Group and ALD and AMH in North Yorkshire, York & Selby Care Group.

Underlying issues:
- An increase in referrals in CYP services for neuro diverse patients across both Care Groups and an increase in AMH services within Durham Tees Valley Forensic Care Group. We have approximately 20k neuro diverse patients waiting to be seen which equates to 30% of the caseload. There has been an increase in caseload of 10% since March 2022 (start of special cause concern) and we know from internal waiting time information that in CYP services, there has been an increase of 9% in neuro diverse patients waiting for the same time-period. We are unable to compare the increase in AMH services as we do not have historic data.
- An increase in referrals in MHSOP services for memory patients in North Yorkshire, York & Selby Care Group
- An increase in referrals has led to a backlog of waiters, whilst referrals have levelled, they are higher than they used to be. More detailed analysis is required to better understand whether an increase in waiters, particularly for neuro diverse patients is the main reason for the increase in caseload.

Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP) and have identified several actions to address the back log of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of quarter 1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024 (July report).



Actions continued:
- NYYSCG CYPS have identified two specific pieces of work that are required before being able to identify SMART actions, these actions will be completed by the end of June 2024, which will then inform their PIP.
- The HNY ICB is leading a Memory Re-Design Event 22-24 April 2024. **(Completed)** The Trust is waiting for outputs from the event.
- The Task & Finish Group within Corporate Services have agreed a core data set to support improvement. The core measures were shared with both Care Groups to ensure these are suitable. The Business Intelligence Team expect to produce the first core set of data by the end of May 2024. **(Completed)**
- The Business Intelligence Team are exploring the use a proxy measure in the interim to aid further analysis – this is planned to be completed by the end of April 2024. **(Not yet completed)** This will now be completed by the end of May 2024.

24) Financial Plan: SOCI – Financial Performance – (Surplus)/Deficit

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

The financial position to 30th April 2024 is a deficit position of **£0.35m**. The Trust has planned for a broadly breakeven position (£0.43m deficit due which reflects the impact of changes in accounting treatment for Private Finance Initiatives) for 2024/25 but needs to deliver a challenging 4.5% £21.78m Cash Releasing Efficiency Scheme (CRES) Programme to achieve this.

- **Agency expenditure** in April 2024 was £0.92m, or **£0.13m below plan**, showing an improved favourable variance in month. This represents a month on month reduction of £0.08m compared to March 2024. The reducing run rate trend includes impacts from actions to exit non-clinical agency assignments, reducing costs relating to complex care packages for a small number of adults with a learning disability, and reduced inpatient agency headcount. Ongoing usage includes high premia rate locum costs for cover of medical vacancies, residual inpatient agency headcount including linked to occupancy and acuity, and costs within Health and Justice. The trust had **no off-framework agency assignments** in month.
- **Independent sector beds** - the Trust used 56 non-Trust bed days in-month (153 in March) and representing a reduction of 97 bed days from the previous month) at a cost of £0.118m including estimates for unvalidated periods of occupancy and average observation levels pending billing. This remains a key area of clinical and management focus including through the new Urgent Care Programme Board (chaired by the Managing Director for DTVF).
- **Taxis and Secure Patient Transport** costs were £195k in April compared to planned costs of £180k. (Annual costs for 2023/24 were £2.675m, which was £1.0m higher than plan, and equated to a monthly run rate of £223k). A quality improvement event was held in 2023 which recommended grip and control actions and development of a new policy. Results remain subject to review and oversight due to limited sustained impact**.** The Chief Nurse is overseeing actions to ensure robust governance around Secure Transport and a procurement is expected to reduce unit costs early in 2024/25.
- **CRES** performance was not reported in April, as 2024/25 financial plans were still being finalised for submission nationally in May. 2024/25 plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year, with £15.72m being recurrent and £6.06m non–recurrent. Currently £2.06m of the non-recurrent target remains unidentified.

F — Our system is not hitting the target/expectation

DQ — 93%

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

24) Financial Plan: SOCI – Financial Performance – (Surplus)/Deficit

Underlying issues:

- We need to reduce bed occupancy including through reduced lengths of stay to reduce reliance on independent sector beds. This will require support from local authority system partners due to rising and sustained high levels of patients who are clinically ready for discharge.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan including due to numbers of staffing above funded levels and including agency premia rates (including some above price cap).
- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures.

Actions:

- Please see actions within measures 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.
- Following discussion with Executive Directors the PIP for E Roster effectiveness has been revised. This includes the original actions but more stretching agreed targets. It is anticipated 80% rotas will be published in line with the Trust target and 80% of teams will achieve the target for annual leave level loading by 1st July 2024.
- Following discussion with Executive Directors it has been agreed that the Agency Reduction PIP will be revised by 30th May 2024.
- The efficiency hub will be co-ordinated by a Programme Manager with recruitment of the post now completing. Terms of reference for the team / group are being established for review at the Financial Sustainability Board.
- The efficiency hub will provide support to enable focus on key strategic financial recovery actions including to manage and reduce over-establishments, track benefits from International Recruitment, ensure the efficient rostering of inpatient staffing and linked to inpatient occupancy, flow and Out of Area Placements moving ahead to 2024/25.

25a) Financial Plan: Agency expenditure compared to agency target

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Agency expenditure for April 2024 was £0.92m, or £0.13m below plan.

NHS planning guidance for 2023/24 introduced system agency cost caps of 3.70% pay bill. These have reduced to 3.20% pay bill for the 2024/25 financial year.

Agency expenditure represents 2.78% pay bill for the year to date (April 2024) which is within the system cost cap and has reduced from around 4.5% (average) prior year and 6% (average) the year before that. Reducing agency shifts and premia paid above national price caps remains a key focus. The Trust has achieved agency reductions equivalent to 119 WTE from April 2023 (240 Whole Time Equivalent; WTE) to April 2024 (121 WTE), and the related annualised premia has reduced from £4.9m in March 2023 to £3.5m in April 2024 (£1.4m reduction), demonstrating a positive impact from actions taken to date and the benefit from sustained focus.

The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to management of sickness absence, but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots) and securing alternative whole system models of care for specialist adult learning disability packages of care and reducing occupancy linked to increasing levels of patients who are clinically ready for discharge and require support to effect discharge.

We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit).

**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

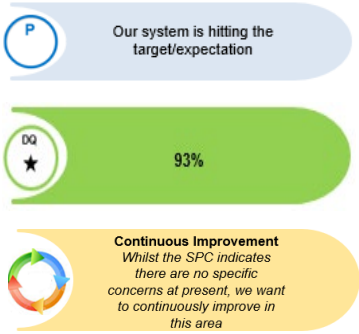
Underlying issues:

We need to continue to ensure a sustainable permanent workforce, including in key shortage professions including medical and nursing, to tackle high occupancy levels in inpatient wards (including with system collaboration) and to use temporary staffing more optimally including through improved rostering and regularly reviewing our safer staffing levels relative to clinical need.

Actions:

The Executive Workforce and Resources Group are overseeing the following actions to improve rostering:

- Re-visit roster rules to ensure optimal rosters and equity for colleagues: This work is ongoing and is reviewed in the monthly safe staffing meeting. Training is being provided for teams in order to optimise their use of the roster. Care Groups are being asked to hold monthly governance meetings reviewing the roster KPIs such as timely publications of rotas.
- Develop roster training programme (running 3 x weekly January to March 2024) – Completed



25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

2,211 agency shifts were worked in April 2024, with **1,388** shifts compliant **(63%)** and 823 non-compliant (37%) (prior month 1,588 shifts compliant or 63% and 919 non-compliant or 37%) with national price caps.

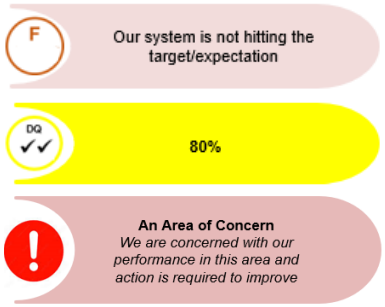
There were **296 fewer overall shifts worked this month** compared to last, with shifts worked being equivalent to **approximately 74 shifts per day** (81 shifts per day in March).

- The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to management of sickness absence but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots)) and securing alternative whole system models of care for specialist adult learning disability packages of care and reducing occupancy linked to increasing levels of patients who are clinically ready for discharge and require support to effect discharge. Other key areas of focus include actions to ensure optimal roster efficiency.
- Further refinement of shift data relating to the above takes place up to the point that NHSE Temporary Staffing data is submitted mid-month, which may result in minor differences between reported data.
- We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit).

**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

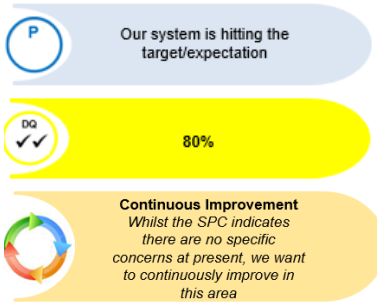
Underlying issues:
Particular persistent challenges relate to levels of medical staffing vacancies requiring cover from premia rate locum assignments which breach price caps.

Actions:
In addition to actions from 25a) supporting improved compliance, the Trust is also progressing a second phase of International Recruitment to aim to recruit a more sustainable medical and nursing workforce and reduce reliance on higher rate agency assignments. Medical assignments attract the highest value and percentage premia rates.



26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS Foundation Trust



What does the data show/context:

The overall rating for the trust is a **2** for the period ending 30th April.
The **Use of Resources Rating** (UoRR) was impacted by Covid-19 with national monitoring suspended. The Trust has continued to assess the UoRR based on plan submissions compared to actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity rating of **a 2**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is rated as **a 2.**
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -0.88% which is a **rating of 3**.
- **The agency expenditure metric** assesses agency expenditure against planned costs for the Trust. Costs of £0.92m are £0.13m (12.04%) less than plan and would be **rated as a 1.** (The agency metric assesses performance against plan). NHS planning guidance for 2024/25 has set a target that provider (and aggregate system level) agency expenditure should not exceed 3.7% pay bill. During April 2024 the Trust's agency costs were 2.78% of pay bill.

Specifically for agency please refer to **25a) Financial Plan: Agency expenditure compared to agency target & 25b) Agency price cap compliance.**

The Trust's financial performance results in an **overall UORR** of **2** for the period ending 30th April.

**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

Underlying issues:
There are no additional underlying issues to report. As recovery actions to support delivery of the Trust's planned breakeven position and improved agency compliance are targeted and progressed these will support achievement of the associated individual UoRR metrics and overall UoRR rating.

Actions:
There are no specific improvement actions required.

27) Cash Releasing Efficiency Savings (CRES) Performance - Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

DQ

80%

Update:

CRES performance was not reported on in April, as plans were still being finalised for submission nationally in May.

2024/25 financial plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year. We plan to deliver **£15.72m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year, with £1.52m expected to be delivered in April.

Following the submission of our financial plan, confirmed recurrent CRES plan key areas include:

- **Pay schemes** include actions to sustain Agency reductions in Inpatient and other clinical areas including from improved rostering, recruitment (including International), to aim to reduce Medical Locum (high premia rate) usage and to address over spending due to over establishments in both Care Groups.
- **Non Pay schemes** including actions to eliminate Independent Sector bed reliance by Quarter 4 as well as savings from LED Light installation, IT licences, mobile phones, printing, the appraisal system and Taxi usage.

**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

Underlying issues:
We need to deliver recurrent CRES schemes to achieve our in-year financial plan and improve our underlying financial sustainability.

Actions:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.

28) Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
CRES performance was not reported on in April, as plans were still being finalised for submission nationally in May.

2024/25 plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year.

We plan to deliver **£6.09m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year, though none of these schemes were expected to be realised in April 2024.

£4.00m of non-recurrent CRES have been identified in the plan, but with a residual £2.06m remaining unidentified presently and a key focus.

Underlying issues:
It has been essential to target non-recurrent CRES to aim to target a broadly break even plan, however reliance on non-recurrent schemes leave an underlying unmitigated financial challenge moving ahead beyond 2024/25.

Actions:
Financial Planning activities will confirm the extent to which the same actions can be delivered recurrently (or non-recurrently) and any other scope to deliver new non-recurrent CRES in 2025/26 to mitigate underlying financial pressures.

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29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Capital expenditure was **£0.6m** at the end of April and **£0.3m above plan**.

£8.5m 2024/25 Capital schemes have been approved for funding from nationally allocated capital delegated via North East and North Cumbria Integrated Care Board (ICB).

The Trust has secured £1.8m of additional cash-backed central funding in 2024/25 to improve IT systems and assist creating our Mental Health hub in North Yorkshire. This is not included in performance measurement against capital allocated through ICBs.

This means the Trust's **aggregate capital programme for 2024/25 is £10.7m**.

Key variances in the year were:

- Lifecycle phasing delivering programme expenditure earlier than planned.
- £90k relating to schemes that were planned to complete in 2023/24 but where costs slipped into 2024/25.

Underlying issues:

There are no underlying issues to report.

Actions:

A key focus is on the recruitment of escorts to enable sensor door installation. Any anticipated delays to planned inpatient environment schemes are communicated to the Environmental Risk Group to manage any associated risks.

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30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£60.98m** at the end of April 2024 against a planned cash balance of **£56.64m** which was a **£4.34m positive variance** to plan.

- This was mainly due to training income received in advance of the period to which it relates.
- The Trust narrowly failed to achieve the 95.0% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined April BPPC of 93.4%. We continue to support the use of Cardea to make processes as efficient as possible, and to ensure suppliers are paid promptly.
- The value of debt outstanding at 30th April 2024 was £4.1m, with debts exceeding 90 days amounting to £0.52m (excluding amounts being paid via instalments and PIPS loan repayments). Three whole of government accounting (WGA) organisations account for 72% of total debts greater than 90 days old (£0.38m), and progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

Underlying issues:

In additional to information at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit, the Trust needs to expend significantly more via its annual capital programme budget than is generated internally from depreciation, meaning the Trust's annual cash reserves are gradually reducing.

Actions:

See actions at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.

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Which strategic goal(s) within Our Journey to Change does this measure support?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	Goal 1 - To Co-Create a great experience for our patients, carers and families	Goal 2 - To Co-Create a great Experience for our Colleagues	Goal 3 - To be a great partner
1	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
2	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√	√	
3	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
4	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
10	The number of Patient Safety Incident Investigations reported on STEIS	√	√	
11	The number of Incidents of moderate or severe harm	√		
12	The number of Restrictive Intervention Used	√	√	
13	The number of Medication Errors with a severity of moderate harm and above	√		
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		√
15	The number of uses of the Mental Health Act	√		
16	Percentage of staff recommending the Trust as a place to work	√	√	√
17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
18	Staff Leaver Rate	√	√	√
19	Percentage Sickness Absence Rate	√	√	√
20	Percentage compliance with ALL mandatory and statutory training	√	√	√
21	Percentage of staff in post with a current appraisal	√	√	√
22	Number of new unique patients referred	√	√	√
23	Unique Caseload (snapshot)	√	√	
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
25	Financial Plan: Agency expenditure compared to agency target			
26	Agency price cap compliance			
27	Use of Resources Rating - overall score			
28	CRES Performance - Recurrent			
29	CRES Performance - Non-Recurrent			
30	Capital Expenditure (CDEL)			
31	Cash balances (actual compared to plan)			

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	1. Safe Staffing	2. Demand	3. Co-Creation	4. Quality of Care	5. Digital	6. Estate / Physical	7. Cyber Security	8. Quality Governance	9. Partnerships and System	10.Regulatory compliance	11. Roseberry Park	12. Financial Sustainability	13. Public confidence
1	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	√	√									√
2	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√		√	√									√
3	Percentage of inpatients reporting that they feel safe whilst in our care	√		√	√									√
4	Percentage of CYP showing measurable improvement following treatment - patient reported	√	√		√	√			√	√			√	√
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√	√		√	√			√	√			√	√
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√		√	√			√	√			√	√
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√		√	√			√	√			√	√
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√				√				√	√
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√	√		√				√				√	√
10	The number of Patient Safety Incident Investigations reported on STEIS	√		√	√		√				√			√
11	The number of Incidents of moderate or severe harm	√		√	√				√		√			√
12	The number of Restrictive Intervention Used	√		√	√		√				√			√
13	The number of Medication Errors with a severity of moderate harm and above	√			√	√			√		√			√
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		√	√		√			√	√			√
15	The number of uses of the Mental Health Act	√	√						√	√	√			
16	Percentage of staff recommending the Trust as a place to work	√	√				√		√	√	√			√
17	Percentage of staff feeling they are able to make improvements happen in their area of work	√		√					√	√	√			√
18	Staff Leaver Rate	√							√		√		√	√
19	Percentage Sickness Absence Rate	√	√								√		√	√
20	Percentage compliance with ALL mandatory and statutory training	√			√			√	√	√	√		√	√
21	Percentage of staff in post with a current appraisal	√			√				√		√			√
22	Number of new unique patients referred		√		√				√	√	√		√	√
23	Unique Caseload (snapshot)	√	√		√				√	√	√		√	√
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit					√		√	√		√	√	√	
25	Financial Plan: Agency expenditure compared to agency target	√	√		√				√		√		√	
26	Agency price cap compliance	√							√		√		√	
27	Use of Resources Rating - overall score	√	√		√				√		√		√	
28	CRES Performance - Recurrent	√	√				√		√		√		√	
29	CRES Performance - Non-Recurrent								√		√		√	
30	Capital Expenditure (CDEL)					√	√		√		√	√	√	
31	Cash balances (actual compared to plan)					√	√				√	√	√	

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National Quality Standards and Mental Health Priorities Headlines

Headlines

- **72 hour follow up** failed target in all areas.
- **EIP waiting times** failed target in all areas except Tees Valley.
- **Talking Therapies waiting times (6 and 18 weeks)** achieved target in all areas.
- **Child Eating Disorders waiting times** failed target in all areas except for Tees Valley (routine cases) and North Yorkshire (urgent cases).
- **Talking Therapies: 1st to 2nd treatment waits** – failed target in all areas except for North Yorkshire. **Reliable Recovery –** failed target in Tees Valley and Vale of York. **Reliable Improvement –** failed target in all areas except for North Yorkshire.
- **Children: 1 contact -** failed plan in all areas. **Paired Outcomes -** failed target in County Durham & Tees Valley.
- **Access to transformed community services** failed target in all areas except Tees Valley where we have no fully Transformed services.
- **Active OAP (inappropriate)** achieved plan in both ICB areas.
- **Specialist Community Perinatal Mental Health (PMH) services** failed target in North Yorkshire and Vale of York

Risks / Issues

Of most concern at month 1:
- 72 hour follow up*
- EIP Waiting Times* (except Tees Valley)
- Child Eating Disorders Waiting Times (except Tees Valley routine cases and North Yorkshire urgent cases)
- Talking Therapies 1st to 2nd treatment (except North Yorkshire)
- Talking Therapies Reliable Improvement (except North Yorkshire)
- CYP 1 contact
- Access to transformed community services (except Tees Valley)

Of concern at month 1:
- Talking Therapies Reliable Recovery (Tees Valley & Vale of York)
- Childrens Paired Outcomes (County Durham & Tees Valley)
- Specialist Community PMH services (North Yorkshire & Vale of York

These measures have been impacted following the implementation of Cito and we are undertaking a comprehensive validation of the data for April 2024 to ensure that we can accurately demonstrate that our patients are safe and are receiving the quality of care that we would endeavour to deliver.

Positive Assurance

- Talking Therapies waiting times (6 and 18 weeks)
- Active OAPs (inappropriate)

National Quality Standards and Mental Health Priorities Headlines

Mitigations

EIP waiting times
We would expect to complete this by the end of May 2024. Further to last month's update, North Yorkshire, York & Selby Care Group have recruited to all 4 posts, two of which are preceptorship roles, start dates July 2024. The service is continuing to recruit temporary staff in the interim to support improvement in waiting times and have a recovery plan in place.

Child Eating Disorders waiting times
DTVFCG have a PIP and the outstanding action is to ensure the patient tracker is fully utilised and data quality is corrected in a timely manner going forward; this has not yet been completed. The Care Group have requested an extension to the action to the end of June 2024. In relation to NYYSCG the underlying issue was Patient Choice. Non-attendance is managed through engagement with patients/families in line with the DNA policy.

Talking Therapies 1st to 2nd treatment waits
DTVFCG have a PIP and the actions are to implement a gatekeeping process for low intensity step ups; review demand and align capacity to ensure availability of slots; develop a standardised VCB for the Leadership Teams so resources and demand can be aligned; amend the report out process and attendance to include monitoring the outcome of assessments and use of CCBT importance and workshops will be prioritised. It is anticipated these actions will improve waiting times by 5-10% by May 2024 (June report). NYYSCG have developed a PIP with an action to temporarily increase capacity through overtime which will reduce the wait between first and second appointment by 31st May 2024 (full impact visible by the end of November (December report)). A further action to complete professional development training by the end of June 2024 will prevent patients being mis-diagnosed with social phobia and is anticipated to reduce the step 3 waiting list by 30% (anticipated impact by the end of September 2024 (October report)).

Talking Therapies Reliable Recovery, & Talking Therapies Reliable Improvement
Whilst we recognise we are not achieving the standard, we would not identify any specific actions based on one month's non-achievement. All Sub-ICB Locations that are not achieving standard are less than 3.5% from plan and work is now underway to identify any underlying issues.

CYP 1 contact
Whilst we recognise we are not achieving the plans, we would not identify any specific actions based on one month's non-achievement. We are less that 1% from plan for County Durham & Tees Valley Sub-ICB Locations; we are 9% and 5% off target for North Yorkshire and Vale of York Sub-ICB Locations respectively and work is now underway to identify any underlying issues.

Childrens Paired Outcomes
The business case for a dedicated outcomes team is no longer being progressed due to lack of funding. Further discussions are required with the services as part of the wider improvement work on outcomes.

Access to transformed community services
Whilst we recognise we are not achieving the plans, we would not identify any specific actions based on one month's non-achievement. All Sub-ICB Locations are less than 5% from plan and work is now underway to identify any underlying issues.

Specialist Perinatal Mental Health
NYYSCG have developed a PIP and the actions are to recruit to the vacant posts and to develop standardised triage criteria to ensure all appropriate woman are accepted onto caseload. It is anticipated the impact of these actions will increase the number of women being assessed resulting in an increase in women accessing services and achievement of standard by end of January 2025.

National Quality Standards and Mental Health Priorities Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

National Quality Requirements

Measure	Agreed S-ICBL Plan	Trust					County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	80%	56.16%				56.16%	52%				52%	58%				58%	62.86%				62.86%	50.00%				50.00%
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	43.64%				43.64%	33.33%				33.33%	64.29%				64.29%	54.55%				54.55%	16.67%				16.67%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment	75%	99.77%				99.77%	100%				100%	100%				100%	99.56%				99.56%	99.60%				99.60%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment	95%	100%				100%	100%				100%	100%				100%	100%				100%	100%				100%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)	95%	90.71%				90.71%	82.43%				82.43%	97.53%				97.53%	93.94%				93.94%	89.47%				89.47%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)	95%	75.44%				75.44%	72.97%				72.97%	66.67%				66.67%	100.00%				100.00%	80.00%				80.00%

Local Quality Requirements

Measure	Agreed S-ICBL Plan	Trust					County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD	Q1 (Apr)	Q2	Q3	Q4	FYTD
Talking Therapies: Percentage of people who have waited more than 90 days between first and second appointments	<10%	54.72%				25.21%	22.91%				22.91%	37.40%				37.40%	4.90%				4.90%	49.02%				49.02%
Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness	48%	49.29%				49.29%	48.86%				48.86%	46.60%				46.60%	51.72%				51.72%	47.35%				47.35%
Talking Therapies: Reliable improvement rate for those completing a course of treatment	67%	67.21%				67.21%	65.46%				65.46%	63.79%				63.79%	70.16%				70.16%	66.56%				66.56%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months)	*	29656				29656	9933				9933	11211				11211	3707				3707	4291				4291
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40.00%	26.80%				26.80%	15.56%				15.56%	23.26%				23.26%	55.56%				55.56%	44.74%				44.74%
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months)	*	10917				10917	5539				5539	0				0	2403				2403	2975				2975
Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	*	1				1	0				0	0				0	1				1	0				0
Number of women accessing specialist community PMH services in the reporting period (rolling 12 months)	*	1315				1315	484				484	487				487	180				180	164				164

NOTES ** Denotes individual plans agreed by area. Trust position represents total activity for commissioned services only (with the exception of Talking Therapies)*

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	13th June 2024
Title:	Trust Our Journey to Change Delivery Plan quarter 4 (January – March 2024) progress update
Executive Sponsor(s):	Mike Brierley, Assistant Chief Executive
Author(s):	Strategy Team

Report for:				
	Assurance	√	***Decision***	
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	√
2: To co-create a great experience for our colleagues	√
3: To be a great partner	√

Strategic Risks relating to this report:

The *Our Journey to Change Delivery Plan 2023/24* is informed by an understanding of all of the BAF risks and the differential levels of risk appetite for each of the risks within it.

Executive Summary:

Purpose: This report provides the end of year position on the Our Journey to Change delivery plan for 2023/24. It provides updates on the overall position, the 5 journeys, 17 priorities & 61 projects pertaining to the delivery plan.

Proposal: Board members are asked to review the updates on journey, priority and project progress over the last financial year. The report provides an additional feature this quarter: a year-end journey overview and a key messages per journey. The report also provides a summary delivery position as a percentage at a project and journey level.

Overview: The updates to this report were provided from various sources via verbal & written reports. The legend outlining RAG categories is below:

Key	
	Completed
	In Progress/ Continuing
	Delayed
	Delayed
	Paused

This report includes:

- **Page 3:** Priority RAG status at end of Quarter 4
- **Page 4:** Project RAG rating
- **Page 5-9:** Individual journey overviews of 2023/24

Prior Consideration and Feedback Where appropriate, progress and issues have been discussed within Care Group or Executive Group meetings. The updates have also been presented at the OJTC workshop on 10th May and Management Group on 21st May.

Implications: Substantial work has been undertaken this year and progress has been made and this work is detailed on pages 5-9. However, 77% of the 61 projects are ongoing and this work will continue as part of the 17 priorities which have been set for 2024/2025.

The tables below outline the percentage of project which have been completed per journey (Table 1) and overall (Table 2).

Table 1: % of completed projects per Journey

	Journey RAG status				
	Complete	In progress /continuing	Delayed		Paused/Not started
Ciinical Journey	16.6%	55.5%	11.1%	11.1%	5.6%
Quality and Safety Journey	0.0%	66.7%	33.3%	16.6%	8%
Co-Creation Journey	0.0%	100.0%	0.0%	0.0%	0%
People Journey	14.3%	57.0%	28.6%	0.0%	0%
Infrastructure Journey	50.0%	10.0%	10.0%	30.0%	0%

Table 2: % of projects completed overall.

Total Journey project RAG status				
Complete	In progress /continuing	Delayed		Paused
22.90%	40.90%	16.39%	16.39%	3.27%

Recommendations: Board members are asked to:

a) Note the information and analysis provided in this report.

b) Provide any comments as necessary.

Priority RAG status at end of Quarter 4

Cliical Journey	Project RAG status					Total projects per priority
Community Transformation	3	6			1	10
CITO			1			1
Autism		4	1	2		7
						18

Q&S Journey priorities	Project RAG status					
Reducing In-patient pressures			1	2	1	4
Patient Safety		3				3
Harm Free Care		1	3			4
Personalising Care Planning		1				1
						12

Co-creation Journey priorities	Project RAG status					
Expand/develop Lived experience posts		1				1
Data collection & Learning		2				2
Diversify/expand Involvement		1				1
						4

People Journey priorities	Project RAG status					
More people		2	1			3
Inclusive & compassionate culture	1	1				2
Working differently		1	1			2
						7

Infrastructure Journey priorities	Project RAG status					
One Team TEWV	4					4
Digital & Data	3	2	1			6
Green Plan				5		5
Estates Masterplan	3		1	1		5
	0					20

Overall number	14	25	10	10	2	61

Project RAG rating

Journey	Individual Projects	End Date & RAG
Clinical Journey Priorities		
Community Transformation	Adult / Older People's community mental health team transformation - DTV	Mar-24
	Crisis - DTV	Jun-23
	I-Thrive - DTV	Mar-24
	Adult LD - DTV	Sep-24
	Forensics – Establishing a Community	Sep-24
	Health and Justice – Reconnect, North Yorkshire	Jul-23
	Older People's community mental health team transformation – NYYS	Mar-24
	Adult community mental health team transformation – NYYS	Mar-24
	Crisis - NYY	Mar-24
	I-Thrive - NYY	Jun-24
Cito	CITO	Jun-24
Autism	Autism Training	Mar-24
	Autism Reasonable Adjustment support and coordination.	Mar-24
	Complex Autism case work	Mar-24
	Children and Young People Neurodevelopmental Assessment Service - DTV	Sep-23
	Adult Neurodevelopmental Service - DTV	Dec-23
	Children and Young People Neurodevelopmental Assessment Service - NYY	Sep-23
	Adult Neurodevelopmental Service - NYY	Sep-23
Q&S Journey Priorities		
Reducing in-patient pressures	Inpatient Flow – DTV AMH and MHSOP wards	Mar-24
	Older adults pathway (NYYS) Ensure 7 day availability for Assessment & Treatment	Mar-24
	Reducing pressure on inpatient beds programme	Mar-24
	Implement bed configuration in line with NE&NC SSs Provider Collaborative Review	Oct-25
Patient Safety	Patient Safety Incident Response Framework (PSIRF)	Apr-24
	Learning from patient safety events (national system) (LFPSE)	Dec-23
	Serious Incident backlog recovery/Local management of incidents	Dec-23
Harm Free Care	Reducing the Use of Restrictive Interventions	Mar-24
	Safeguarding / Parental/Carer Mental Ill Health impact on children (PAMIC)	Mar-24
	Reducing in Sexual Safety Incidents	Mar-24
	Reducing suicide / misadventure	Mar-24
Personalising Care Planning	DIALOG+ full implementation through CITO	Jul-23
Co-creation Journey Priorities		
Lived Experience Posts	Expand and develop lived experience roles and leadership, including peer support workers	Dec-23
Data Collection & Learning	Improve & accurately capture patient experience data	Ongoing
	Review/transform PALS and complaints pathways with co-creation principles	Dec-23
Diversify & Expand Involvement	Embed and grow co-creation across the organisation	Oct-23
People Journey Priorities		
More people	New Starters and Onboarding	Sep-24
	International Recruitment	Dec-23
	Workforce Planning	Mar-24
Inclusive & compassionate culture	Leadership Development programme	Ongoing
	Health and Wellbeing Council	Mar-23
Working Differently	Workpal	Feb-24
	Smarter Working	TBC
Infrastructure Journey Priorities		
One Team TEWV	Full review of Corp service staff lists & reconciliation of data on Oracle/ESR	Jun-23
	Develop digital and data service standards	Jan-24
	Set up a new Corporate Services Leadership Group	Jul-23
	Voluntary and Community Sector provider grants scheme	Mar-24
Digital & Data	Electronic Prescribing and Medicines Administration (EPMA)	Mar-25
	Improving Connectivity	Jul-23
	IIC re-procurement and migration	Jan-24
	Robotic Process Automation	Oct-23
	Enhancing collaboration	Jun-23
	Asset Management	Mar-24
Green Plan	Embedding the Green Plan and Carbon reduction	May-23
	Heat Decarbonisation Plan	Sep-23
	Installation of additional electric charging points at trust properties	Dec-23
	Trust Environmental Pledge - 'Pledge for Greener'	Dec-23
	Look to address the carbon footprint from supplier to door when procuring goods	Mar-24
Estates masterplan	Health, safety and assistive technology	Rolling
	New base for Stockton AMH services	Sep-23
	Medical Education Facilities	Mar-24
	One Public Estate participation	Mar-24
	Strategic Estates Planning	Mar-24

Clinical Journey – overview of 2023/24

Community mental health team transformation:

- **AMH/MHSOP:** this work has progressed well across both Care Groups with the creation of community hubs.

- **Crisis**: Clinical and workforce models mobilised to enable timely launch of new NHS 111 (2) in both Care Groups. Everyturn appointed in NYY, and service commenced.

- **I-Thrive**: DTV: Work continues on this project to confirm the core offer into 24/25. Co-created CAMHS web pages will be launched in June 2024. NYY: Delivery sits with the commissioner timetable and has moved into 2024/25.

CITO went live 5 Feb 2024. Cito has highlighted several data quality issues. Work continues to improve Cito performance issues and address concerns of data integrity.

Autism/Neurodevelopmental: training continues to be delivered. Neuro-developmental work continues across both Care Groups however it is different in different areas, including across specialities. National issue, & place-based solution needs a whole system approach.

Adult Learning Disabilities: LD inpatients CQC restrictions lifted and has reopened to planned admissions. Embedding HOPES model and practice. Positive step but still more to do.

Forensics - establishing a community: Strong partnership continues in establishing a community within Ridgeway, working closely with service users and carers on co-creation projects. Continue to develop Stepped Care Psychological Interventions and Treatment for a range of offending behaviours.

Health and Justice – Reconnect, North Yorkshire: It is now confirmed this will be included in the re-tender for Non-Custodial Services.

Key messages:

Community mental health transformation and autism continue into 24/25. Community hubs are progressing well in both Care Group areas.

Our new electronic patient record system is live.

Significant improvement in safety and quality has allowed the reopening of Bankfields Court to planned admissions.

Autism - developed a trust wide autism service providing consultation/ training/ supervision.

Forensic Services - several winners at Positive Practice in Mental Health Awards May 2024.

Quality & Safety Journey – overview of 2023/24

Inpatient flow: Patient flow work continues however further amendments are being made to the Central bed management policy which has delayed its ratification. It is anticipated that this and the associated Admissions, Transfers and Discharge Policy should be ratified by July 2024. The PIPA refresh is now complete. All wards have completed their individual PIPA action plans and are being continually reviewed under a PDSA approach.

Reducing Pressures Inpatient Programme: There has been a significant reduction in OAPs through actions taken by the care groups and operational teams, however getting down to zero and sustaining continues to prove challenging.

Patient Safety Incident Response Framework: PSIRF was implemented on 29th January 2024. Patient Safety Incident Investigations and early learning processes have been reviewed to ensure appropriate rigour.

Serious incident backlog recover/ local management of incidents: All investigations from the historical backlog are now allocated with the 93% completed and closed and the remaining investigations are progressing to closure post directors panel. A sustainability plan is in place to ensure no recurrence of backlog.

Learning from patient safety events; national system: The InPhase incident recording application, which is LFPSE compatible went live in October 2023. The trust is fully compliant.

Reducing the use of Restrictive Interventions: Positive and safe improvement plan in place and reviewed annually reflecting current evidence-based practice.

Safeguarding / parental/carer mental ill health impact on children (PAMIC) Working group established with clinical services to take forward into 2024/25.

Reducing suicide/misadventure: The suicide prevention team have now moved into patient safety thus aligning strategic goals, ensuring alignment and potential gaps to be addressed.

Reducing Sexual Safety Incidents: We have no reported breaches from January to December 2023. The number of sexual safety incidents have reduced from a peak of 98 in May 2023 to 39 in December 2023.

Key messages:

PSIRF and LFPSE projects have successfully completed.

SI backlog has been addressed and plans in place to ensure future sustainability.

There have been no breaches in mixed sex accommodation between Jan-December 2023.

Reducing the use of restrictive interventions and reducing suicide/misadventure work continues into 24/25.

Co-creation Journey – overview of 2023/24

Expand and develop lived experience roles and leadership, including peer support workers: Ongoing partnership to co-deliver training in Tees Valley, Durham network go live June – lived experience staff network established.

Improve & accurately capture patient experience data: 94% rate their experience good or very good, new system being procured involving patients and carers, important data from feeling safe and quality visits informs change.

Review/transform PALS and complaints pathways with co-creation principles: new complaints process now being rolled out, increased compliance, focus on resolving issues quickly and learning from them. Triangulating data with other areas

Embed and grow co-creation across the organisation: 400+ involvement members, actively seeking out different voices, reviewing training and support for those involved. Good progress however co-creation framework and comms strategy, as well as payments review vital.

Key messages:

Achieved all delivery plan actions and work will be continued in 24/25.

Workforce development progressed with implementation of Professional Head of Peer Work. Peers now appointed at each level of the developed job description suite.

Two care group co-creation Boards in DTVF and NYYS established July 2023 both have key-cocreated priorities.

Co-creation leadership team in place.

People Journey – overview of 2023/24

New Starters and Onboarding: New timescales agreed to end of September 2024. Phase 1 complete November 23. Phase 2 to be completed by September 2024**.** Significant impact on timeliness of all stages of recruitment process

International Recruitment: Work continues with NHS England on specific recruitment. International nursing recruitment on target for 2023/24, refresh 2024 plan due end of year.

Workforce Planning: Ongoing engagement with Care Groups and Clinical Networks. Work to deliver initial plans by July 2024 is on track.

Leadership Development Programme: programme continues.

Health and Wellbeing Council: Council now established and operating well.

Appraisal system: WorkPal renamed and new trust-wide appraisal and supervision recording system now in place and work continues on developing functionality.

Smarter Working: Linking with national guidance and toolkits, and pilots underway, reporting end of May, will inform future plans through the summer.

Key messages:

HCA council established.

Significant work accomplished for international recruitment project.

All other work is ongoing and will be carried over into 2024/25 under the 'Deliver our People Plan' priority.

Infrastructure Journey – overview of 2023/24

One Team TEWV: all actions complete. Reviewed & streamlined corporate systems to enable services to work together better.

Digital & Data:

- Electronic Prescribing and Medicines Administration (EPMA): inpatient roll out completed; community plan approved for 24/25 roll out.
- Improving connectivity work: wireless network improvements, improved user experience.
- Integrated Information Centre (IIC) re-procurement & migration: Revised delivery dates proposed. Configuration work undertaken. Current focus on completing data transfers and User Acceptance Testing. Additional costs due to dual running of current and new platform.
- Robotic Process Automation: Project complete. Transitioned to business as usual in Quarter 3.
- Enhancing Collaboration: Project complete. Moves from Modern gov and Pando to Microsoft Teams prior to Modern gov contract expiry (May 24).
- Asset Management: Centralised Asset Management project fully re-initiated. Phase 2 focus on existing provision of software licences. Phase 3 on mobile telephony provision moving at pace.

Green Plan: Milestones not achieved due to recruitment challenges. Delivery is a key 2024/25 priority.

Health, safety and assistive technology (Oxehealth): Oxehealth developed throughout the year following full review of initial pilot. Monthly steering group chaired by Deputy Chief Nurse has project oversight, supported by regular clinical and installation meetings. These groups have specific areas of focus and have identified work streams that run alongside the installation plans, including related policies, training and comms. Programme to continue into 24/25.

New base for Stockton Adult Mental Health (AMH) services: Build complete, services have moved in.

M**edical Education Facilities:** Scheme delayed due to technical issues & the need to re-scope works (excluding structural library provision). Works will now take place over the summer 2024.

One Public Estate participation: project complete.

Key messages:

One Team Tewv work complete.

EPMA inpatient roll out complete.

Improving connectivity, Robotic Process Automation and Enhancing Collaboration projects complete.

Community EPMA roll out continues in 24/25

Green plan work to carry forward to 24/25 as a key priority.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 June 2024**
Title:	**Our Journey to Change Delivery Plan 2024/25**
Executive Sponsor(s):	**Mike Brierley**
Author(s):	**Chris Lanigan**

Report for:				
	Assurance		***Decision***	√
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	√
2: To co-create a great experience for our colleagues	√
3: To be a great partner	√

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
		The delivery plan has been developed to address environmental risks and opportunity as a whole

Executive Summary:

Purpose: This report is intended to assure the Board that the Trust's Our Journey to Change (OJTC) has been developed appropriately and can be approved.

Proposal: It is proposed that the Board of Directors consider and approve the Trust's OJTC Delivery Plan (attached at **appendix 1**).

Overview: The Trust Delivery Plan is a "high level" plan which sets out the contextual background and then the Trust's 16 developmental priorities for the year ahead. For each of them it describes:

- The "reason why" behind the priority
- Key areas of focus
- What "success" would look like
- Interdependencies with other internal and partner work
- Key milestones

On 14 March, a working draft Trust delivery plan was presented to the Board of Directors. The national NHS planning guidance was published on the penultimate working day of the 23/24 financial year and ICB discussions around financial expectations continued into mid-May. The outcome of those negotiations is that the working draft OJTC Delivery Plan presented in March can broadly be delivered within the available resources and so can now be formally considered by the Board of Directors.

The Council of Governor's consideration of the plan raised a concern from a governor about why refugees / asylum seekers were not identified as an area of focus in the *reducing health inequalities* plan on a page (page 23). The Trust's Consultant in Public Health notes that we already have a BAME link worker in post whose focus is supporting access to our services for asylum seekers and

refugees. The Trust has applied for research funding for this area, and if that bid is successful then this could be an area of focus for next year's plan.

The delay to the final approval of the plan necessitated a review to check whether environmental change during April and May required any changes to the detail within the plan. There are therefore a small number of changes from the working draft plan considered by the Board in March which are summarised in the table below.

Page	Plan on a page	Change made
16-17	Transforming Community Services	Change of priority lead to reflect care groups' role in delivering key service changes
19	NENC adult secure bed model	Changes to milestone dates to reflect changes to the North East Specialist Provider Collaborative's plans
20	Expanding our Health & Justice Services	Revised date for HMP Millsike contract commencement
22	Young Adults Services	Addition of milestone dates
27	Improve Patient Experience	Changes to milestone dates
31	Estates Master Plan	Changes to milestone dates (including bringing forward the catering infrastructure completion date)
32	Digital & Data Plan	Changes to milestone dates

Quarterly monitoring will still take place after the end of June and then subsequently after the end of Quarters 2, 3 and 4. There will be reports summarising progress and issues being taken through Management Group and the Board of Directors.

The process to develop the 25/26-27/28 Delivery Plan will commence shortly. This process will:

- Align with the work to review Our Journey to Change (including the forthcoming *Big Conversation*);
- Connect our clinicians' work on clinical models with care groups' and transformation programmes' planning;
- Encourage services to identify their target operating models and actions needed to achieve these over the next 3 years;
- Identify a range of benefits metrics to be used to measure impact of plan implementation.

A refreshed lived experience reference group is being formed as a sounding board during this process and will start meeting in July.

Prior Consideration and Feedback The 24/25 delivery plan has been discussed by the Trust's Lived Experience planning reference group and all relevant Trust governance meetings.

Implications: The implications of the Plan have been considered and it can be delivered within the resources available to the Trust during 24/25.

Recommendations: The Board of Directors is recommended to approve the Our Journey to Change Delivery Plan 2024/25.

journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our Journey to Change Delivery plan

2024/25

Who we are and who we care for

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) was formed in April 2006 and was authorised as a foundation trust on 1 July 2008. We provide mental health and learning disability services for the people of County Durham and Darlington, Teesside, North Yorkshire, York, and Selby.

From education and prevention to crisis and specialist care — our talented and compassionate teams work in partnership with our patients, communities, and partners to help the people of our region feel safe, understood, believed in and cared for.

Almost 8,500 staff work across more than 90 sites, including Foss Park, a state of the art 72-bed hospital and research space in York which opened in 2020. Our other main hospitals are in Durham (Lanchester Road), Middlesbrough (Roseberry Park), Darlington (West Park) and Scarborough (Cross Lane).

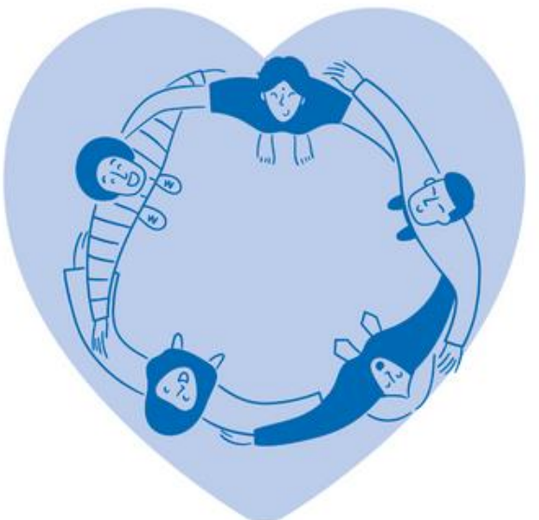
While we provide over 700 inpatient beds, we deliver treatment to most people we serve in their own homes or the places they live in.

We also provide mental health care within prisons, and an immigration removal centre, located in the North East, Humber North Yorkshire, Cumbria and parts of Lancashire.

We manage our services through two Care Groups, which are supported by corporate services. These care groups are:

- Durham, Tees Valley and Forensics
- North Yorkshire, York and Selby

Most importantly, everything we do is guided by **Our Journey to Change** and our values.



Our Journey to Change sets out where we want to be and how we'll get there. It includes our goals that we co-created with patients, carers, colleagues and partners. We are working hard to embed our values and make sure everyone, in every role across our Trust, demonstrates respects and compassion and takes responsibility for the care we give.

journey to change

Launched in August 2020, Our Big Conversation was the biggest listening exercise in the history of the Trust. Over 2,100 people shared 35,800 ideas, comments, and votes, exploring what could be possible if we got everything right and what we must do to achieve this.

We heard that some people had a good experience with the Trust, but this wasn't consistent, and we heard that there is a lot we need to work on.

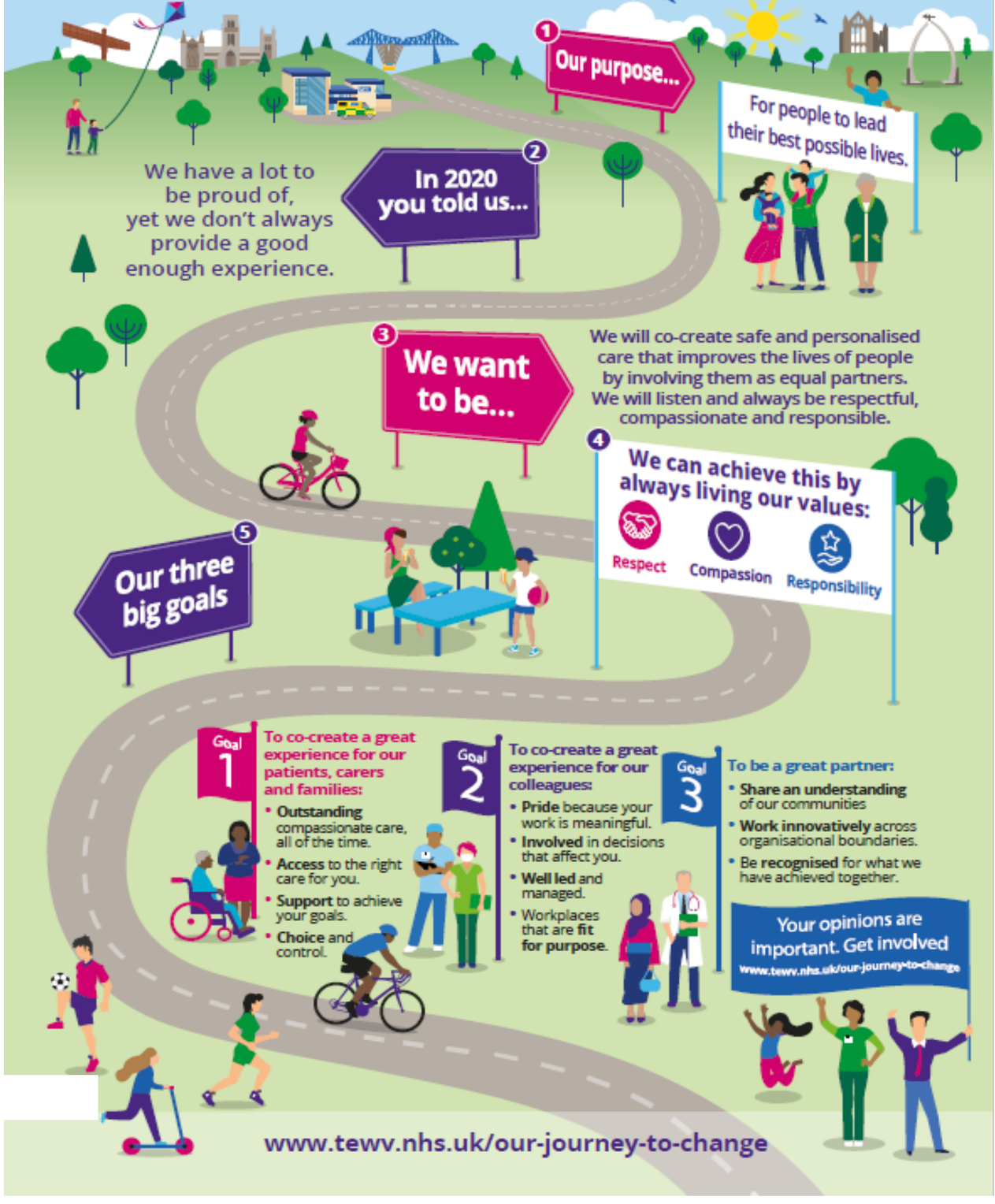
From the rich conversations and feedback we received from Our Big Conversation, we developed big ideas for change and a new strategic direction called **Our Journey to Change**.

It sets out why we do what we do, the kind of organisation we want to be and how we will get there by delivering our three goals and living our new values of respect, compassion, and responsibility all the time.

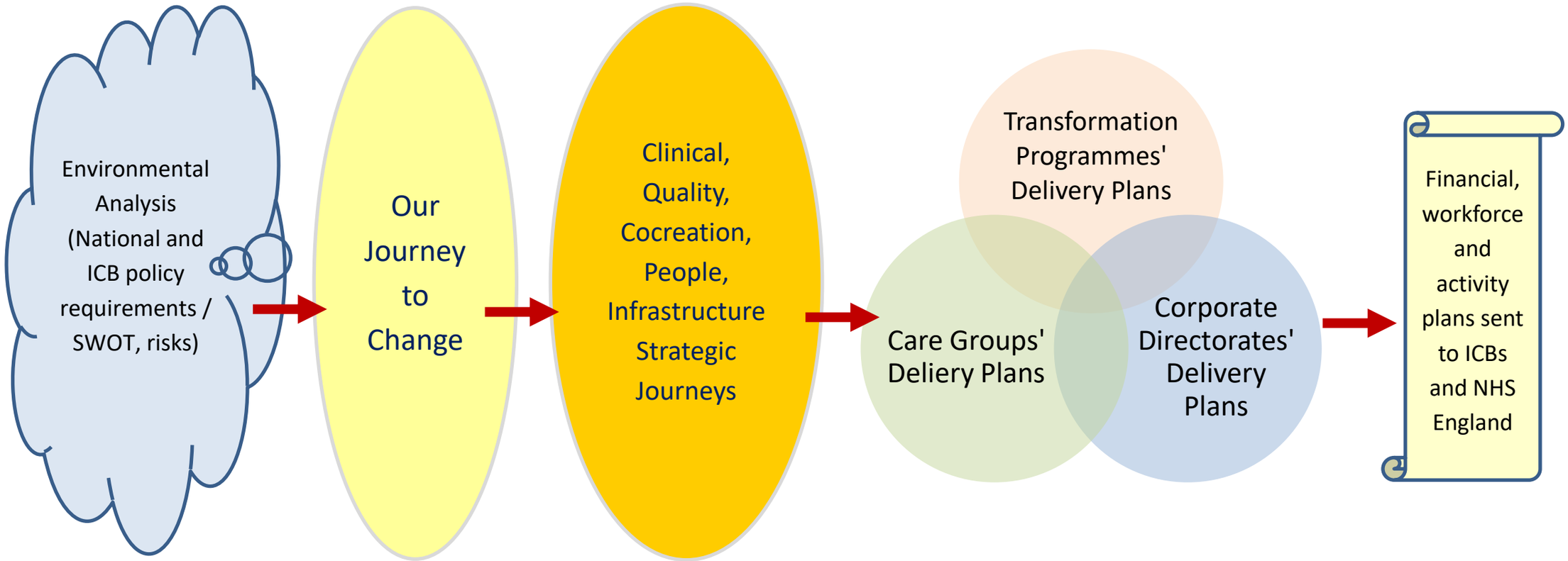
The big goals we have committed to deliver over the next five years are:
- to co-create a great experience for patients, carers, and their families
- to co-create a great experience for our colleagues
- to be a great partner

Our Journey to Change is at the forefront of everything we do, and all our decision making and 'supporting journeys' are aligned to it.

We have five underpinning journeys which are:
- clinical
- quality and safety
- people
- co-creation
- empowering infrastructure



Our Planning Framework



This document summarises our environmental analysis, our strategic journeys and our delivery plans. However, the delivery of Our Journey to Change also depends on incremental, day to day improvements that will be driven by our governance systems, and making sure that every interaction between staff, patients and partners is in line with our values of respect, compassion, and responsibility.

Co-Creation of our Delivery Plans

Our Journey to Change commits TEWV to cocreate a better experience for service users / carers, staff and partners. In developing our plans, we:

- Set up a Trust-wide Lived Experience Planning Reference Group.
- Set up a staff Our Journey to Change Champions Group.
- Engaged with our Partners, including commissioners (ICBs) and delivery partners.
- Invited people from all 3 groups to our Trust wide planning workshops.

The directors leading our Transformation programmes have engaged with people with lived experience (including indirectly through Healthwatch), colleagues and partners through workshops and other methods as they have developed their plans.

Our Care Group Plans were informed by our engagement with service users and carers, and with staff at service level.

Co-creation of our plans is essential because it ensures they are more robust, will tackle the real issues and have wide ownership by all the people whose help is needed to make them a success.

National and Integrated Care Systems' priorities

The NHS has a long-term plan for mental health which identifies several priorities for NHS commissioners and providers, including:

- improving access to existing services such as talking therapies, crisis services and community mental health services for both adults and children
- setting up and expanding new services such as perinatal, individual placement and support into work for people with severe mental health conditions
- transformation of community mental health services through place-based partnerships

During 2023/24 NHSE launched a new **Inpatient Quality Transformation** programme which seeks to improve the therapeutic level of inpatient care, support positive workforce culture, eliminate out of area placements, and develop effective early warning systems that enable support to be offered to struggling wards or hospitals.

23/24 also saw the initial implementation of the **Right Care: Right Person** policy in **police forces** across England. This will reduce the involvement of the police with mentally ill people. This will assist in reducing stigma and avoiding unwarranted involvement in the criminal justice system but will pose some challenges for mental health service providers such as TEWV.

The national priorities for **learning disability** services (known as *building the right support)* are to reduce the inappropriate use of hospitals and to reduce over-medication.

UK prison populations continue to expand, and the impact of mental illness in the **criminal justice system** is well understood nationally. Health and Justice commissioners are increasingly looking to commission specialist, "stand alone" mental health services for prisons.

The North East North Cumbria ICS (NENC) and Humber North Yorkshire ICS (HNY) have both developed integrated care strategies and 'joint forward plans'. HNY also approved a mental health, learning disability and autism strategy in 2021. These set out goals such as increasing life expectancy, improving health service quality and reducing health inequalities. For mental health and learning disabilities, they reference principles such as the importance of preventing the determinants of ill-health, early intervention, trauma informed care and quality improvement. Workforce development and utilising community assets, including the voluntary sector are also common features.

The NHS also has **financial challenges**. Mental Health services also face pressure from **increased demand** (especially from autistic people and children / young adults, which is partially linked to the impact of the pandemic period), insufficient **workforce** supply and limitations in social care and housing capacity which have led to an **increase in inpatients' average length of stay**.

How we are acting on regulators' findings about the Trust

BACKGROUND
The Trust's CQC inspection took place 29 March 2023 to 02 June 2023. As part of the inspection, the CQC visited 59 of our wards/teams. This comprised of inspections of wards/teams from a range of Core Services including Adult Learning Disability Community and Inpatient services, Secure Inpatient Services and Community and Inpatient MHSOP services. The CQC published the results of the Trust's latest trustwide inspection on its website on 25 October 2023.

WHAT THE CQC SAID ABOUT SERVICES PROVIDED BY THE TRUST
The CQC report demonstrates our continuous improvement and the positive impact that this has had on people's experience of the services that we provide. It also acknowledges that we still have more to do.

Importantly, the report recognises the hard work and commitment of Trust colleagues in making improvements. A running theme throughout the report is that our staff are kind and caring and demonstrate our values in the care that they provide. This is something that is seen every day, not just during CQC inspections. We know there is more to do but we're proud that we're moving forward together.

The CQC inspections took place from March to June 2023 and while the Trust's overall rating has stayed at requires improvement, there are no longer any areas that are rated as inadequate and the majority of our services are rated as good. Overall, the CQC recognises that we're making good progress.
This has been a real team TEWV effort. It is of particular note, that Ridgeway Secure Inpatient Services, wards for people with a learning disability or autism and wards for older people had all improved since their last inspection.

Inspectors found that our Trust had a clear vision and strategic direction, which is understood by all staff. They could also see a positive culture change. This was demonstrated by colleagues who felt supported and valued and had confidence in our freedom to speak up process. Most importantly by patients who told inspectors that staff were 'kind and considerate', 'friendly', 'kind and supportive' and that they were 'actively involved in their care planning'.

We all agree that further improvements are needed, however, we have come a long way in a relatively short space of time and in difficult circumstances. The areas for improvement are already in our sights and are being worked on every day. As with other trusts throughout the NHS, successful staff recruitment and retention and development of the excellent staff we have, remains a pressing priority and is key to us achieving all our goals.

Key facts and figures:

- Seven out of 11 of our services are rated ‘good’. Four areas are rated as ‘requires improvement’. This is an improvement since our last inspection in 2021.
- All services were rated as ‘good’ for caring.
- Nine out of 11 services were rated as ‘good’ or ‘outstanding’ for effective.
- No warning notices were served as a result of the inspection.
- No services were rated as ‘inadequate’.

As expected, the areas for improvement include issues seen nationally such as staffing and waiting times. We have also got some more work to do around mandatory training and recording supervision, physical health monitoring and responding to complaints. The backlog of serious incidents is highlighted as a ‘must do’, and we are committed to completing these in a timely way, with significant progress now made in reducing this. There is a clear plan in place to reduce delays and are making good progress.

We know that there is further work to do however, the fact that the CQC has told us we’re making improvements and that these positive changes have impacted on the quality of our care, is a really important step on Our Journey to Change.

ACTION
The Quality Governance Team have co-created the CQC Improvement Plan in collaboration with Care Group colleagues and Specialty/Directorate leads, in response to the CQC Must and Should Do recommendations made within the inspection report. Two Improvement Planning Events were held 31 October 2023 and 01 November 2023 to develop the improvement actions. The events were well-attended and the framework used was well received by those involved.

Improvement actions have been developed taking into account the significant work which has already been completed, avoiding duplication where actions are already being addressed by established workstreams or ongoing improvement plans are being delivered. This includes how we check that there is ongoing assurance of actions being embedded and sustained.

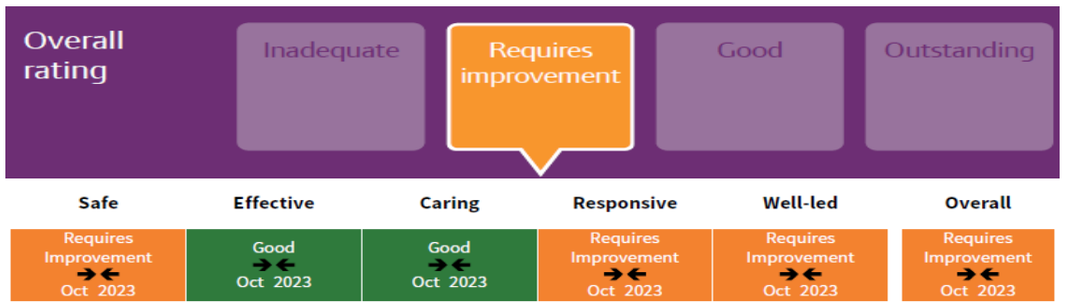
The Trust CQC Improvement Plan against the Must Do recommendations was formally submitted to the CQC 27 November 2023 after approval by the Extraordinary QuAC 22 November 2023. It is acknowledged that minor changes were made in response to consultative comments from Committee members. These were primarily amendments to timescales for some individual actions to ensure effective delivery.

The Quality Governance Team will continue to maintain the evidence repository to provide assurance of completion and implementation of improvement actions. Delivery progress for the CQC Improvement Plan (Must and Should Do actions) will continue to be formally reported to the Quality Assurance Committee, noting where actions are implemented and embedded.

Learning themes from the CQC Improvement Plan informed the Trust wide Learning Event 03 November 2023, where these were triangulated with broader quality governance intelligence, including learning from serious incidents, Quality Assurance Programme data and Complaints/PALS feedback.

Our overall ratings are shown below, and detailed service level ratings on the next page.

CQC Inspection 2023 Ratings



	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement → ← Oct 2023
Community-based mental health services of adults of working age	Requires Improvement ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023
Wards for older people with mental health problems	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Requires Improvement ↓ Oct 2023	Good ↑ Oct 2023	Good ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023
Forensic inpatient or secure wards	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Specialist community mental health services for children and young people	Requires improvement Sep 2022	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Sep 2022
Community-based mental health services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Wards for people with a learning disability or autism	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023
Specialist eating disorders service	Requires improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021

Environmental Analysis (SWOT)

A SWOT analysis looks at what is changing outside and inside the Trust and seeks to log the strengths, weaknesses, opportunities, and threats to achievement of Our Journey to Change. The Trust's analysis was informed by the views of:

- clinicians and managers that work for Care Groups
- our Lived Experience delivery planning reference group
- our Clinical Networks
- corporate teams that work across the Trust
- Board of Directors

The Trust strategy team also considered evidence from internal reports (such as our Integrated Performance dashboard) and external reports about the Trust and its services.

The SWOT used to inform this plan is shown below:

Strengths

a) OJTC – clear ambition for the future	b) Career development and opportunities	c) Lived experience/ peer roles
d) Organisational focus / resilience in sticking to its strategy and priorities	e) Medical / Clinical education and training / relationships with higher education institutions	f) Wide range of roles / professions formally represented in governance structure across trust
g) Care Group structure allowing us to engage with two different ICSs	h) Cleanliness of wards	i) Openness to challenge, willingness to learn and organisational memory
j) Workforce – open, transparent, improving culture	k) Estate	l) Workforce commitment / closeness to the communities we serve
m) Development of non-traditional posts	n) Partnership – working improving (operational & commissioning)	o) Project / programme / Quality Improvement capacity, approach and tools (including coaching)
p) Wellbeing offer	q) Co-creation	r) Use of Microsoft Teams / hybrid working

Weaknesses

a) Workforce – gaps in staffing / agency reliance, burnout, high proportion of inexperienced staff & managers – difficulties in releasing staff for training	b) Demand for adult MH bed days higher than we can meet, leading to TEW purchasing care for some patients from the independent sector	c) Transitions – across all services
d) Inconsistency in quality of management / lack of diversity	e) High community caseloads	f) Lack of flexibility to meet individual clinical needs
g) Lack of clarity on what we are paid to deliver now and, in the future,	h) Crisis (response times and variable compassion of response)	i) Information / communication flow through the Trust and externally (related to size of Trust/patch)
j) Variation / inconsistency in service delivery models / practices	k) Stakeholder management – getting the right people to the right meetings to influence effectively	l) Duplication and complication of filing and messaging (Teams/paper/ folders/email/phone)
m) Insufficient capacity to deliver governed therapies	n) Different levels of services commissioned in different places	o) Budget pressures/Cash Releasing Efficiency Scheme (CRES) delivery
p) Hardest jobs often hardest to retain staff	q) Offer to autistic and learning disabilities (perception of mental health centric Trust)	r) Lack of support or investment for innovation
s) Hierarchical relationships in some services	t) Neuro waiting times (i.e., autism, ADHD diagnosis)	

Opportunities

a) Forthcoming New national major conditions strategy and long-term mental health plan	b) University Partnerships / increasing our R&D profile	c) Community transformation / I-Thrive (our future clinical/business model + staffing/skills)
d) One public estate (more efficient use of existing public sector estate)	e) Teesside Medical School proposal	f) Workforce planning and redesign
g) Re-use of estate for supported housing or other relevant services	h) Population health management	i) Bed management
j) Service user and carer involvement (both care planning and process improvement)	k) Levelling up / focus on health inequalities	l) CITO /Electronic Prescribing and Medicines Administration (EPMA)

m) Lived experience and peer roles	n) ICS led reduction of unwarranted place-based variation	o) Technology / automation / AI
p) Recruiting from communities that we're not recruited often from in the past	q) Possible medium term regulatory direction	r) Improved CQC report
s) Increased influence over commissioning	t) New clinical treatments / models	u) Inpatient Quality Transformation national program
v) Provider collaboratives / regional working	w) 111 option 2	x) Governor relationships and role
y) Commissioner investment in alternatives to admission provision	z) Reprovision of long-term continuing care	aa) Evidence-based care
bb) New tenders for MH prison services		

Threats

a) Potential for increasing disparities between Care Groups / ICSs	b) New national major conditions strategy and requirements may not have supported funding	c) Risks of subcontracting to other organisations without quality / performance assurance being fully in place
d) Local Authority finances and capacity	e) Current lack of national measures of mental health, learning disability and autism service quality	f) Patient and public expectations outstrip ability to deliver at the level of resource available
g) NHS funding envelope may not match costs or allow expectations to be met	h) Future regulation / public / workforce expectations of Zero Carbon progress	i) Overused technology leading to a de-personalised service/ digital exclusion or opposition to use of technology by staff or patients
j) Some increasing demand (autism diagnosis, young adults' mental health)	k) Impact of legacy reports, court case and inquests on Trust reputation and staff morale	l) Public desire to see more positive outcomes from spend on mental health services
m) Insufficient social care / housing capacity leading to people who are clinically ready for discharge remaining in our beds	n) Voluntary and Community Sector capacity constraints	o) Stigma about mental health re-emerging / downplaying of the impact / "realness" of mental illness
p) Right care right person (reducing police role)		

Our clinical, quality, co-creation, workforce and infrastructure journeys

Each of our five journeys sets out our ambitions – i.e., what is the clinical, quality, cocreation, workforce and infrastructure destination that we are journeying to. They also set out some of the principles that will guide our journey.

Clinical: development models of care for all children, adults and older people (and for mantal health, autism and learning disabilities) which:

- support community transformation (including multi agency hubs).
- improve the quality of our inpatient services.

Quality: improve outcomes, experience and safety, including continuous improvement to culture and achievement of / exceeding standards.

Co-Creation:

- Value lived experience of life changing mental illness, living with a learning disability and/or neuro divergent, and the wisdom it can bring to our organisation.
- Close partnership working with patients, families, and carers.

Workforce: compassionate and inclusive culture, more people, new ways of working.

Infrastructure: Our ambition is for the Trust's infrastructure to be an invisible helping hand, supporting us to deliver excellent care where:

- Our places work efficiently, contributing to a sense of well-being.
- Our technology & data connects people easily and improves care delivery.
- Our systems and processes release time for clinical teams to care.

2024/25 - Plan on a Page

journey to change

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

Our big three goals

1. Cocreate a great experience for our patients, carers & families

2. Cocreate a great experience for our colleagues

3. Be a great partner

- **Clinical Journey**
  - Transforming Community Services
  - Transforming Urgent Care
  - North East & North Cumbria Adult Secure Bed Model
  - Expanding Our Health & Justice services
  - Autism
  - Young Adult Services
  - Reducing health inequalities
- **Quality & Safety Journey**
  - Personalised Care Planning
  - Physical Health
  - Improve patient safety
- **Co-creation Journey**
  - Improve patient experience
  - Further develop our co-creation infrastructure
  - Lived Experience / Peer roles
- **People Journey**
  - Deliver our People Plan
- **Infrastructure Journey**
  - Estates Masterplan
  - Digital & Data Plan
  - Green Plan

Efficiency to help us meet population needs within our budget

These will be underpinned by:

- Service user, carer, staff & partner engagement to inform plans & gather intelligence on impact
- Detailed plans (why, how, when, who)
- Measuring impact, i.e. clinical outcomes, patient experience and clinical safety
- Quality improvement methodology
- Trauma informed care
- Governance

. How will we plan and deliver these priorities?

This diagram shows how we will deliver these priorities through “vertical” transformation programmes, each of which will need to take the principles, and processes developed by our “horizontal” priority leads into account. This is followed by summaries of the plan for each priority. These will evolve during the year as further development work is undertaken.

Transformation Programmes / Cross cutting priorities	**Transforming TEWV Community Teams** Includes CYP, Adult Mental Health, MH Services for Older People, Adult Learning Disability services	**Urgent Care Transformation** 111/Crisis, Pathways, Flow, Inpatient Quality Transformation, workforce development and culture	**Secure inpatient bed model implementation** Supporting the NENC Provider Collaborative programme	**Health and Justice expansion** Responding to relevant tender opportunities
Autism				
16-25 year olds				
Inequalities				
Clinical outcomes				
Safety				
Physical Health				
Improve experience				
Co-Creation				
Lived Experience roles				
People Plan				
Estates				
Digital and Data				
Green Plan				

Transforming Community Services

Executive Sponsor: Zoe Campbell **Priority Leads:** Zoe Campbell / Patrick Scott

What is the reason for this priority?

The NHS England Long Term Plan priority aims to transform community provision for adults and older adults with serious mental illness. It also aims to increase accessibility of mental health support for children and young people and community support for people with learning disabilities (Assuring Transformation). We aim to clarify TEWV's core and unique offer in the context of wider system partners in delivery of community-based support and embed personalized care planning as we move away from the care programme approach. We will shift focus to sustainable early intervention and prevention to reduce the need for more intensive support such as inpatient care.

What will success look like?

- Improved patient experience and outcomes
- Reduced need for inpatient care and crisis care.
- Consistent achievement of new national 4 week waiting time standard (with system partners)
- Increased access to evidence-based interventions.
- Reduced re-referrals and re-admissions.
- Reduced caseloads and reduced time on caseload.

Key areas of focus

- Access to and delivery of evidence-based interventions based on need.
- Delivery of new 4 week waiting time standard for adults and older adults
- Implementation of new outcome metrics
- Workforce development and change
- Specific local solutions for pressures relating to neurodiversity assessment, diagnosis and wider support.
- Alignment of mental health and learning disability services with Integrated Neighbourhood Teams
- Development of appropriate dashboards within TEWV and with partners to demonstrate impact of changes.
- Implementing and embedding the move away from CPA to personalized care.
- Implementation of MH Hub (North York)
- Development of Hubs where these are not already in place.
- Specific local solutions for pressures relating to neurodiversity assessment, diagnosis and wider support.
- Alignment of mental health and learning disability services with new Community MH Hubs
- Development of appropriate dashboards within TEWV and with partners to demonstrate impact of changes.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Alignment with Urgent Emergency Care programme to support sustainable shift to more early intervention and prevention.
- Significant need for data analytics and reporting capacity at place and with system colleagues to evidence impact of changes.
- Significant need to continue working with partners at place.
- Finance and HR support to facilitate different ways of working, including possible shift of activity out of TEWV where appropriate to do so.
- Clarity and assurances regarding resources available

Key Milestones/Deliverables – Durham:

AMH/MH SOP (Severe Mental Illness)

- March 2024 – complete mapping and baseline assessment of current evidence-based intervention offer and delivery (including % of caseload offered and accessing)
- March 2025 – all adults and older adults within TEWV community services are offered appropriate evidence-based interventions.

CYP

- Working with the DTV partnership, to implement the respective Core Offer for the Getting Help and Getting More Help teams.
- To continue to develop the system neurodevelopment offer and to implement the recovery plan to reduce the neurodevelopment assessment backlog.
- To review PCN ARSS roles and explore options to have full coverage across DTV.
- To expand MH support team in schools' provision in County Durham

LD

- Complete review enhanced offer across Durham alongside review of partnership agreement of integrated arrangements in County Durham

Dementia

- Continue to develop the dementia pathway to meet demand.

Key Milestones/Deliverables – York:

AMH/MH SOP (SMI)
- March 2024 – complete mapping and baseline assessment of current evidence-based intervention offer and delivery (including % of caseload offered and accessing)
- April 2024-2025 - new community hubs operational across City; peer support workers in place in each
- March 2025 – all adults and older adults within TEWV community services are offered appropriate evidence-based interventions.

CYP
- **Apr-Jun 2024** - implementation of all age crisis hub for CAMHS
- **Jul-Sept 2024** – undertake service review of Single Point of Access

LD
- **Jan-mar 2025** - to develop, resource and operationalise the Intensive Support Team within the service.

Dementia
- **Jan-Mar 2025** - work with Commissioners to review the specification for MHSOP service delivery.

Key Milestones/Deliverables – North Yorkshire:

AMH/MH SOP (SMI)
- March 2024 – complete mapping and baseline assessment of current evidence-based intervention offer and delivery (including % of caseload offered and accessing)
- April 2024-2025 - new community hubs operational across City; peer support workers in place in each
- March 2025 – all adults and older adults within TEWV community services are offered appropriate evidence-based interventions.

CYP
- **Apr-Jun 2024** - implementation of all age crisis hub for CAMHS
- **Jul-Sept 2024** – undertake service review of Single Point of Access

LD
- **Jan-mar 2025** - to develop, resource and operationalise the Intensive Support Team within the service.

Dementia
- **Jan-Mar 2025** - work with Commissioners to review the specification for MHSOP service delivery.

Key Milestones/Deliverables – Tees Valley:

AMH/MH SOP (SMI)
- March 2024 – physical healthcare model in place across all 5 Tees Valley localities
- April 2025 - community hubs operational in all localities with offer of appointments with TEWV staff in a range of locations
- March 2025 – all adults and older adults within TEWV community services are offered appropriate evidence-based interventions.
- April 2025 – all Tees Valley AMH community hub referrals assessed within 28 days.

CYP
- March 2025 – working with the DTV partnership, to implement the respective Core Offer for the Getting Help and Getting More Help teams.
- To continue to develop the system neurodevelopment offer and to implement the recovery plan to reduce the neurodevelopment assessment backlog.
- September 2024 - CYP ARRS roles evaluation
- September 2025 - expansion of MHST offer in Darlington.

LD
- Undertake work with partners and key stakeholders, including people with lived experience and family carers to define and move towards sustainable, fair and person-centered model of care.

Dementia
- Continue to develop the dementia pathway to meet demand.

Transforming Urgent Care

Executive Sponsor: Patrick Scott **Priority Lead:** Nicola D'Northwood

What is the reason why for this priority:

Accessible and responsive mental health support is crucial for people of all ages during a crisis. Care closer to home is also vitally important. Compassionate support which is recovery-focused, with an approach that does not keep people in hospital longer than necessary, as outlined in the NHS England Long Term Plan and is part of the Inpatient Quality Transformation programme. It is essential that our services consist of crisis pathways which meet the needs and preferences of people accessing crisis care. Therapeutic environments are also essential to aid a person's recovery and services must promote wellbeing, dignity and be respectful to people's needs and wishes. Carer and family involvement is also the focus of this priority and effective joined-up care at the right time, in the optimal care setting, to improve the experience and outcomes for people using our services.

What will success look like:

- Patient experiences of urgent care will improve.
- More care provided closer to people's own homes.
- Staff will feel more supported to deliver care that makes a difference to people's lives.
- Partners will report that services are more joined up, meeting the needs of people in crisis.
- More therapeutic interventions will be available to people using our services.
- Carers and families feel listened to and valued partners in their loved one's care planning.

Key areas of focus:

We have identified key areas of focus as follows:

- Patient Safety/Patient Choice & accessibility of services and information
- Responsiveness/Accessibility of services & Transitions
- Workforce development, Inclusivity & Culture
- Personalised care/Care closer to home.
- Neurodevelopmental (Autism)
- Joined up care/Partnership working.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Alignment with Community Transformation programme/s (CMHT for AMH&MHSOP /BRS for ALD and iThrive for CAMHS) to support sustainable shift.
- Continue working with partners to enable transformation across the urgent care pathway.
- Data analytics and reporting capacity at place to evidence impact of changes.
- Significant level of support required to ensure effective co-creation.
- Quality Improvement and Project/Programme Management Office (PMO) support for improvement and project management of change.
- Communications support to help with any campaigns, flow of information.
- Finance, Human Resources and Planning support to facilitate different ways of working.

Key Milestones/Deliverables

- Cocreating a long-term vision for urgent care and transformation programme (March 2025)
- Implementing and embedding the Crisis 111 Option 2 (April 2024)
- Completing the cultural support offer programme for inpatients (March 2026)
- Implementation and embedding of the OPTICA system (March 2025)
- Fully implement 4 stages of RCRP (March 2025)

North East & North Cumbria Adult Secure Bed Model

Executive Sponsor: Naomi Lonergan **Lead:** Clare Abley

What is the reason why for this priority:

There are significant patient flow pressures across the North East & North Cumbria (NE&NC) Adult Secure (AS) Service footprint, which are predominately associated with the male mental illness pathway and an under occupancy in the female pathway. A consequence of these pressures has led to an increase in the number of patients waiting to access a secure inpatient bed, the length of time a patient waits to access a secure inpatient bed and the number of patients who are receiving their care in out of area placements. This is attributing to a significant forecast overspend position for the NE&NC AS Provider Collaborative.

hat will success look like:

- A bed base which meets the needs of the local population:
  - Reduce the time waited for admission.
  - Work towards meeting the national aim for prison transfer within in 28 days from referral.
  - Reduce the number of out of area placements associated with insufficient capacity.
- An effective patient flow system, supported by real time data and a decision-making framework

Key areas of focus

Reconfiguration of our bed base and additional beds will help in isolation, they do not solve the problem. The refreshed bed model is one of four key enabler workstreams that have been identified to support delivery of a sustainable solution. The other three workstreams are:

- **Patient Flow –** all parts of the patient journey giving equal focus to admission, transfer, and discharge.
- **Service Delivery -** collaborative development our non-secure pathways with our internal and external partners
- **Workforce Strategy -** A joint workforce strategy, by profession will support our response in the medium to longer term the resource and skills needed to deliver our future deliver model.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) as lead Provider
- Health & Justice Directorate
- Support from: Planning & Business Development; Finance; People & Culture; Digital & Data; Nursing & Governance; Estates & Capital Planning
- System partners (Integrated Care Board, Local Authorities, Third Party Providers to support with discharge planning and alternatives to admission).

Key Milestones/Deliverables

- Female Model December 2024
- Individualised Care Area Model of Care July 2024
- Low Secure Male Mental Health September 2024
- Male Learning Disabilities and Autism Spectrum Diagnosis Model July 2024
- Medium Secure Male Mental Health TEWV August 2024
- Medium Secure Male Expansion Mental Health Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust December 2024
- Low Secure Male Mental Health Expansion Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust December 2024
- Strategic Forward View December 2024

Expanding our Health & Justice Services

Executive Sponsor: Patrick Scott **Priority Lead:** Lisa Taylor

What is the reason for this priority?

We have a good market share currently with previous successful applications for provision of mental health and learning disability services across the Health & Justice sector. We have proven ability to mobilise awarded contracts outside of TEWV's immediate geographic boundaries and proven model of care which delivers high quality, effective care for patients. These services have gained good CQC feedback and there is successful partnership working across the service which strengthens our model and affords further opportunities for development of services.

What will success look like?

- Number of opportunities responded to co-created with partner organisations.
- Number of opportunities responded to co-created with Service Users & Carers.
- Number of opportunities responded to and successfully submitted.
- Number of opportunities where submission is successful.
- Increase in market share across Health & Justice services.
- Increase in contract income and contribution to Trust overhead.

Key areas of focus:

- As agreed by Executive for those services subject to a competitive tendering process the focus will be as follows:
  - Mobilisation of HMP Full Sutton & Millsike following successful contract award
  - Maintaining our existing business
  - Response to business opportunities within HMPs within the agreed geographical area
- Submission of further bids in response to development opportunities and Commissioner requests ~~e.g.~~ increases in population capacity, new services
- Increased visibility in the wider H & J arena – conferences and training
- Development of wider robust quality and assurance processes.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Support in responding to opportunities and if successful mobilisation, required from:
  - Planning & Business Development
  - Finance
  - People & Culture
  - Digital & Data
  - Nursing & Governance
- Rethink Mental Illness (our partner in the delivery of the Model of Care within Prisons)
- Partners identified dependent upon geography and service specification requirements.
- Interdependencies aligned to the Programme to Implement the NENC & HCV Provider Collaborative Clinical & Bed Model.

Key Milestones/Deliverables:

- Mobilisation for contract commencement HMP Full Sutton – June 2024
- Mobilisation of HMP Millsike for contract commencement - April 2025
- Review of individual opportunities using the Trust Business Model to confirm rationale prior to progressing – as opportunities advertised – ongoing.

Autism

Executive Sponsor: Lisa Taylor **Priority Lead:** Kirsten White/Elspeth Webb

What is the reason for this priority?

1-2 % of population is Autistic. More than 25% of autistic people receive two or more diagnoses of mental health problems and 15% of autistic people are hospitalised due to a mental health problem. Autistic people will have disproportionately higher levels of contact with TEWV services than neurotypical people. Prevalence of autism within an adult psychiatric outpatient service was 19%. TEWV data suggests that at least 17% of people accessing our services have an autism marker on Paris (TEWV's patient record system).

Autistic people have poorer health and social outcomes: 8 out 10 autistic people have co-occurring mental health conditions and autistic people with mental health problems are 4 times higher (51%) than neurotypical people (11%). 6 out of 10 autistic people have considered suicide, more than 3 out of 10 autistic adults have attempted suicide. Overall, autism and autistic traits are risk factors for suicidal behaviour.

What will success look like?

- Culture across the organisation of Autism informed compassionate care in the context of mental health service delivery.
- Standardised, safe, quality service for Autistic people accessing TEWV.
- Organisational compliance with Autism legislation and statutory guidelines
- Deliver a sustainable autism informed structure within TEWV to ensure that the needs of Autistic children, young people and adults accessing our services are met.
- Ensure that the trust can provide care pathways that can be adjusted to meet the needs of autistic people within both inpatient and community services to meet the requirements of autism legislation and CQC baselines.

Key areas of focus:

- Develop and embed sustainable Mandatory Autism Training in line with NHS England Code of practice.
- Sustainable and continued Autism support and consultation to clinical and corporate services.
- Developing Autism informed evidenced framework within Trust Wide Patient Safety practices and system.
- Embed Autism informed care across all systems.
- Enable and inform organisational compliance with Autism legislation and statutory guidelines.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- CITO (new Electronic Patient Record system)
- Care group plans
- Adult and Children Autism diagnostic services
- Communications team
- Workforce Planning team under Sarah Dexter-Smith
- Mental health Community Transformation
- NENC/ NYH ICB
- Development of inpatient services
- All Clinical Networks

Key Milestones/Deliverables:

- Delivery of mandatory autism training over 3 years.
- All Trust wide Services have access to ongoing autism consultation/supervision to deliver reasonably adjusted mental health care 24/25
- Advocate the Autistic Voice- employment of Autistic person within the Autism service with 24/25 (June 24)
- Develop an Effective Autism communication strategy within 24/25 (July 24)

Young Adults Services

Executive Sponsor: Kedar Kale / Hannah Crawford **Lead:** Jamie Todd

What is the reason why for this priority:

To ensure that young people continue to have their mental health needs met with the right approach within a local system by the right person/service whilst moving from adolescence to adulthood. If we get this right, we think that we can make a difference to the lives and experiences of this group of people by reconfiguring the way we operate services within TEWV and across the system.

Evidence: The Inbetweeners and Niche Reports. Data including No of people aged 18-25 on wards / Length of stay (detained/informal)/ community offer for 16-25/SI's/ current experiences of our patients and feedback we have received.

What will success look like:

We will improve our understanding of the Quality, Safety and Experience for young adults who use our services by

- Increasing the proportion of young adults who feel safe in our care.
- Understanding more about the care and experience of young adults (18-25) within inpatient services including numbers of admissions, lengths of stay and develop proposals for improvement.
- Ensuring the revised Transition procedure is embedded across all services.

Key areas of focus

We will:

- Define a clear vision purpose and scope.
- Focus on inpatient, community and crisis care, quality and safety.
- Review the experience of 18–25-year-olds in the context of the urgent care and community transformation programmes.
- Develop a governance framework and establish a steering group.
- Use data and a 'missed opportunities' deep dive to support the work going forward.
- Engage across the trust and across specialties.
- Review progress after 6 months and set new priorities where appropriate.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

This piece of work is:

- Trust wide /Across Care Groups and all specialities (not MHSOP) inc SIS/H&J
- System wide, especially Local Authorities
- Closely linked to the Urgent Care and Transforming community services programmes
- Reliant on Corporate support, inc Planning & Performance/PMO /Digital and Data/People and Culture/Nursing & Governance

Key Milestones/Deliverables

As this work is at an early stage, timescales are currently to be confirmed. However, the following is proposed:

- Agreement from the Trust to support this priority and move forward including appropriate resources. June 2024
- Establishment of Steering group – including monthly meetings to identify priorities in the following areas: inpatient, crisis, community and quality and safety June 2024
- Define vision, purpose and scope. September 2024
- Undertake initial scoping work:
  - Data collection and analysis. December 2024
  - Learning from 'missed opportunities' work to develop revised proposals for how we oversee services for young adults. December 2024
  - Engagement across specialties. March 2025
- After scoping a clearer programme of work will be developed. March 2025

- **We will seek to review progress after 6 months and set new priorities where appropriate.**

Reducing Health Inequalities

Executive Sponsor: Kedar Kale/Hannah Crawford **Priority Lead:** Catherine Parker

What is the reason for this priority?

The area covered by TEWV contains some of the most deprived neighbourhoods in England with some of the country's poorest social, physical, and mental health outcomes. We know people do not access or experience our services equitably and it is recognised in our clinical journey and Trust Approach to Health inequalities that we must take action to identify and remove the systematic barriers to high quality care for all. National requirements aligned to this include NHS England's Inequality Duty for NHS Trusts, Equality Duty, Use of Force Act and The Patient Carer Race equity framework (PCREF).

What will success look like?

- Increased staff awareness of health inequalities and its impacts
- Improved pathways and formal joint working between community, inpatient and substance misuse provision
- Reduction in DNA/WNB in pilot areas/teams
- Improved use of inequalities data in decision making and accountability
- Readiness for delivery of the PCREF
- Higher levels of engagement between services and Gypsy, Roma Traveller communities

Key areas of focus:

- Building awareness and understanding of inequalities across staff groups
- Improving access to and quality of our data on inequalities
- Poverty Proofing our service pathways
- Dual Diagnoses partnerships
- Gypsy Roma Travellers engagement
- Patient carer and race equity
- Closing the gap in did not attend/was not brought
- Expand a community engagement approach to increase service accessibility and inclusive employment

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- People plan – specific focus on using employment approaches to support this agenda
- Patient safety journey- preventing suicide plans
- Physical Health workstream
- Local authority public health teams and commissioned substance misuse services

Key Milestones/Deliverables:

- Development of a suite of staff education materials on inequalities by October 2024
- Launch of the equality and diversity dashboard by June 2024
- Launch A health inequalities team challenge by June 2024
- Trial a model of closing the gap on Did not attend/was not brought by March 2025
- Roll out the learning from poverty proofing review across specialities (including implications for staff) by March 25
- Embed inequalities in Action plan for delivery of compact with Teesside university by March 25
- Develop a strategic Approach to dual diagnosis By October 24
- Ensure data sets are developed to support to report on and implement PCREF by March 25
- Review and identify best practice and recommendations from the Gypsy, Roma, Traveller engagement/consultation work being carried out by York University by July 2024
- Promote and celebrate Gypsy, Roma Traveller History Month by July 2024

Personalised Care Planning

Executive Sponsor: Zoe Campbell **Priority Lead:** Chris Morton

What is the reason for this priority?

To meet the needs and expectations of people who use our services are met as we move towards more holistic and integrated care. To comply with NHS directives and policies promoting personalised healthcare as a means to enhance patient engagement and outcomes. To address inefficiencies within the care progamme approach framework and to streamline processes and improve care delivery. We will leverage innovations in care planning and delivery to set benchmarks within the community mental health framework by ensuring seamless care transitions. This includes support across various health and social care services and prioritising mental health and wellbeing with a bespoke approach to support recovery and resilience.

What will success look like?

- Every patient receives care tailored to their specific needs, preferences, and health goals.
- Meaningful Coproduction in care planning, leading to improved satisfaction and health outcomes.
- More efficient and effective use of healthcare resources, reducing unnecessary procedures and interventions.
- better overall health and wellbeing through comprehensive, holistic care approaches.
- Stronger partnerships between healthcare providers, community and voluntary sector organisations, and people who use services, fostering a supportive, proactive care ecosystem.
- Clear metrics and evidence demonstrating the benefits of personalised care planning, serving as a model within the NHS.
- Meaningful and appropriate carer and family involvement throughout peoples care journey.

Key areas of focus:

- **The move from CPA to Personalised Care represents a programme of work focused on a number of key stands (Responsible organisation(s)):**
  - Policy development (TEWV and system wide) - covering roles, responsibilities and accountability for care and safety of patients (TEWV, Partner Orgs)
  - Co-produced care planning - implementing DIALOG to support this. (TEWV)
  - Increasing access to evidence based psychological therapies and psychosocial interventions (TEWV)
  - Workforce development: identifying and addressing skills deficits & training needs. (TEWV)
  - Implementation of the key worker role (ICS - all partner orgs including TEWV)
  - Interoperability (ICB)

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Strong interface with the Care Group and frontline workforce through co-creation networks and governance structures, via Lived Experience Directors.
- Effective partnership with local authorities, other NHS trusts, and VCS organizations to share resources and expertise.
- Developing interoperable IT systems for efficient patient information exchange across services.
- Ensuring organizational policies across partners support personalized care principles and practices.
- Joint workforce development initiatives to standardize care practices among partners.
- Integration of services to provide seamless transitions for patients across different care settings.

Key Milestones/Deliverables:

- Ratify Trust Policy on Personalised Care Planning (May 2024)
- Roll out of DIALOG to enhance co-produced care planning now that CITO has gone live. (Ongoing)
- Develop and implement strategy to increase access to evidence based psychological therapies (June 2024)
- Establish Workforce Development group to support delivery of transformation (May 2024)
- Work with ICBs and partner organizations to establish the role and responsibilities of the Key Worker (May 2024)
- Work with ICBs to establish effective interoperability between systems (Ongoing)
- Ensure there is a comprehensive communications plan to ensure all stakeholders are aware of developments and the related implications (June 2024)

Physical Health

Executive Sponsor: Beverley Murphy **Priority Lead:** Helen Day

What is the reason for this priority?

Addressing mental health equally with physical health, referred to as *parity of esteem* was enshrined in law by the Health and Social Care Act 2012. Despite a plethora of evidence connecting the impact of severe mental illness on physical health outcomes and vice versa there is still much to do locally and nationally. Good physical health is one of the core building blocks of good mental health, whilst poor physical health can be both a cause and consequence of mental health. In turn, mental health problems can worsen the impact of poor physical health leading to poorer overall outcomes.

What will success look like?

- A workplan, consisting of a delivery and improvement plan, with clear outcomes, measurement approach and clear oversight/governance.
- Clinical Advisory Groups (CAG) focused on continual improvement with outcomes developed by staff, service users and carers which are aligned to local and national recommendations.
- An approach to physical health, for people using our services, that is known about and talked about locally and with system partners.

Key areas of focus:

- Improve integration of care with physical health care providers, including primary and acute care, to support service users receiving ongoing and / or specialist physical health care.
- Enable a system wide approach to the management of major heath inequalities such as diabetes.
- Clinical Advisory Groups objectives and achievable targets for clinical outcomes, education and competency and patient feedback with identified methods to measure impact including audit results, patient feedback, staff feedback, partner feedback.
- Communication and engagement plan

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Support and partnership working with Clinical Effectiveness Department
- Support from Care Group directors to embrace physical healthcare to be an integral part of identified and agreed key roles such as Personal Development Plans.
- Support and partnership working with external, partners in ICB, acute and primary care colleagues. This may need the support of TEWV Executive board in light of ongoing complex and multiple system pressures.

Key Milestones/Deliverables:

1. Scoping of recommendations to inform final Clinical Advisory Group and overarching plans complete: end of April 2024
2. Clinical Advisory Group priorities, workplan and targets: end May 2024
3. Communication plan developed by end April 2024 and engagement through to June 2024
4. Final approach to physical health, for people using our services, presented to Executive Directors and Quality Assurance Committee June 2024

Improve Patient Safety

Executive Sponsor: Beverley Murphy **Priority Lead:** Dawn Jessop

What is the reason for this priority?

In line with TEWV Journey to Change (OJTC) a 5 year strategy was set out including the Quality and Safety journey. Four areas linked to patient safety were identified within this and continue to be an ambition and focus for patient safety. We are committed to a shared single view of quality where, working in systems, we will deliver care that is:

- Safe
- Effective
- Well led.
- Equitable
- Provides a positive patient experience that is responsive, personalised and kind

Our ambition is that by 2028, we will achieve the specific aims and measurable improvements set out in our Quality Journey, through continuous learning and improvement using a range of key tools and enablers.

What will success look like?

- PSIRF and learning will be embedded through a monthly Organisational Learning Group (OLG) to have oversight of themes, and to increase the triangulation of learning across our internal system and with partners.
- InPhase modules will be developed and implemented to ensure compliance with LFPSE and increased visibility on themes of incidents and learning.
- Reduced use of restrictive interventions including the use of Prone restraint.
- Physical health strategy will be in place and visible throughout the organisation.
- Harm reduction and suicide prevention work to be embedded within patient safety.

Key areas of focus:

- Four workstreams to support the Quality and Safety elements of OJTC: Implementing the new National patient safety Incident Response Framework (PSIRF), Switching to the National Learning from Patient Safety Events System (LFPSE), implementing a new incident reporting system (replacing Datix with InPhase) and to clear any backlog of patient safety incidents.
- Physical Healthcare
- Reducing Restrictive Interventions
- Triangulated learning from complaints, safeguarding and serious incidents and other areas of soft intelligence.
- Aligning suicide prevention and harm reduction work with patient safety priorities

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Trust wide working between Patient Safety, Care Groups and Corporate Teams
- Ensure suicide prevention work is integrated in ICB/patient safety.
- Embedded positive and safe practitioners within each care group.
- Roll out of Physical health strategy within care groups.

Key Milestones/Deliverables:

- September 2024 – implementation of further InPhase modules
- January 2024 – Implementation of PSIRF and inaugural meetings of OLG
- February 2024 - May 2024 – Integration of suicide prevention leads to patient safety.
- March 24 – positive and safe leads to commence in care groups.
- August 2024 – review of priorities and setting of further milestones.

Improve Patient Experience

Executive Sponsor: Ann Bridges **Priority Lead:** Chris Morton/Emma Haimes

What is the reason for this priority?

To comply with fundamental standards of care as stipulated in the Health and Social Care Act. To proactively identify areas of concern and risks to patient safety and experience and to highlight areas of good and exceptional practice for learning. To respond to national patient experience benchmarking indicating areas for improvement. To ensure that patients feel safe on the wards and address any identified gaps in the availability of staff and the provision of activities, which are crucial for a positive patient experience. To identify areas requiring improvement through patient experience metrics and narrative feedback, pointing to issues such as waiting times, access to services, and the overall feeling of safety and care.

What will success look like?

- Improved scores in patient experience surveys and FFT results.
- Achievement of national average or above in patient satisfaction metrics.
- Positive feedback on safety, care quality, and responsiveness to patient needs.
- Demonstrable improvements in areas previously identified as requires improvement.
- Increased participation in patient and carer experience surveys and feedback mechanisms, demonstrating active engagement and willingness to contribute to service improvements.
- Service specific Patient and Carer Experience Groups.
- Rise in positive feedback about feeling safe while in care, with particular emphasis on improved staff availability and the provision of meaningful activities on wards.
- Reduction in the number of complaints received, alongside faster resolution times, indicating a more responsive and patient-centric service.
- better communication with patients and carers about how their feedback has led to tangible changes in care ("You Said, We Did" initiatives), fostering a sense of involvement and co-creation in service improvement.
- Demonstrated ability to swiftly adapt services in response to patient and carer feedback, leading to continuous improvements in the quality of care.

Key areas of focus:

- **Comprehensive Quality Improvement Initiative:**
  - Implementation of a Trust-wide quality improvement initiative specifically targeting enhancements in patient and carer experience.
  - Inclusion of co-creation methods with patients, carers, and families to ensure that improvements are genuinely user centred.
- **Engagement and Feedback Mechanisms:**
  - Strengthening of the patient and carer feedback mechanisms to ensure comprehensive and real-time capturing of experience data.
  - Utilisation of patient focus groups, especially on topics like feeling safe, to identify and prioritize areas for improvement.
- **Procurement of New Patient Experience System:**
  - Cocreated steps towards the re-procurement of new data capture system
- Initiatives aimed at increasing the response rates to patient experience surveys. Strategies to enhance engagement with carers.
- Patient and Carer Experience Group becomes more governance-oriented, providing robust assurance and facilitating effective triangulation with other sources of intelligence.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Strong interface with the Care Group and frontline workforce through co-creation networks and governance structures, via Lived Experience Directors.
- Improved relationships with clinical networks and clinical practice to embed patient experience.
- Strengthened partnerships with VCS and community forums.
- Sustainable budget to support patient experience.
- QI support to undertake a comprehensive review of Patient and Carer Experience using co-creation methodologies.
- Expanding the Local Issue Resolution (LIR) process trust-wide

Key Milestones/Deliverables:

- Achieve a significant increase in survey response rates, especially reducing wards/teams with zero responses by August 2025.
- Full review and enhancement of the patient and carer experience program using co-creation methodologies by August 2025.
- Re-procurement and implementation of the new data capture and analysis software (e.g., Meridian System) to better gather and utilize patient experience feedback by August 2025.
- Continuous benchmarking against National Friends and Family Test (FFT) Data with a target to improve positioning by August 2025.
- Expansion of the Feeling Safe Measure to better capture all aspects of patient safety and well-being by August 2025.
- Ensure Complaint Themes and Trends are shared with the Organisational Learning Group for service improvement by July 2024.

Further develop our co-creation infrastructure

Executive Sponsor: Ann Bridges **Priority Lead:** Liam Corbally

What is the reason for this priority?

Meaningful co-creation has the potential to improve patient and carer experience in harnessing better relationships between patients and their loved ones, our staff and the organisation. Improving patient outcomes through better understanding what matters to people is a benefit for all involved. Improved patient safety through considering how people feel safe in our care and in supporting staff to have better and more authentic relationships and develop greater insight with patients, carers and families, this will improve experiences all round. Partner experience, through a culture of being more collaborative and respecting different types of knowledge and expertise will also be enhanced. There will also be the opportunity to create more space for user led organisations to work with TEWV through valuing lived experience.

What will success look like?

- For patients, this will mean that they feel they have a voice and are listened to and are given opportunities to meaningfully engaged to support change in TEWV through co-creation.
- Our patients will feel able to make a difference in service development, decision making and delivery, and that their needs are better met when they are involved in an equal and reciprocal relationships with staff and others.
- For our carers and families, this will mean they feel recognised and heard a valuable resource and asset, than can help inform services and help improve care of their loved ones.
- For our staff, to work in partnership and mutual, collaborative relationships to gain a better understanding of the people they support to co-creation and feel really connected to and understand their lived experience, through a deeper understanding of the people, not processes.
- Our partners will feel confident to work closely with us as equal partners, in the design, delivery and evaluation of services to improve quality, safety and responsiveness.

Key areas of focus:

- Further development of the final chapters of co-creation framework, including reimbursement, support and training for staff, support and training for involvement members, and safeguarding.
- Increasing diversity across co-creation to involve different people that represent all the communities we serve.
- Agree the structure and grow the resource and capacity within the team.
- Secure dedicated co-creation budget to support involvement of patents and carers.
- Identify key areas of involvement work in the Care Groups and corporate services.
- Develop patient and carer network, across the Care Group areas, and strengthen links into / out of the Co-creation Boards.
- Develop different specialty support for services outside of AMH and MHSOP.
- Increase awareness and promote co-creation.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Strong interface with the Care Group and frontline workforce through co-creation networks and governance structures, via Lived Experience Directors.
- Collaborative working with peer support on shared objectives that value and growing lived experience roles at all levels of the organisation.
- Improved relationships with clinical networks and clinical practice to embed co-creation through trauma informed approaches.
- Strengthened partnerships with VCS and community forums.
- Sustainable budget to support co-creation and involvement.

Key Milestones/Deliverables:

- Involvement and engagement team lead role recruitment complete – May 2024.
- Co-creation communication and engagement strategy developed– June 2024.
- Co-creation framework development complete and roll-out to commence – Sept 2024.
- Training and support requirements for the team, and for involvement members agreed – Oct 2024.
- Further development of co-creation network to create spaces for staff to be upskilled on co-creation– Dec 2024.

Lived Experience/ Peer Roles

Executive Sponsor: Ann Bridges/ Hannah Crawford **Priority Lead:** Liam Corbally/Mark Allan

What is the reason for this priority?

Peer support can have a transformative impact on service user's lives and the care delivered by a team. Embedding lived experience expertise in real time, throughout all we do, is a key component of developing safe and high-quality rights-based services in the Trust. It is also a core part of assurances to CQC and the public; OJTC Clinical and Cocreation agendas; Transformation work in all areas.

What will success look like?

- Lived experience roles at all levels of the Trust.
- Increase in peer leadership roles to cover all key localities, workstreams & specialities.
- Notable - planned and responsible - increase in peer supervisor and peer worker roles.
- Continuation of strong recruitment and retention data through expansion.
- Continuation of positive experience feedback from services users, peer workers, and colleagues on teams.
- Increased notable system leadership and partnership initiatives.

Key areas of focus:

- Partnership working and system leadership
- Continuing to develop high quality and safe peer practice
- Supporting peer worker wellbeing
- Supporting workforce development: into & within peer structures
- Expanding number of services we support and the number of roles
- Collecting Feedback, evaluating pilots and celebrating success

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Significant Peer role expansion requires mainstreaming peer role creation (and peer leadership input) within Trust and Care Group workforce planning processes.
- Trust Commissioning Processes
- Strong interfaces with Cocreation to support mutual goals and avoid duplication.
- Peer support central to transformation work (Crisis / Community / Inpatient etc).
- Strong recruitment support interface to create positive onboarding experience.

Key Milestones/Deliverables:

- Systemwide Lived Experience Strategic Leads Network / Community of Practice – April 2024
- Supervision Protocol (required by CQC action plan) – June 2024
- Celebration event – August 2024
- Year on year increase in number of roles – December 2024
- S.I.S (including Carer) roles appointed to – March 2025
- Roll out regional networks to Durham and Y&S – March 2025

Deliver our People Plan

Executive Sponsor: Sarah Dexter Smith **Priority Lead:** Kate North

What is the reason for this priority?

Our biggest strength is our staff/people with our greatest risk not having the experienced, skilled, trained staff we need to deliver excellent care for our patients. Fundamentally underpinned by the Big Conversation and subsequent People Journey aligns with the national NHS People Plan.

What will success look like?

- Increased retention rate and low turnover (11%) with sickness absence consistently reduced (to 5.5%).
- Responsive health interventions with staff telling us they have a healthy work-life balance and career opportunities.
- Staff Survey showing 60% of staff recommending the Trust as a great place to work.

Key areas of focus:

1. Health & Wellbeing: work-life balance, sickness absence, staff support offer, Occupational Health & Gold Award
2. Leadership and Development: develop and implement Academy to succession plan and grow future leaders
3. Inclusive Cultures: community engagement, staff networks, staff survey, reasonable adjustments.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

People & Culture is an enabler providing expert advice/guidance across the Trust; therefore success is dependent upon close and collaborative working across the Trust.

Workforce Planning and Safe Staffing will be key to ensure predictable and appropriate staffing levels.

Key Milestones/Deliverables:

- Newly procured Occupational Health Service in place - June 2024
- Further development of Health & Wellbeing offer with Better Health at Work Gold Award submission – April 25
- Development and launch of TEWV Leadership Academy Dec 24 with annual implementation review - Dec 25
- Inclusive Engagement programme developed and in place with staff networks, allies and stakeholders - Sept 24

Estates Master Plan (EMP)

Executive Sponsor: Liz Romaniak **Priority Lead:** Simon Adamson & Sarah Clarke

What is the reason for this priority?

To support delivery of *Our Journey to Change's* Infrastructure Journey and to deliver space and financial efficiencies, we will focus on creating Better, Smaller and Greener buildings. Operating transformed services within smarter places to add value and increase efficiency. We recognise that improving access and having services that meet patient need is essential to the delivery of high quality clinical care. Our plan is to level-up the estate, improving the alignment of our buildings to transformed models of care within capital affordability constraints. We will work in partnership to progress One Public estate opportunities.

What will success look like?

- Improved access and more co-locations in community facilities.
- Reduced operating costs.
- Capital generation from disposal and bidding opportunities.
- Increased efficiency including estate reductions in: size, percentage of vacant space, average m² or cost avoidance.

Key areas of focus:

- Becoming more community facing at Place working with partners.
- Better aligning our estate to clinical strategy.
- To always be able to offer a safe alternative to admission.
- Trauma informed design – creating environments that feel safe and take account for sensory processing issues.

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Smarter working
- Clinical strategy including bed trajectories.
- One Public Estate (OPE) opportunities.
- Public sector authorities and other community and voluntary services.

Key Milestones/Deliverables:

- Mar 25 – Harrogate Community Hub (Jesmond House)
- Sept 24 - Medical Education North Operational
- Sept 24 – Medical Education South Scoping
- Mar 25 - Assistive Technologies (Sensor Doors – Phased/continuous handover throughout programme)
- Aug 24 - Catering Infrastructure (Phased Approach)
- Mar 25 - Community Transformation (Various)
- Aug 24 – Detailed Design Sign Off Achieved - Catterick Integrated Care Centre (CICC)

Digital and Data Plan

Executive Sponsor: Mike Brierley **Priority Lead:** Lorraine Sellers

What is the reason for this priority?

Achievement of Digital and Data objectives aligns to *Our Journey to Change* priorities. Embedding co-creation and clinical ownership (Strategic goal 1) reducing / mitigation of current digital risks and adherence to CQC requirements (particularly Inpatient Internet availability) achievement of Data Security and Protection Toolkit requirements, Data Protection Act/Information Governance legislation and overall achievement of core digital capabilities by 31 March 2025 is key to our goal.

What will success look like?

- Patients will have visibility of own care records.
- Clinical and service user / carer cocreation
- Improvement to current availability of internet access for inpatients allowing greater use of recovery internet-based tools.
- Increased adherence to records management standards.
- Saving of clinical time due to easy-to-use intuitive EPR and EPMA systems
- Increased system interoperability to work with partner organisations.

Key areas of focus

- Embedding CITO (Electronic Patient Record - EPR) system
- EPR Developments – Summary Care Records (SCR), Visual Display Boards (VDB), App's, Pathways, Reporting
- Establishing System Integration & further Robotics Processing Automation (RPA)
- EPMA community roll out.
- Providing inpatient internet to all wards
- Electronic Document Management Strategy (EDMS) development
- Development of a Patient Portal
- Review / Update of Digital Strategy 2024 onwards
- Asset Management development – Phase 2 software, Phase 3 Mobile Telephony
- Records disposal and retention
- Use Artificial Intelligence & Data Science for data analysis.
- Cyber security
- Improvements to network infrastructure

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Care group / clinical engagement with development of EPR systems and embedding CITO.
- Service user / carer and lived experience support with establishing patient portal.
- Partner organisations input into Digital and Cyber strategies and system integration.
- NHS England frontline digitisation team finance and support
- Finance partner support
- Pharmacy team resource for EPMA
- Alignment with PMO Software / reporting standards

Key Milestones/Deliverables

- By end July 2024, move Business Intelligence system to cloud.
- By end July 2024, deliver increased network bandwidth across 20 Trust sites experiencing performance issues and deliver Multi Factor Authentication (MFA) to all NHSmail users.
- By end July 2024, Phase 2 and 3 of Asset Management will be fully complete.
- By end of October 2024, clinical records that have achieved retention will be identified and appraised for destruction.
- By end December 2024, pilot wards have inpatient internet and a review of this will have been undertaken.
- By end December 2024, an updated Digital and Data strategy will be written and approved.
- By end December 2024, VDB's for CITO are located in each ward area.
- By end March 2025 a Trust EDMS will be written and approved.
- By end March 2025, requirements for a patient portal will have been co-created.
- By end March 2025, full EPMA community roll out is achieved.
- By end March 2025, all inpatient wards have inpatient internet.
- By end March 2025, CITO technical developments will mean that development of appropriate clinical apps and further pathways will be achieved, clinical input into SCR is possible, and an Integration engine will have been procured with a proof of concept undertaken.

Green Plan

Executive Sponsor: Liz Romaniak **Priority Lead:** Simon Adamson & Ken Tench

What is the reason for this priority?

To progress NHS England's commitment on '*Delivering a Net Zero NHS*' all NHS providers and Integrated Care Boards (ICBs) are required to submit a Green Plan setting out aims, objectives and methods for carbon reduction.

Our Green Plan explores how we can deliver exemplary health care, whilst reducing emissions and resource consumption, in the face of a changing climate.

What will success look like?

- We have calculated our carbon footprint from 2018/19 to 2020/21, using the financial year 2020/21 as our baseline.
- This baseline is used to determine the emissions reductions trajectory needed to meet the NHS' net zero targets 'NHS Carbon Footprint' and 'NHS Carbon Footprint Plus' in 2040 and 2045 respectively.
- This equates to target reduction of approximately 4% year-on-year from all emission sources.

Key areas of focus:

Our Green Plan is divided into nine Areas of Focus:

- Workforce & Systems Leadership
- Sustainable Models of Care
- Digital Transformation
- Travel and Transport
- Estates and Facilities
- Medicines
- Procurement
- Food and Nutrition
- Climate Change Adaptation

Interdependencies and requirements from corporate services / partners / other programmes / Care Groups:

- Strategy and Resources
- People and Culture
- Human Resources
- Dietetics
- Communications
- Executive Director (Climate Adaptation Lead)
- Estates /Facilities and Capital
- Business Continuity Plan Lead
- Information Technology
- Procurement
- Care Groups
- Infrastructure Services
- Clinical Teams
- Pharmacy
- Finance

Key Milestones/Deliverables:

- Heat Decarbonisation Plan - June-July site surveys, plan delivery September 2024. Capital bid for funding measures 2025
- Installation of additional electric charging points at trust property – August 2024 surveys complete, September 2024 out to tender, carry out installations typical 3-month lead in time.
- 'Pledge for Greener' - Launch May 2023 with second phase initiative winter 2024
- Look to address the carbon footprint from supplier to door Selective list - Look to address the carbon footprint from supplier to door Selective list 2024/25

Tees, Esk and Wear Valleys
NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 14 March 2023		**Report of: People, Culture and Diversity Committee**
Date of last meeting: 30 May 2024		The meeting was quorate.
1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Story/Experience • Minutes of the meeting and confidential meeting held on 20 February 2024 • Key Issues Report 20 February 2024 • Annual Committee Performance Evaluation • Committee's terms of reference • Corporate Risk Register • Board Assurance Framework • People Journey Delivery Report • Staff Networks • Quarterly Apprenticeship Update • Workforce Planning – deep dive	
2a	**Alert: The Committee wishes to alert the Board on the following matters:** • A request for a review of the level of assurance provided in the **Corporate Risk register** (CRR) is still ongoing with limited assurance. Concern expressed by the Chair that the report does not meet the needs of the Committee and provide the right levels of assurance. This is being looked at by the Head of Risk Management and the Chief Nurse, with an expectation that reporting will be improved for the August 2024 meeting. Clarity is needed on the risks assigned, management and mitigations. • Flagging an emerging risk about violence and aggression towards staff, the severity and numbers of incidents.	
2b	**Assurance: The Committee can confirm assurance on the following matters:** • An extremely positive career success story was heard from a staff member who is a community nurse in TEWV. From an original career in the army as a royal engineer he came to the trust on the bank, working in support roles at bands 2 and 3 and went on to take up an apprenticeship role, where he moved up to band 5, qualifying recently as a Registered Nurse. He talked about how he had received excellent supervision during his years as an apprentice and he had now joined the IPBS team which is split into two cells: LD and an autism cell, which is at pilot stage and he was excited about putting his skills, knowledge and experience into practice. • A **deep dive into four risks** from the corporate risk register aligned to the people and culture committee demonstrates good assurance on the decision making relating to the changes in risk scores and mitigating actions being taken. • There is good assurance that the strategic risk "safe staffing" is being managed effectively in the **Board Assurance Framework**. • There is good assurance that a robust process is being followed for running **staff networks** for colleagues from protected groups. The networks continue to meet monthly and include armed forces, BAME, neurodivergence, Rainbow, long term health conditions, menopause café and working carers. An event held at the Last Post, veterans' bar and museum in April 2024 was an opportunity to share information about the services available in the Trust. Membership of the various network groups continues to grow and welcome new members every month.	

	• Agency spend has reduced from 5.5.% in April 2023 to 3.2%, with whole time agency reduced from 240 to 133 wte. • The new starter process continues to show improvement with a 25% improvement on the time taken from the date of advert to all checks being completed. • The number of people completing core mandatory training within the required timeframe has improved 21.6% over the baseline. IG training completed has also improved by 23%. • There is good assurance that the right actions are being taken to maintain the Trust's Apprenticeship workforce. There are 503 apprentices enrolled onto 34 different apprenticeships with 29 providers. 80 staff members started an apprenticeship during this quarter. Consideration will be given to passing funds to smaller organisations where this would align with our strategic goals. • The TEWV Leadership and Management Academy was launched in May.
2c	**Advise: The Committee would like to advise the Board on the following matters:** • Feedback following the **Key Issues Report,** (20 February 2024), presented to the March Board meeting were that the issues with the limited level of assurance in the Corporate Risk Register had been raised. • The outcome of the **annual Committee assessment tool,** completed by four of the six members drew attention to the need to regularly check that it is seeking assurance on strategic risks, rather than managing operational matters. There is some work to do to ensure the workplan is driven by the key risks included in the BAF and this will be considered at the time out session. Other supporting governance arrangements for improvement include timely distribution of papers, (5 clear days before the meeteing), updates for the action log, reducing the length of reports and making report summary sheets more succinct. • The **terms of reference** have been reviewed and refreshed. One change agreed is that the pack of papers will no longer be shared externally, since the meeting is a private and confidential meeting. The agenda will be shared with any observers who request to attend the meeting. (This is in line with the governance arrangements for other Board committees). Members were content to approve the minor amendments and recommend that they be formally ratified by the Board of Directors at its June 2024 meeting. • The **Committee's workplan for 2024/25** has been reviewed and updated. With the caveat of adding some missing items, which include two internal audit reports (AuditOne), where the outcome was 'reasonable assurance', relating to Leavers' process and recruitment process, which will go to the Executive PCDC and then come back to committee in August. Actions are already underway and assurance on steps being taken following the recommendations will be reported to the Audit & Risk Committee in September 2024. • Pay progression will continue in the current way, ie automatic progression unless there is an existing HR sanction in place. Despite EDG approving moving to full pay progression, it is now evident that the re-implementation of the process will have little impact. • A detailed statistical analysis of protected characteristics in relation to the type of process that individuals are involved in and the outcome/sanction put in place will be presented at the committee's time out session for consideration. Results demonstrate that disciplinaries resulting in an outcome of 'no case to answer' is extremely low meaning that very few staff are entering our formal disciplinary process without adequate reason. There are some small but important differences for some groups which are being investigated further.

	• The recent national quarterly pulse survey has been sent to services to integrate into existing action plans built from the staff survey and CQC action plans. • The people and culture dashboard has been launched and how the committee will triangulate the data across its agendas will be considered at the time out session. • Progress continues with strategic workforce planning. A trust workforce plan was submitted to the ICBs in May to support the annual NHSE operational planning round. The committee received a brief paper on progress with strategic workforce planning in the priority areas with a more detailed discussion planned for the next meeting.	
2d	**Risks**	No new risks identified for inclusion in the BAF. Risks re violence and aggression will be considered following a detailed meeting in two weeks.

Recommendation: The Board is asked to:

i) note the contents of the report.
ii) ratify the Committee's revised terms of reference.
iii) note the increasing risk of violence and aggression towards staff.

3	**Any Items to be escalated to another Board Sub-Committee/Board of Directors**	None
4	**Report compiled by:** Donna Keeping, Corporate Governance Manager, Jillian Murray, Non-Executive Director (Committee Chair), Sarah Dexter-Smith, Executive Director of People and Culture	

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 June 2024**
Title:	**Annual Report by Interim Guardian of Safe Working Hours for Postgraduate Doctors**
Executive Sponsor(s):	**Dr Kedar Kale**
Author:	**Dr David Burke – Interim Guardian of Safe Working**

Report for:				
	Assurance	**X**	***Decision***	
	Consultation		***Information***	**X**

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	
2: To co-create a great experience for our colleagues	**X**
3: To be a great partner	

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
5	**Staff retention**	The experience of postgraduate doctors, and compliance with their terms and conditions of employment, is important to maintain viable training positions.
1	**Recruitment**	The experience of postgraduate doctors, and compliance with their terms and conditions of employment, is important to make TEWV an attractive place to work for doctors considering substantive appointment at completion of their training.

Executive Summary:

Purpose:

This report aims to provide assurance that postgraduate doctors are safely rostered and that their working hours are safe and in compliance with their terms and conditions of service.

The Board receives annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for postgraduate doctors. This is the annual report for 2023-2024, and there is also quarterly data relating to Q4. Appendices 1 to 3 have been provided to me by Medical Staffing, and they include aggregated data on exception reports, details of fines levied against departments, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting, when needed, good practice and/or persistent concern. Appendices are shared with the corresponding NHS England body for the different sectors.

The 2016 national contract for postgraduate doctors introduced the role of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and are compliant with safe working hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.

The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The Guardian is required to levy a fine against a department(s) if a postgraduate doctor:

- works on average over 48 hours/week
- works over 72 hours in 7 days
- misses more than 25% of required rest breaks
- when on non-residential on call (NROC) does not have a minimum of continuous rest for 5 hours between 22:00 and 07:00
- does not have the minimum 8 hours total rest per 24 hour NROC shift
- has more than the maximum 13 hour residential shift length
- does not have the minimum 11 hours rest between resident shifts

Proposal:

- I am satisfied that all exception reports submitted by doctors on the 2016 contract have been actioned by Medical Staffing. Some exception reports may yet be submitted by doctors in relation to the quarter. In terms of timescales for Q4, 0% (8% in Q3) of exception reports in the North, and 100% (70% in Q3) in the South, were responded to within 7 days. I have continued to liaise with the Head of Medical Staffing who advises that staffing pressures have caused the decrease in response time in the North, but I am informed that this will now improve. Response times in the South have improved to a substantial level of assurance.

- There continues to be a risk of breaches in the two non-residential Core Trainee / GP rotas in the NYY&S Care Group. Throughout the year, fines levied have predominantly been in relation to these rotas. Introduction of more residential rotas where possible will alleviate breaches relating to achievement of 5 hours of continuous overnight rest.

- There have been some postgraduate doctor vacancies across the Trust. The Trust has an ongoing approach to filling these posts through the Trust Doctor Scheme, which is described below. However, the internal system for covering out of hours rota gaps appears to continue to function well in that there is no reported use of agency locums on out of hours postgraduate

doctors' rotas.

- There is a well-functioning Postgraduate Doctors' Training Forum in each of the Care Groups with good attendance by trainee representatives from localities across the Trust.

Overview:

Q4 Position

- **Appendices 1 and 2** give details relating to DTV&F (North) and NYY&S (South) Care Groups respectively for the quarter January to March (inclusive) 2024. The layout of the appendices has been improved to align better with rota geography and medical grades.

- In the North there have been 8 exception reports in Q4, which is a small decrease over Q3. However, it is similar to Q2 and Q1.

- There have been 14 exception reports in the South in Q4, which is a decrease from Q3 (23), Q2 (39), and Q1 (26.) I continue to emphasise the importance of exception reporting to postgraduate doctors' representatives in the postgraduate doctors' training fora (PDTFs) and at inductions, as do Medical Staffing.

- The reasons for the exception reports are given within the appendices. In the South, a frequent reason remains in relation to not achieving 5 hours of continuous rest between 10pm – 7am on NROC rotas.

Annual Position

- **Appendix 3** gives annual data relating to trustwide postgraduate doctor vacancies (normal working day positions), as well as the number and value of Guardian fines. Each are given by location.

- Across the year for the whole Trust, vacancies have averaged to 19.52 WTE per quarter. I am advised by the Medical Staffing Manager, that vacancies are filled through the Trust Doctor Scheme. Recruitment rounds for Trust Grade doctors are run every 4 months with a programme of training provided, and support provided from the Trust Doctor Tutor and the International Medical Graduate Tutor. The Trust supports Trust Doctors to enter Core Training in Psychiatry. Any vacancies not covered by Trust Doctors are then covered through locum agency use when necessary. The remaining uncovered normal working day shifts, after accounting for annual leave, have been presented in **appendix 3**.

- It is important to note that the Trust does not cover higher trainee (ST4-6) vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees. After accounting for higher trainees, there have been 363

uncovered normal working day shifts across the year for the whole Trust.

- All fines over the year have been generated in the South Care Group. These have been predominantly in relation to NROC rotas, and doctors not achieving a period of continuous rest between the hours of 22:00 and 07:00. If the Trust were to replace these with residential rotas, this would be likely to resolve this recurrent theme.

- Details about Guardian fines, and disbursements, are given in **appendix 3**. A detailed list of expenditure is given in **appendix 4**. My understanding from discussion with the Head of Medical Staffing, and with the finance department, is that guardian fines that have been levied have shared a cost centre with income from postgraduate doctor wellbeing funds received from CNTW and LYPFT. Expenditure has been put against guardian fines; however, anything that was not fundable from those fines was paid from the wellbeing fund which shares a common purpose. Expenditure exceeded guardian fines by £713, but the cost centre ended the financial year in surplus of £25,420. The wellbeing fund is not within the remit of the Guardian of Safe Working. Going forward, for 24/25, the guardian fines will be levied to its own cost centre. The financial position for 23/24 is summarised below, with figures provided to me from Medical Staffing and the finance department:

	2023-2024
Wellbeing fund income	-£26,133
Total guardian fines	-£12,854
Expenditure	£13,567
Total Surplus	**-£25,420**

Other

- During a CQC inspection towards the end of last year, postgraduate doctors provided feedback about the doctors' facilities. As a result, Medical Development have undertaken a facilities survey in order to understand this better, and any local variance with workspace, with a view to ensure that any improvements are made where needed. The questions were compiled in conjunction with the trainee doctors' representatives and included details around the teaching, rest, and office facilities. The results have been looked into and shared with all trainee representatives. A number of outcomes have already been made and actioned, and the plan continues to be developed in conjunction with the Postgraduate Doctors' Training Forums.

- I will be participating in the Annual Dean's Quality Meeting on 14th June 2024.

Implications:

- **Compliance with the CQC Fundamental Standards:**
  The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour.

- **Financial/Value for Money:**
  The new contract is underpinned by the principle that postgraduate doctors are paid for the work they do. It is necessary that the Board understands that extra costs will be incurred for breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to postgraduate doctors is necessary and appropriate.

- **Legal and Constitutional (including the NHS Constitution):**
  The Learning Agreement signed by the Trust with NHS England sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow postgraduate doctors to fulfil their curriculum needs within a sound learning environment.

- **Equality and Diversity:**
  The Champion of Less Than Full-time (LTFT) Working is a core member of the Postgraduate Doctors' Training Forums.

- **Other Implications:**
  There is ongoing potential for industrial action to impact the number of exception reports.

  Fines are likely to continue to be generated in the South Care Group in relation to NROC rotas, as detailed above. Established patterns of breaches such as these should continue to be reviewed by the Trust.

Recommendations:

- The Board are asked to read and note this annual report from the Guardian of Safe Working.

- The Trust should consider the replacement of the two CT/GP NROC rotas in NYY&S with residential ones.

Background Papers:

Appendices 1, 2: detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively. Annual summary data in **appendix 3**. These appendices have been written and provided by the Medical Staffing Manager. **Appendix 4** is the detailed expenditure from the Guardian fines provided by the finance department.

Appendix 1 DTV&F (North Care Group)

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	124
Number of doctors / dentists in training on 2016 TCS (total):	124
Amount of time available in job plan for guardian to do the role:	1 PA.
Admin support provided to the guardian (if any):	4 days per quarter.
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (regarding working hours) from 1st January 2024 up to 31st March 2024

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	0	0	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2/GP - Teesside & Forensic Services Juniors	0	2	2	0
CT1-2/GP –North Durham	0	0	0	0
CT1-2/GP – South Durham	0	0	0	0
CT3 – Teesside & Forensic Services Seniors	0	2	2	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 - Teesside	0	1	1	0
ST4-6 –North & South Durham Seniors	0	1	1	0
Trust Doctors - Teesside	0	2	2	0
Trust Doctors -	0	0	0	0

North Durham				
Trust Doctors - South Durham	0	0	0	0
Total	**0**	**8**	**8**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services (CT1-3/GP/ trust doctor)	0	6	6	0
Teesside & Forensic Senior Registrars	0	1	1	0
North Durham (CT1-3/GP/trust)	0	0	0	0
South Durham (CT1-3/GP/trust)	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	1	1	0
Total	**0**	**8**	**8**	**0**

There were four reports of late finishes reported in the last quarter (two by the same CT3, two from the same Trust doctor). 1 report was in relation to a missed break (from the same Trust Dr who reported late finishes). 1 report was in relation to shadowing a resident shift from a new GP Registrar joining the Trust. This is offered to all new doctors joining the trust as part of their induction and each doctor can claim up to 4 hours of shadowing. There were also 2 exception reports submitted for breach of 5 hours continuous rest.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	0	6	0
Teesside & Forensic Senior Registrars	0	0	1	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0

North Durham Senior Registrars	0	0	1	0
Total	**0**	**0**	**8**	**0**

Delay in response was due to medical staffing staff shortages. This has been addressed now and going forward the Medical Staffing Advisor has a weekly reminder in their diary to check any exception reports and respond to them promptly.

Work schedule reviews

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Work schedule reviews by locality	
Teesside & Forensics	0
North Durham	0
South Durham	0

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	0	13	0	0	80
	CT1	42	29	0	378.5	280.6
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	Middle Tier (ST/SAS)	16	13	0	280	278
North Durham	F2	0	1	0	0	4
	CT1	45	39	0	370.5	297.5
	CT2			0		
	GP			0		
	CT3	0	5	0	0	120.50
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	30	25	0	533	372.5
South Durham	F2	0	0	0	0	0
	CT1	28	28	0	286.5	286.5
	CT2			0		
	GP			0		
	CT3	1	1	0	0	24
	Trust Doctor	0	0	0	0	0
	Middle Tier	47	47	0	858	858

	(SR/SAS)					
Total		**209**	**201**	**0**	**2706.5**	**2601.67**

There are less shifts worked than requested due to 8 middle tier shifts not being picked up, or they were picked up by specialty doctors and therefore haven't been included.

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	1	1	0	4	4
Sickness	13	13	0	135.5	135.5
On call cover	186	178	0	2502	2397.17
Special leave	9	9	0	65	65
Total	**209**	**201**	**0**	**2706.5**	**2601.67**

Vacancies

Vacancies by month					
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**
Teesside & Forensics	F1	0	0	0	0
	F2	1	1	1	1
	CT1	0	1	1	0.6
	CT2	1	2	2	1.6
	CT3	1	1	1	1
	ST4 -6	1	1	1	1
	GP	4	1	1	2
North Durham	F1	0	0	0	0
	F2	0	0	0	0
	CT1	0	0	0	0
	CT2	1	0	0	0.3
	CT3	1	0	0	0.3
	ST4 -6	1	0	0	0.3
	GP	2	1	1	1.3
South Durham	F1	0	0	0	0
	F2	0	0	0	0
	CT1	0	0	0	0
	CT2	0	0	0	0
	CT3	0	0	0	0
	ST4 -6	2	1	1	1.3
	GP	2	2	2	2
Total		**17**	**11**	**11**	**12.7**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	0	£00.00
North Durham	0	£00.00
South Durham	0	£00.00
Total	**0**	**£00.00**

Appendix 2 NYY&S (South Care Group)

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	72
Number of doctors / dentists in training on 2016 TCS (total):	72
Amount of time available in job plan for guardian to do the role:	1 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st January 2024 up to 31st March 2024

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F2 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
CT1-2 / GP - Northallerton	0	0	0	0
CT1-2 / GP – Harrogate	0	0	0	0
CT1-2 / GP - Scarborough	0	5	5	0
CT1-2 / GP - York	0	5	5	0
CT3 – Northallerton	0	0	0	0
CT3 – Harrogate	0	2	2	0
CT3 – Scarborough	0	0	0	0
CT3 – York	0	0	0	0
ST4-6 - Northallerton	0	0	0	0
ST4-6 - Harrogate	0	0	0	0
ST4-6 - York	0	2	2	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	0	0	0

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Trust Doctors - York	0	0	0	0
Total	**0**	**14**	**14**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
NYY PG doctors	0	7	7	0
NYY Middle tier	0	2	2	0
Scarborough PG doctors	0	5	5	0
Scarborough Middle tier	0	0	0	0
Total	**0**	**14**	**14**	**0**

There were 9 exception reports submitted by the NYY PG doctors (7 from the PG doctors and 2 from the Senior Registrars). 3 of those where in relation to claiming additional time worked whilst on NROC on-call, 5 were in relation to early starts and late finishes and there was also an education report for a doctor informing us that they were unable to attend their weekly teaching due to it falling on a rest day.

There were 5 exception reports submitted by the Scarborough PG doctors, 3 were in relation to claiming additional time worked whilst on NROC on-call and 2 were in relation to early starts and late finishes.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
NYY PG doctors	2	5	0	0
NYY Middle tier	0	2	0	0
Scarborough PG doctors	3	2	0	0
Scarborough Middle tier	0	0	0	0
Total	**5**	**9**	**0**	**0**

Work Schedule reviews

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Work schedule reviews by locality	
Northallerton	0
Harrogate	0
Scarborough	0
York	0

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Harrogate, Northallerton, Selby & York	F2	5	0	0	80	0
	CT1/CT 2/GP	70	63	0	800.5	733.5
	CT3	0	12	0	0	176.5
	Trust Doctor	0	0	0	0	0
	SAS	48	41	0	732	652.5
Scarborough	F2	0	1	0	0	16
	CT1/CT 2/GP	19	15	0	312	213
	CT3	5	8	0	80	128
	Trust Doctor	0	0	0	0	0
	SAS	87	81	0	1591	1481.5
Total	**0**	**234**	**221**	**0**	**3595.5**	**3401**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
On call cover	21	19	0	205.5	189.5
Vacancy	178	169	0	2910	2759.5
Sickness	20	19	0	240	228
Increase in workload	0	0	0	0	0
Special leave	3	3	0	48	48
Extra weekend support	8	7	0	128	112
Annual Leave	4	4	0	64	64
Total	**234**	**221**	**0**	**3595.5**	**3401**

***The discrepancies in the figures in these tables are due to:**	• *Not all middle tier shifts requested were picked on patchwork.* • *Shifts are covered by different grades because Higher grades could cover lower grades' shifts.* • *Some middle tier shifts were covered by consultants which are not included in this report.*

Vacancies

Vacancies by month					
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**
Northallerton	F1	0	0	0	0
	F2	0	0	0	0
	CT1-3	1	2	2	1.6
	ST4 -6	2	2	2	2
	GP	1	2	2	1.6
	Trust Doctor	0	0	0	0
Harrogate	F1	0	0	0	0
	F2	0	0	0	0
	CT1-3	1	1	1	1
	ST4 -6	1	2	2	1.6
	GP	1	1	1	1
	Trust Doctor	0	0	0	0
Scarborough	F1	0	0	0	0
	F2	1	1	1	1
	CT1-3	0	1	1	0.6
	ST4 -6	0	0	0	0
	GP	0	0	0	0
	Trust Doctor	0	0	0	0
York	F1	0	0	0	0
	F2	0	0	0	0
	CT1-3	1	1	1	1
	ST4 -6	3	2	2	2.3
	GP	3	1	1	1.6
	Trust Doctor	0	0	0	0
Total		**15**	**16**	**16**	**15.3**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	9	£3164
Harrogate, Northallerton & York	8	£2530
Total	**17**	**£5694**

Appendix 3 Trustwide

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Annual data summary from 1st April 2023 to 31st March 2024

Vacancies

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
North Durham	F1	0	0	0	0	0	0
	F2	1	0	0	0	0.25	0
	CT1 CT2 CT3	0	0	1.3	0.6	0.475	16.875
	ST4 -6	2	0	0	0.3	0.575	120.5
	GP	0	0	0	1.3	0.325	16.875
	Trust Doctor	1	0	0	0	0.25	0
South Durham	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1 CT2 CT3	1	0	0	0	0.25	59.25
	ST4 -6	5	0	0	1.3	1.575	331.5
	GP	0	0	0	2	0.5	28.125
	Trust Doctor	0	0	0	0	0	0
Teesside & Forensics	F1	0	0.3	0	0	0.075	17.175
	F2	1	0	0	1	0.5	56.25
	CT1 CT2 CT3	2.3	0.6	2	3.2	2.025	27.225
	ST4 -6	0	0	0	1	0.25	0
	GP	1	0.6	1	2	1.15	34.35
	Trust Doctor	0	0	0	0	0	0
North Yorkshire & York	F1	1	0.6	0	0	0.4	0
	F2	1	0	0.3	1	0.575	16.875
	CT1 CT2 CT3	3.6	2.9	3	4.2	3.425	43.2
	ST4 -6	2	4	6	5.9	4.475	982.5
	GP	0	0	5	4.2	2.3	11.25
	Trust Doctor	0.6	0	0	0	0.15	35.55

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
Total		**22.5**	**9**	**18.6**	**28**	**19.525**	**1797.5**

Fines

Locality	Quarter 1 Number of fines levied	Quarter 2 Number of fines levied	Quarter 3 Number of fines levied	Quarter 4 Number of fines levied	Annual Total
North Durham	0	0	0	0	**0**
South Durham	0	0	0	0	**0**
Teesside & Forensics	0	0	0	0	**0**
North Yorkshire & York	0	0	20	17	**37**
Total	**0**	**0**	**20**	**17**	**37**

Locality	Quarter 1 Value of fines levied	Quarter 2 Value of fines levied	Quarter 3 Value of fines levied	Quarter 4 Value of fines levied	Annual Total
North Durham	£0	£0	£0	£0	£0
South Durham	£0	£0	£0	£0	£0
Teesside & Forensics	£0	£0	£0	£0	£0
North Yorkshire & York	£0	£0	£7160	£5694	£12854
Total	**£0**	**£0**	**£7160**	**£5694**	**£12854**

The following has been spent within the past year:

Spend	Q1	Q2	Q3	Q4	Total
Prior Year Refund	- 592	-	-	-	- 592
Hot Drinks	668	1,192	105	3,111	5,076
Other	-	142	517	-	659
Aromatherapy Oils	-	-	110	66	176
Blankets/Cushions	-	-	217	252	469
Fans	-	-	196	49	244
Radiators	-	-	136	64	199
Event	-	-	1,500	5,835	7,335
Total	76	1,334	2,780	9,377	13,567

Appendix 4 Detailed Expenditure

Month	Supplier	Narrative	Value £	Sub-Category
Apr-24	DP SUPPLIES	Refund relating to prior year spend	- 222	Refund
Apr-24	DP SUPPLIES	Refund relating to prior year spend	- 226	Refund
Apr-24	CPC PLC	Refund relating to prior year spend	- 96	Refund
Apr-24	D.P. Supplies (North West) Ltd	Hot Drinks	176	Hot Drinks
Apr-24	CPC PLC	Refund relating to prior year spend	- 48	Refund
May-24	D.P. Supplies (North West) Ltd	Hot Drinks	428	Hot Drinks
Jun-24	D.P. Supplies (North West) Ltd	Hot Drinks	65	Hot Drinks
Jul-24	D.P. Supplies (North West) Ltd	Hot Drinks	1,192	Hot Drinks
Sep-24	Blackwell Uk Ltd	Oxford Handbook of Clinical Medicine Oxford Handbook of Clinical Specialties	62	Other
Sep-24	Blackwell Uk Ltd	Oxford Handbook of Psychiatry	29	Other
Sep-24	Blackwell Uk Ltd	Psychiatry	32	Other
Sep-24	Blackwell Uk Ltd	The Doctors Guide to Critical Appraisal	19	Other
Oct-24	Ward Bros	Unidentified	200	Other
Nov-24	Amazon Business EU SARL	Aromatherapy Oils (Phatoil essential oils set with wood diffuser) x1 |	25	Aromatherapy Oils
Nov-24	Currys PC World Business	Tassimo Coffee Machine (Black)	105	Hot Drinks
Nov-24	Amazon Business EU SARL	Blankets (Brentfords Teddy Fleece) x2	27	Blankets/Cushions
Nov-24	Amazon Business EU SARL	Cushions	130	Blankets/Cushions
Nov-24	Amazon Business EU SARL	Tower Fans (LIVIVO 32 Tower Fan with Timer Ultra Slim)	196	Fans
Nov-24	Emergent Crown Contract Office Furnishings Ltd	8611-136r33 1981mm x 914mm x 457mm double door cupboard Grey	213	Other
Nov-24	Amazon Business EU SARL	Indoor Plants	104	Other
Nov-24	Amazon Business EU SARL	Blankets	61	Blankets/Cushions
Nov-24	Yorkshire Purchasing Organisation	Oil filled Radiators	136	Radiators
Dec-24	Amazon Business	Aromatherapy Oils	85	Aromatherapy Oils

	EU SARL			
Dec-24	Rage Room Events Ltd	Invoice Number 0109 to be paid for Room Rage Event 25102023	1,500	Event
Jan-24	D.P. Supplies (North West) Ltd	Hot Drinks	3,111	Hot Drinks
Jan-24	Yorkshire Purchasing Organisation	Oil Filled Radiator	64	Radiators
Feb-24	Amazon Business EU SARL	Cushions	104	Blankets/Cushions
Feb-24	Amazon Business EU SARL	Tower fans (LIVIVO 32 Tower Fan with Timer Ultra Slim) x 2	49	Fans
Feb-24	Zen C	2 workshops to be paid for Junior Doctors well being	700	Event
Feb-24	Amazon Business EU SARL	Blankets (Brentfords Teddy Fleece) x2	26	Blankets/Cushions
Feb-24	Yorkshire Purchasing Organisation	Code D66370 Oil Filled Radiator	71	Blankets/Cushions
Mar-24	Amazon Business EU SARL	Aromatherapy Oils (Phatoil essential oils set with wood diffuser) x1 s	66	Aromatherapy Oils
Mar-24	AMAZON.CO.UK	Cushions	52	Blankets/Cushions
Mar-24	Gisborough Hall Hotel	TEWV NHS Wellness Day 10 06 2024	2,292	Event
Mar-24	Aldwark Manor Estate	The Aldwark Estate well being event totalling ?341250 170624	2,844	Event

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13th June 2024**
Title	**REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN**
Executive Sponsor(s):	**Sarah Dexter-Smith, Director for People and Culture**
Author(s):	**Dewi Williams, Freedom to Speak up Guardian**

Report for:				
	Assurance	**x**	***Decision***	
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	**x**
2: To co-create a great experience for our colleagues	**x**
3: To be a great partner	

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	**Safe Staffing**	The Freedom to Speak Up Guardian service is part of the key control on ensuring staff are able to raise concerns in a safe and constructive way about the controls in place for this risk. The service also provides an opportunity for learning for the Board.

Executive Summary:

Purpose: The purpose of this report is to inform the Board of Directors about the last 6 months of Freedom to Speak Up (FTSU) activity, with data covering Quarter 3 and 4 of 2023/24.

It demonstrates the impact we have made, how through joint working we have responded to speaking up from a range of people, and how we work with services to share learn lessons and develop action plans which help those who spoke up feel listened to and valued.

Proposal: It is considered that there is good assurance that this control is operating effectively.

Committee members are asked to note this report and provide guidance on any further information required.

Overview: <u>Background</u>
The role of the FTSU Guardian (FTSUG) was created in response to the recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

The FTSUG supports staff who have raised concerns. He is supported by a FTSU Officer The role reports independently to the CEO and NED FTSU champion but is managed within People and Culture. The FTSUG works alongside the Trust board to help develop more ways to empower and encourage staff to raise their concerns.

Data

Information on the activities of the FTSUG service is detailed in appendix 1.

The upward trend in case numbers continues. The Associate Director for Operational Delivery, Wellbeing and Resourcing met with the FTSU team to establish a way of representing the severity within these numbers and the links to employee relations cases. The initial feedback is that this does not reflect a corresponding increase in severity of concern but does indicate an increasing willingness to speak up around a range of issues, something which is also reflected in the staff survey data from last October.

	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Total Cases	46	44	61	55

The data shows that:

- The highest proportion of staff choosing to speak up within Quarter 3 were from Additional Health Professions and accounted for 16%. For comparison they make up 9% of the Trust. We hypothesise that this may reflect the relative power that this group have in having professional leadership outside of their management structures and therefore potentially feel safer in raising concerns (e.g. psychological professions, pharmacists, and social workers).
- In Quarter 4 the highest proportion of staff choosing to speak up were from a Nursing and Midwifery profession and accounted for 36%. For comparison they make up 26% of the Trust. This is an encouraging shift.
- Equality and Diversity Inclusion data is attached in appendix 2. It shows that the majority of staff speaking up to us are from a White British ethnicity. The majority of staff speaking up to us have described their sexual orientation as Heterosexual and most describe their religion as No religion. The majority of those speaking up have said that they do not have a long-standing illness or disability. This reflects overall Trust data.
- Detriment: 3 cases of detriment were referred to the Associate Director for Operational Delivery, Wellbeing and Resourcing within People and Culture. In the future there will be quarterly summaries of the cases of detriment. Outcomes and themes will then be provided to the NED FTSU champion and to the Director of People and Culture for review. The themes had included having their fitness to practice being reviewed.
- Training: Most recent information on compliance shows Speak Up at 83% and Listen Up is at 83%. This is a strong position relative to the time this has been available for. Follow up is at 61% and

is available to Senior leaders and is strongly recommended for all board members.

Activity

The development of training and support for the Speak Up champions is now progressing following the recent release of new guidance issued by the National Guardians Office. An event took place in December to share the new guidance issued and to re-launch the role. A further event took place in February and there is now a definitive list of confirmed ambassadors for publication on the staff intranet. It is proposed that the role will be known as 'speaking up ambassador'.

Impact / Triangulation of information to advise the board

The FTSU team will be meeting with the Director of People & Culture and the Associate Director of Delivery and Resourcing on a quarterly basis to review the data regarding the actions taken/lessons learnt and to review the cases where individuals have said that they remain unhappy despite having their concerns reviewed.

The speaking up raising concerns group continues to meet on a monthly basis to share any soft intelligence as a result of hearing from those colleagues who regularly have contact with teams to understand if there are any issues arising. The FTSU team have made arrangements to visit specific teams based upon the soft intelligence that has been received. Members of the group tell us that they have encouraged those that they have received contact from to speak up and this is reflected within the increase in the number of contacts that we continue to receive.

The group have shared intelligence that, despite contact with FTSU, concerns in one service appear to be ongoing and this has resulted in a further planned visit to that particular service, and escalation to more senior managers.

The committee are asked to note some of the case examples which show the lessons learnt during the last 6 months within appendix 3. The lessons learnt within the examples identified the need for better staff planning, the importance of better communication, a requirement for staff training and wellbeing support for staff, a need to increase staff resource and a requirement for some leadership reflection.

Prior Consideration and Feedback

The Integrated Care Board (ICB) requested that the FTSU team participate in an audit relating to case handling. We completed an on line questionnaire, and were interviewed by the freedom to speak up guardian for the ICB. The purpose of the audit was to provide assurance to Trust Board members as well as looking at learning across the ICB. The findings will be shared with the ICB Chief Nurse and also the CEO.

Implications:

The increase in the number of contacts that the FTSU team are receiving is an indication that more people feel able to speak up which will help to improve the culture of the organisation. Early detection and

mitigation of issues allows for more timely intervention, resolution and prevention of more significant issues.

Appendix 1 – further information

Report Title: Report of the Freedom to Speak Up Guardian

(1) Caseload

The upward trend in case numbers continues.

The table below displays the figures for ongoing cases over the last 6 months. And shows the previous 6 month for comparison but demonstrates the overall increase in numbers coming forward.

	Quarter 1 2023	Quarter 2 2023	Quarter 3 2023	Quarter 4 2024
Total Cases Received	46	44	61	55
Bullying and Harassment	10	5	7	4
Worker Wellbeing	20	15	29	32
Patient Safety/Quality	22	9	15	18
Inappropriate Behaviours	18	20	25	17
Other	18	7	17	20
Demeaning Treatment	2	3	3	3

(Individual cases received often include multiple themes, each case is only counted once.)

(a) Assessment of Cases

The highest proportion of staff choosing to speak up within Quarter 4 were from a Nursing and Midwifery profession and accounted for 36% of the cases received. No cases were received from Estates professionals or students during Quarter 4.

6 cases were received anonymously during this period.

(2) Impact on those Speaking Up

Following the closure of each FTSU case, those who have spoken up are asked to provide their feedback on their experience of accessing the FTSU service. We ask specifically, if they have encountered any demeaning treatment because they spoke up and would they speak up again in the future.

Of the 6 people who responded,100% said they would speak up again.

Some of the comments received included the following:

"I feel emotional thinking about how I know I smile and joke a lot but really this has been one of the toughest periods of my life - also one of my greatest in terms of self-development. You have remained consistent and principled throughout and you will probably never know how much that has got me through - thank you so much and I hope things all work out for you. Feel free to share if your team collects feedback or whatever"

"Both the FTSU officer and the senior member of staff listened, took my concerns seriously, were compassionate and followed up in the way they agreed to. I remain optimistic that it will lead to positive changes in the care of my friend. I was also really grateful for the apology about the way I had been treated"

"All positive, caring, understanding, professional and keep views balanced so not 'witch hunt'. Recommend service to anyone. Hope lasses follow it up."

We don't chase up staff who choose not to respond to this question but do support those who indicate they have suffered detriment as a result of speaking up.

(3) Service Development

The FTSU team share an overview of the lessons learnt as a result of people speaking up with our speaking up raising concerns group on a quarterly basis and also review this information with the Director of People and Culture and the Associate Director of Operational Delivery and Resourcing.

The FTSU team are meeting with the Lead for Organisational Development (OD) to review those cases where the actions taken/lessons learnt have resulted in a recommendation for OD intervention in order to discuss and triangulate this data.

The FTSU team also regularly signpost and encourage those who have indicated to us that they are intending to leave the Trust to complete the intention to leave form on the staff intranet so that a discussion can take place with a member of the OD team.

Our service model remains under review. We were audited by Audit One in Q2, and our processes have been reviewed by representatives from the Integrated Care Board.

(4) Training

We continue to provide bespoke training for teams or individuals on request, and specialist training for senior staff wishing to undertake reviews.

We continue to develop training and support for our speak up ambassadors.

(5) Support networks

We continue to hold our monthly speak up forum with colleagues from across corporate services who work across multiple teams. We share soft intelligence and then agree how best to feed this information through to the services to ensure early notice of challenges. We are dependent on individuals to come forward. This also triggers guardian visits to services to ensure staff know their speaking up options. The guardian

remains very grateful for the support provided by the guardian officer. The additional support has enabled us to provide more proactive support to services much earlier after hearing initial concerns from the wider group.

Opportunities for learning lessons occurs within the forum. We also use the staff intranet and Facebook to share anonymised case examples, primarily to share the message that it is worth speaking up, and the trust does listen and act on concerns raised by our staff.

Professional representation of cases

Profession	Proportion of Trust wide profession	Cases received in Q3 by profession	Cases received in Q4 by profession
Admin and Clerical	19.9%	20%	16%
Additional Clinical Services	27.4%	11%	4%
Nursing and Midwifery	26%	28%	36%
Medical and Dental	3.32%	0%	7%
Allied Health Professionals	5.29%	3%	7%
Additional Professional services	9%	16%	11%
Not known		7%	13%
Other		13%	6%

Admin and Clerical: Non-clinical staff, including non-clinical managers, administration officers, executive board members who do not have significant patient contact as part of their role.

Additional Clinical Services: Staff directly supporting those in clinical roles. In addition, support to nursing, allied health professionals and other scientific staff are included. • Have significant patient contact as part of their role

Nursing and Midwifery: Registered nurses and midwives.

Medical and Dental: Registered doctors and dentists.

Allied Health Professionals: Registered clinical staff providing diagnostic, technical and therapeutic patient care, including dieticians, radiographers and physiotherapists. • Includes qualified ambulance staff such as paramedics

Additional Health Professionals: Scientific staff, including registered pharmacists, psychologists, social workers, and other roles such as technicians and psychological therapists.

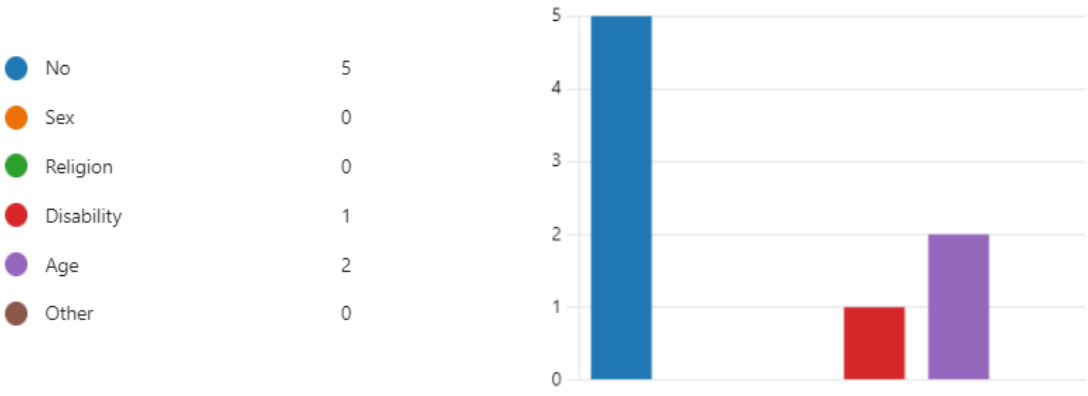
Other – Governors, Volunteers

Equality and Diversity and Inclusion data collected since August to December taken from Microsoft forms.

Data collected during Quarter 4

3. Do your concerns involve a protected characteristic?

More Details



5. How would you describe your ethnicity?

More Details

White British	7
White - Any Other Background	0
Mixed - White and Black African	0
Mixed - Any Other	0
Asian/Asian British - Pakastani	0
Asian/Asian British - Indian	0
Asian/Asian British - Bangladeshi	0
Asian/Asian British - Any Other	0
Chinese	0
White Irish	0
Mixed - White and Black Caribb...	0
Mixed - White & Asian	0
Any Other Ethnic Background	0
Prefer Not to Say	0

6. How would you describe your sexual orientation?

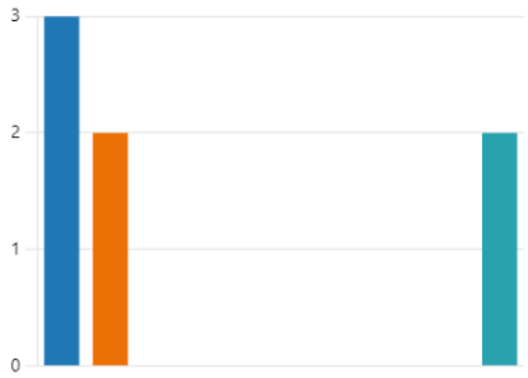
More Details

Hetrosexual (Straight)	6
Homosexual	0
Bisexual	0
Other	0
Prefer not to say	1

7. How would you describe your religion?

More Details

No religion	3
Christian	2
Buddhist	0
Hindu	0
Jewish	0
Muslim	0
Sikh	0
Chinese	0
Any Other Religion	0
Prefer Not to Say	2



8. Do you have a long standing illness or disability?

More Details

Yes	0
No	4
Maybe	1
Prefer not to say	1

Appendix 3: Lessons Learnt

Speak Up	**Staff Wellbeing/Staff Safety/ Patient Safety/Quality.** 3 workers spoke up about their concerns relating to the current levels of acuity on the ward and the importance of ensuring that there are appropriate staffing numbers /skill mix to mitigate this.
Lisen Up	The FTSU team raised this with the acting General Managers for the service.
Follow Up	**Actions taken / Lessons learnt:** Information was used as part of ongoing review of the service. The Associate Director of Nursing, Associate Director of Therapies, General Managers, Care Group board members, Care Group Director of Operations & Transformation in AMH/MHSOP, Director of Nursing and Care Group Medical Director had spent two weeks on site and had attended report out meetings to understand bed flow and patient acuity. Also, to review any barriers such as housing/social needs, forensic/security needs etc. A number of changes were identified: • A daily staffing call carried out by the Modern Matrons/Ward managers to review acuity, to plan staffing for the days/week ahead to ensure gaps are filled. • Introduction of an in hours DNC. The role will be to assess staffing across the site and to check Safecare is updated. Additional training set up to understand Safecare and to ensure all Registered Nurses had a refresher training on this. This role will also assess skills across the site reporting on how many staff are trained in Positive and Safe/CPR for added assurance. Then out of hours, the DNC can be contacted if risk or acuity changes. • Increase in resource to attend report outs and to support clinical care and treatment. • A review of police management of incidents. Meetings held with local police constabulary. • Review of support offered to staff including access to wellbeing/supervision groups. Request for autism team to start a monthly session to support staff and further consideration required to ensure staff can attend group sessions that are available.

Speak Up	**Staff Safety/Wellbeing / Patient Safety/Quality** A worker had spoken up about concerns relating to staff within the team who were feeling burnt out due to ongoing staffing pressures. There was a concern amongst peers that the team felt unsafe. Staff had left the team and some staff were on sick leave.
Lisen Up	The FTSU team contacted the General Manager for the service who along with the Service Manager met with the team.
Follow Up	**Actions taken / Lessons Learnt:** The team manager would be asked to request 360 degree leadership feedback to support development and reflection.

	The Service Manager and General Manager met with staff to provide reassurance around re-allocation of caseloads.

Speak Up	**Inappropriate Attitude / Behaviour / Staff Wellbeing / Safety / Demeaning Treatment** A worker spoke up about unacceptable behaviours and the lack of management action taken to address the concerns. The worker also spoke up about experiencing detriment as a result of speaking up. .
Lisen Up	The Associate Director of Operational Delivery and resourcing met with the worker along with a colleague from the Organisational Development Team.
Follow Up	The case of detriment was recorded in line with process and the Organisation Development team helped to facilitate a mediated discussion.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 13 June 2024		
Date of last meeting: 2 May 2024		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • Summary of the Executive Review of Quality Group • Integrated Performance Report (IPR) • CQUIN • CQC Activity and delivery of the Trust's CQC Improvement Plan • Quality Assurance and Improvement Programme and NICE Implementation – Annual Report • Annual Clinical Audit of Emergency Equipment 2023/24 • Quality Account 2023/24 • Learning from Deaths • Learning from Deep Dive into Restrictive Practice Data • Review of the Trust's Statement of Purpose • Physical Health Strategy Progress • Environmental Risk Group • Annual Patient Publication of Information • Medical Devices Q4 Report • National Safety Alerts Quarterly Assurance Report • Corporate Risk Register • Board Assurance Framework The Committee held a confidential meeting on 2 May 2024 to approve the minutes of the confidential meeting held on 4 April 2024
2a	**Alert**	The Committee alerts the Board on the following matters: **From the NYYS and DTVF Care Groups:** • DTVF had 178 episodes of seclusion. Assurance can be provided that the duration for every episode has been reviewed. Six of these patients are ready for discharge to a personalised placement that is not yet available. Executive Review of Quality Group will monitor progress on those waiting for placements. • Three uses of tear proof clothing one in AMH (NYY) all related managing imminent safety risks. • There was no prone restraint, mechanical restraint of the use of tear proof clothing in DTVF. • Six patients in DTV admitted to a more restrictive environment (PICU) due to lack of AMH beds. • The NY decommissioned seclusion room was used once and clinical and operational leaders have met to agree the management strategy of this ongoing risk. • One shift at Foss Park, (NY) in older adults was covered 100% by agency staff. This is not the standard we want; however, it was recognised in advance and a full mitigation plan was in place with many of the staff being regular agency workers who know our patients well. Full supervision for agency staff is in place. • CiTo, as expected following the major implementation of an electric patient record, has led to some concerns with performance. This is understood and gold command are monitoring and supporting services. Moving to full business continuity measures was considered and is not needed at present.

		Other business matters: • The draft phase one scoping report in relation to the options for a quality assurance review by NICHE was considered with some questions raised about the planned methodology. The Chief Nurse will respond by 10 May 2024. • Limited assurance was provided about the historical management of medical device assets, however there is now a system and process in place and specialist skill has been appointed to ensure we have robust management in place. This work will take approximately 18 months to conclude with incremental improvements expected.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** • No breaches of mixed sex accommodation. • There has been a positive impact on call answer rates in Crisis teams following the launch of NHS 111. • One long term segregation in secure inpatient services was terminated. • A result of partnership working by the TEWV pharmacy team has resulted in 'Stomp' being included in the pharmacist's curriculum at University of Teesside to avoid the over use of medication for those people with learning difficulties. • No use of mechanical restraint, prone restraint or supine over 10 minutes during March for NYY. • A patient from Bankfields Court was supported to visit costa café for the first time in over four years and continues to do so. • The estates works to facilitate an improved environment for a gentleman in SIS to enable access to fresh air will be ready in three weeks, in the meantime he has accessed fresh air and was playing football outdoors at the weekend. **Other business matters:** • Good assurance on the evidence of recent reductions in the number of incidents that have needed to escalate to a full patient safety incident investigation (PSII). This demonstrates early learning. • Three 'must do' and five 'should do' CQC recommendations were completed in month, as part of the CQC Improvement Plan. • Good assurance demonstrated on progress with the Quality Assurance and Improvement Programme and NICE implementation. • Good assurance evidenced from the annual requirement to assess all emergency equipment against the Trust Resuscitation policy. Health and Justice achieved 100% compliance for their three applicable areas and ALD specialty achieved 100% compliance for 13 out of 14 areas. • Good assurance that the Trust is meeting its obligations under law to produce and publish the Patient Publication of Information for 2024. • Good assurance on reporting and learning from deaths. Change to current process in line with CNTW practice, will mean that part one mortality reviews will be undertaken by a third party (LeDer). Trust policy will be amended to reflect the change. Committee sought clarity on reported deaths of autistic patients. • The progress to develop a Trust strategy for physical health care for June 2024 shows good assurance. • The process in place for oversight of suicide prevention assessments (identification of environmental ligature anchor point risks) demonstrates good assurance. • The timeline for stakeholder consultation, internal review, approval and publication of the Quality Account demonstrates good assurance. June Committee will receive the final version, including stakeholder, cocreation feedback.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** • Executive oversight of Birch ward continues.

		• Significant time has been spent considering how to improve our performance on clinical and patient related outcomes. • Durham and Darlington Crisis Team remained in short term BCP. Main issues were sickness and vacancy. **Other business matters:** • Reasonable assurance provided from the Integrated Performance Report, with little change from last month, noting that CiTo and InPhase will impact on recording information. Several actions to improve the quality of incident data recorded in InPhase are underway. • Renewed focus is being given to making improvements to outcome measures (PROMS/CROMS) by the care groups, taking intelligence from 'walking the wall' where a commitment has been made to make progress. • Good assurance on the process through daily huddles to review any incidents of moderate harm and the after-action reviews with evidence of more robust and early learning taking place. • Reasonable assurance for the final CQUIN position, which is now suspended nationally, where three of the five quality measures did not achieve the national quality standard, one of which was uptake of flu vaccinations where the minimum threshold was not met. • A request to extend the deadline to 30 may for the CQC recommendation (12a) linked to review of the BAF and Board/Committee papers to demonstrate effectively and timely approach to addressing/mitigating risks was not approved. Committee sought clarity on the outstanding work as the committee were aware of the significant improvement to the BAF. • Following the annual clinical audit of emergency equipment some unannounced audits will be implemented for teams that didn't achieve full compliance for emergency response bag checks. Dip sampling via the fundamental standards programme throughout the year will also support the message about the formal assurance needed for this serious area of safety. • Committee received and accepted the annual review of the Trust's 'Statement of Purpose'.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that risks are understood, are being managed effectively with more visibility of triangulating current and emerging risks, with evidence of early learning.
3	**Actions to be considered by the Board**	The Board is asked to note the report.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

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Committee Key Issues Report		
Report Date to Board of Directors – 13 June 2024		
Date of last meeting: 6 June 2024		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • Summary of the Executive Review of Quality Group • Integrated Performance Report (IPR) • CQC Improvement Plan • Community Mental Health Survey 2023 • Trust Quality and Learning Report • Quality Assurance and Improvement Programme and NICE Implementation – Annual Report • Quality Account • DTVF Adult learning disabilities • PALS/Complaints Annual Report 2023/24 • Duty of Candour Quarterly Report • Pharmacy and Medicines Optimisation • Triangle of Care – Carers Plan • NICHE Recommendations Quarterly Report • Rapid Review of data in Mental Health Inpatient Settings • Retrospective Review of service and care delivery on Birch Ward • Learning from the Lives and Deaths of people with learning disability/autism - LeDer • Board Assurance Framework
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • Despite improvement in response to call rates to crisis line 111(2) 90%, triage call answer rate is 62% for DD and 88% for Tees. GIRFT(Getting it right first time) work being undertaken jointly with the Royal College of Psychiatrists and also being actively pursued in the urgent care transformation programme. • AMH neurodevelopmental ADHD/autism waiting times discrepancies noted, which is being picked up by the care group board. • CYPS neuro triage waiting time has increased gradually to five months and a service review report to Clinical networks is due in June. • MHSOP people waiting over four weeks for organic assessments increased. • Issues with data quality noted for seclusion. Manual data collection indicates a reduction in Seclusion episodes in ALD. In 2022/23 benchmarking the trust was 3rd highest in the country. • Two patients remain in long term seclusion in SIS. • AMH seclusions increased and overall increase in restrictive practices. • Increase in young people dying by suicide in Teesside. Work ongoing with Public Health. Suicide Prevention lead to provide update at next meeting. • Medication alerts on CiTo for Lithium and Clozapine have not appeared as required. Manual record checks are being undertaken and escalated to silver command. • Increased temporary staff usage, particularly weekends. This is being actively monitored at Care Group Board. • Increase in assaults on Cedar. Two RIDDOR cases where staff lost consciousness. Working group has been set up to bring all corners of the organisation together to help keep people safe. • Potential MSA breach being investigated. • IPR - CYPS PROMS shows special cause concern. Work is underway with team managers to ensure clinicians encourage patients to complete agreed outcomes at the start and end of their journeys as appropriate.

		From NYY Care Group: • Issues with wards maintaining own records for 72-hour follow up. Data cleansing is required. • AMH Ripon in BCP due to being unable to recruit to vacant posts. Patients waiting are within keeping in touch allocation and position slowly improving. 11 out of 28 actions in the recovery plan were completed by 8 May 2024. • CAMHS single point of access team (SPA) in BCP due to reduced staffing and core team doing additional hours which is not sustainable. Access targets not affected. Recruitment premium is being offered for this particular area to ensure safe staffing. • Ongoing issues obtaining support from social care for client group needing appropriate placements/and or care packages. Focused work taking place in close liaison with LA and ICB stakeholders. • Infrastructure: North Moor House continues to report network issues despite system upgrade and staff taking longer for data entry on CiTO. • Ongoing issues with Care plans/safety plans completion. Not clear if related to CiTo or user error. **Other business matters:** Both care groups have reported issues with data quality in relation to IIC/CiTO/Inphase and the Positive and Safe Dashboard. Bronze and silver command continue to address issues. Performance team are also actively looking into this and an update will be provided at the next meeting.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** DTVF: • Good assurance from manual data to indicate reduction in restrictive interventions in ALD. Prone restraints lower than what was reported on Inphase. Work being done with staff around recording in Inphase. • No Prone or supine restraints in MHSOP. • Birch ward has a robust plan to reopening and increasing bed capacity in a phased manner. • No use of tear proof clothing. • No new blanket restrictions reported to the Positive and Safe group. • Eight patients at Bankfields court, all but two are clinically ready for discharge. Work is being progressed with ICB in relation to delayed transfer of Care in ALD. NYYS: • No MHSOP or AMH shifts covered by 100% agency. • No prone restraint/segregation. • No breaches reported on any ward for mixed sex accommodation. • Overall number of falls continue to decrease, 12 on Wold view in April down from 35 in March. **Other business matters:** • Good level of assurance on progress made in adult learning disabilities (DTVF) Phased plans in place for re-opening beds at Bankfields. Long term seclusion patients down from seven to one. Recent CQC feedback was very positive. No patients receiving intramuscular medication (rapid tranquilisation), making the trust the only place in the country where this is being achieved. • ICB colleague in attendance at the meeting commended the professionalism at Bankfields and the tireless efforts of staff to make significant improvements over the last 18 months. The clinically led team have taken the service to exemplar level. • Good assurance demonstrated on progress with the Quality Assurance and Improvement Programme and NICE implementation. • Special Cause improvement demonstrated in children and young person's CROMS, reported in the IPR.

		• Board Assurance Framework now updated with exception of three risks relating to IT and cyber/digital, which will be completed in time for the June Board meeting. • Good assurance for rating of 'about the same' from the Community Mental Health Survey 2023 when compared to 53 other mental health trusts in England. Trust response rate equated to 21%, which is slightly ahead of the national average of 20%. • Positive outcome of green status for the clinical re-audit of pressure ulcer point prevalence. All inpatient areas were included in the audit. • Following receipt of stakeholder comments, the Quality Account 2023/24 was approved noting that it provides a fair, balanced and understandable description of the quality of services. It will now go to the special Audit and Risk Committee meeting on 17 June 2024. • The PALS and Complaints annual report 2023/24 was approved. Significant progress can be seen through the levels of compliance with the timescales to answer formal complaints with an increase from 12% to 54% this year. Further improvements expected for 2024/25. MP complaints have decreased to 39, compared to 107 last year. Complaints progressing to a Further Local Resolution has decreased this year by 13%. • Good assurance on work undertaken to develop 'Carers Trust Triangle of Care' over the last 12 months. • Good assurance on progress with and understanding of recommendations following independent investigations undertaken by NICHE.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** • Executive oversight of Birch ward continues with a significant detailed plan. • Significant time has been spent considering how to improve our performance on clinical and patient related outcomes. • Reasonable assurance on the monitoring of feeling safe from both care group, where there is a strong commitment to safe wards. This is something the Council of Governors may want a briefing on. **Other business matters:** • Good assurance provided from the Integrated Performance Report. Several actions being progressed to improve the quality of incident data recording on InPhase, reported through IIC. • Extension deadline approved for CQC recommendation (28f) physical health monitoring, 3) completion of disciplinaries until end of July and September respectively. • Extension deadline for CQC recommendation (27a), support for staff to attend reflective practice and wellbeing opportunities in secure inpatient services **not** approved for end of October. Clear steer from QAC this is not acceptable. Service to review this. De-briefing is in place following any incident. • Extension deadline approved for CQC recommendation 35) to improve number of bathrooms on wards until end of September 2024 to allow for completion of estate works. • Intense focus on outcomes being given by Executives through using the 'walk the wall' to make changes at ward and team level. • Reasonable assurance outlined in the Trust Quality and Learning report. Two areas showing special cause for concern: incidents per 1000 caseload and medication errors per 1000 OBD (wards only). This report has been refined to avoid duplication with other reporting to committee. • Following a more in-depth assessment of the recommendations for the rapid review of MH data within inpatient settings, responsible owners to consider addressing

		identified gaps by beginning of quarter 2 with a follow up review of those areas partially compliant. • Reasonable assurance on progress with implementation of Duty of Candour and ongoing implementation of actions. • Good assurance on progress with medicines optimisation. Two key areas of risk are the management of cardiovascular assessments pre-ADHD treatment and the risk of wrong patient prescribing and/or administration. These are being managed appropriately. Committee will be kept informed. • Committee welcomed a presentation on learning from the lives and deaths of people with learning disabilities and/or autism. It was noted that very few Autism deaths were reported to LeDer since January 2022. Nationally 36 reviews completed including two from NYY. Data not available from NENC for DTVF at this time.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that risks are understood, are being managed effectively with close monitoring and oversight of the impact of actions and early learning.
3	**Actions to be considered by the Board**	The Board is asked to note the report. The Board should also note that a development session, facilitated by Deloitte was held on 22nd May. There were some good, clear outputs which will be taken forward through the Executive Chief Nurse and the QAC Chair. The Board should also note that both of our ICBs are now in attendance at our meetings.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Kedar Kale, Medical Director, Chief Nurse and Donna Keeping, Corporate Governance Manager

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Tees, Esk and Wear Valleys
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report	
Report Date:	13 June 2024
Date of last meeting:	13 May 2024 – committee was quorate

1 **Agenda: The Committee considered the following agenda items during the meeting**

- Integrated Performance Report (IPR)
- CQC Mental Health Act Monitoring Activity February – April 2024
- Discharges from Detention
- Section 136 - Police emergency powers to take a patient to a place of safety
- Section 132b – Information to detained patients including reading of rights
- Quarterly Positive and safe Improvement Plan
- Progress Reports from the Multi-Agency Mental Health Legislation Operational Groups (DTVF & NYY)
- Case Study
- Mental Capacity Act/Deprivation of Liberty Safeguards
- Deep Dive into patients detained in Crisis Assessment Suite waiting for Admission
- Revised policies: Independent Mental Health Advocacy (IMHA) and Section 17 Leave for detained patients
- Revised Workplan 2024/25
- Mental Health Legislation Committee revised Terms of Reference
- Proposed Committee dashboard measures for inclusion in the IPR

2a **Alert: The Committee alerts members of the Board to the following:**

- Some patients were discharged without their rights being read, with the top few wards in NYY requiring frequent escalations. This will be looked into via the fundamental standards group.
- Committee has sought further assurance and information on the background and details from an individual case study.
- Committee sought further assurance from the care groups on the Mental Capacity Act (MCA) training figures for MCA/DOLS.

2b **Assurance: The Committee assures members of the Board on the following:**

- The number of uses of the Mental Health Act has remained within common cause variation during the reporting period.

- Directors of Nursing and Medical Directors from the care groups attended the meeting, which enabled effective debate/check and challenge on the relevant operational matters behind the legislative data and included taking forward actions on an early action review, the uptake of Mental Capacity Act training and escalating to the fundamental standards group the top six wards where patients had been discharged without their rights.

- The first meetings have taken place for the newly established interagency MH Operational groups, led by the two care groups. The purpose of the groups is to take a proactive role and actively engage with partners, including the two ICBs and various local authorities to help influence service transformation and improve the health of the communities we serve. The terms of reference are currently being produced for both groups.

- **CQC MHA monitoring Annual Report and quarterly report** – there is good assurance regarding the oversight of inspection activity and completion of actions. It is noted that 84% of Provider Action Statements (PAS) were submitted to the CQC within the stipulated deadline with three being submitted a day late. Triangulation of common themes from the inspections has demonstrated fewer newly emerging themes.

	• **Discharge from detention -** There is substantial assurance that the number of times detained patients are discharged by the tribunal or hospital mangers is within normal range. Ten out of 254 discharged with one patient re-detained within three weeks. • **Section 136 –** There is a good level of assurance that the legislative requirements for patients held in the trust on a s136 are being met in all areas. Out of 145 patients under 136 in this period, 1 patient required an extension over 24 hours. This was in relation to requiring medical treatment in acute hospital. • **Section 132b –** there is substantial assurance that there is a robust escalation process in place for any patients who have not had their rights within three days of detention. In 760 detentions during this period the escalation process was used 127 times. (16%). Eight patients were discharged with no evidence of rights being read. (approx. 1%). • Reasonable assurance on the implementation of the **Positive and Safe Improvement Plan** – the action plan needs updating as it did not reflect current progress. There were 43 instances of prone restraint, (all associated with rapid tranquilisation). Both care groups provided evidence of focus and increased scrutiny to reduce levels of prone restraint. For DTV following a deep dive into 13 incidents only two were found to be prone restraints, indicating incorrect data entry. For NYY there have been no prone or mechanical restraint in over a year and on average there is one seclusion episode every four to six weeks. • **Mental Health Act/Deprivation of Liberty Standards (DoLS) –** there is reasonable assurance that the trust is meeting its requirements under the Mental Capacity Act and a reasonable level of assurance that the use and reporting of DoLS is being carried out as required. Overall compliance for MCA throughout the Trust is at 86%. •
2c	**Advise: The Committee advises the Board on the following:** • Improvements are needed on the application of the Mental Capacity Act on instances when patients are admitted informally and this will be picked up by the internal MH operational group. • It was agreed that the Mental Health Legislation team will discontinue monitoring the data related to s136 and this will be picked up through clinical services. The only reported detentions to the s136 suite by the MHL team will be when it is the outcome of a s136 assessment. • A report will be presented to the Quality Assurance Committee to provide a deep dive into the data on the use of crisis assessment suites. The care groups have been gathering data over recent months to develop some standards to ensure that legislation is being met. The Committee has reviewed its terms of reference and agreed the following changes: 1. Meetings will be held three times per year, (meeting in the previous month to the Board of Directors), plus an additional time out session for developmental work and forward strategic thinking. 2. The Lived Experience Directors have been asked to contribute to enhancing the patient/carer experience input into future meetings, to meet the obligation set out in the terms of reference, [3.3] *"To gain assurance that the Trust actively listens to, and learns from, the experiences of service users, families and carers in the application of mental health legislation".* 3. To gain assurance that the Trust is meeting its reporting obligations to the Care Quality Commission, future reports will include information on the deaths of detained patients. • Dashboard measures are being agreed for committee to monitor progress on those areas which relate to Our Journey to Change and the Board Assurance Framework. There is one measure

	currently in the Integrated Performance Report (IPR) the number of uses of the Mental Health Act. No cause for concern. • The two policies: section 17 leave for detained patients and Independent Mental Health Advocacy were approved. 4. The CQC Mental Health Act Annual report was received and noted.	
2d	**Review of Risks**	No additional risks identified.
Recommendation: The Committee proposes that the board notes the report and the levels of assurance confirmed.		
3	**Actions to be considered by the Board:** There are no actions for the Board to consider.	
4	**Report prepared by***: Kedar Kale, Executive Medical Director and Donna Keeping, Corporate Governance Manager*	

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	13 June 2024
Title:	NHS England Core Standards for Emergency Preparedness Resilience and Response
Executive Sponsor(s):	Zoe Campbell – Managing Director North Yorkshire, York & Selby Care Group & Accountable Emergency Officer (AEO)
Author(s):	Simon Marshall

Report for:				
	Assurance	✓	***Decision***	
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	Safe staffing	Robust Emergency Preparedness, Resilience and Response process help to mitigate this risk
6	Estate / Physical Infrastructure	Robust Emergency Preparedness, Resilience and Response process help to mitigate this risk
7	Cyber Security	Robust Emergency Preparedness, Resilience and Response process help to mitigate this risk

Executive Summary:

Purpose:

It is a requirement for NHS providers to undertake an annual Emergency Preparedness Resilience and Response (EPRR) self assessment which is led by NHS England via Local Health Resilience Partnerships (LHRP).

The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards. Compliance with the standard gives assurance that NHS organisations in England can respond to emergencies and business continuity incidents and are resilient in relation to continuing to provide safe patient care.

This years assurance process has been very different. NHS England regional team included providers and ICB's in the North East & Yorkshire and North West in a pilot where the approach to the assessment of the core standards has been 'rebased'. The Appendix 'Core Standards Overview for Boards' prepared by NHS England provides a detailed explanation and rationale for and

implications of the change.

Proposal: As a result of the change in the approach to assessment against the core standards the Trust, like all Trusts in the Humber and North Yorkshire and the majority in the North East and North Cumbria ICS's is now declaring a self assessment as Con-Compliant.

Overview: The self-assessment gives assurance to the Trust Board that the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst still maintaining provision to service users. However, it is now recognised across the region that the environment is changing and more work needs to be done to improve resilience across the sector.

Over the next 12 months, the NENC ICB will be working with all health providers to identify best/leading practice for each domain that will be shared and discussed collaboratively in monthly EPRR system meetings with the aim of enhancing the threshold of evidence. It has been confirmed that the ICB rather than NHSE will lead on this process for 2024. The Trust has committed to continue to work collectively with both ICB's, NHS England and other provider trusts (particularly CNTW) throughout the year in order that all partners are in a position to report a higher degree of compliance following the 2024/25 self assessment round.

Prior Consideration and Feedback The Trust has fully engaged with both ICB's and other provider trusts in support of a system wide response throughout the self assessment process.

The report has been considered by Audit and Risk Committee.

Implications: See attached report.

Recommendations: Based on the assurances provided by the Audit and Risk Committee, Board is requested to:

a) acknowledge the change in process, timelines for submission and the enhanced evidence requirements inherent in the new self-assessment process

b) acknowledge the way in which the self-assessment process has been conducted for 2023 resulting in a final self-assessed position of non-compliance

c) agree that the differential gap in evidential requirements will substantially inform the 2024 EPRR work plan

d) accept this report which gives assurance that although there have been significant challenges within the revised core standards process and acknowledging this major change in expectations and requirements, the evidence provided within this report should assure the Audit and Risk Committee that the trust continues to anticipate; assess; prevent; prepare;

respond and recover from any disruptive events or incidents.

MEETING OF:	**Board of Directors**
DATE:	**13 June 2024**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this paper is to provide Trust Board with assurance on how the Trust is complying with NHS England's Core Standards for Emergency Preparedness, Resilience and Response.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health and patient safety.

2.2 The Core Standards for EPRR aim to clearly set out the minimum standards which NHS organisations must meet to ensure that they can effectively respond to emergency and business continuity incidents whilst maintaining services to patients.

2.3 In addition they enable agencies to co-ordinate Emergency Preparedness, Resilience and Response activities and provide a framework for self- assessments and assurance processes.

2.4 The overall EPRR assurance rating is based on the percentage of core standards that trusts can self-assess against.

Organisational rating	Criteria
Fully compliant	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

2.5 In previous years, NHS Providers have been required to provide a RAG-rating for each applicable standard and comment on the evidence that supported this assessment.

2.6 The trust self-assessment position in 2022 following the peer review process was 89% **substantially compliant.**

3. KEY ISSUES:

3.1 In June 2023, NHSE confirmed to the North East, North Cumbria (NENC) and Humber & North Yorkshire Integrated Care Boards (ICBs), and health organisations, a revised process for the 2023-24 EPRR Assurance Process would be piloted in the region. For the first time, NHS providers within the North East and Yorkshire region were asked to submit physical evidence via a national portal. This was to

demonstrate how the trust complies with the standards from an NHSE viewpoint in support of the trust's self-assessment compliance rating.

3.2 NHSE undertook a review of the evidence submitted to understand the self-assessment position. Each core standard was reviewed against new NHSE EPRR Assessment guidelines (issued in June 2023) and rated, along with providing documented reasons for any challenge.

3.3 Following the completion of our initial self-assessment, the Trust's compliance rating (as at 29 September 2023) was assessed as 83% partial compliance

3.4 The primary evidence was submitted on 29 September 2023. Initial feedback was received from NHSE on 30 October 2023 from the primary evidence review with a number of challenges being raised into a noted variation from the Trust self assessed rating and that of NHSE reviewers. In line with the timelines, a portfolio of supplementary evidence was submitted on 6 November 2023.

3.5 The assessed position provided by NHSE following the check and challenge significantly reduced the overall assessment score and the compliance rating to non-compliant.

3.6 Significant concerns have been raised by the North East and Yorkshire health providers and the NENC ICB on the application, context, validity of the challenges and final assurance positions. This includes:

- No confirmed guidance or information being provided on the depth, format or content of evidence pertaining to the new standards being issued nor the requirements for compliance before the assessment process commenced
- The method of scoring and assessment within this new review process which has been extremely prescriptive in terms of specificity of approach and a clear compliant / non compliant outcome
- Short timescales within the assurance timeline to gather and submit evidence alongside the competing priorities for EPRR teams in supporting an extended period of Industrial Action
- The absence of national NHS guidance for providers in a number of areas including CBRN, evacuation and shelter and mass casualty which are referenced within the standard compliance requirements.

3.7 All Trusts in North East, North Cumbria (NENC) and Humber & North Yorkshire (HNY) Integrated Care Boards (ICBs) were assessed as non-compliant by NHSE following there check and challenge process

3.8 In light of this position the NENC ICB arranged a number of extraordinary meetings to review the position (including their own assessed rating) to provide context, support and leadership for provider teams, alongside dedicated one to one sessions with individual providers to review their position. The TEWV meeting was held on Wednesday 22 November. During the meeting the Trust agreed an approach to the final version of the self assessment that would be submitted to the ICB peer review and the Local Health Resilience Partnership. It was noted that the Trust had successfully responded to a number of EPRR 'incidents' since the last self assessment:

- Operation Silver Bullet – cyber incident on a supplier affecting access to trust data
- Supplier failure of inpatient food provider
- Hartlepool tall ships race event (disruption)
- Significant number of indirect and direct periods of industrial action

3.9 The first standard is ***'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 within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio***'. The trust was deemed to be non-compliant on this standard despite submitting evidence of an EPRR policy identifying Zoe/MD of NYY&S as the AEO. The view of the Trust and the ICB is that the Trust is compliant. This 'test' supported by the ICB was used as the benchmark for the final approach to the self assessment.

3.10 The change in the assessment regime has had a more significant impact on mental health providers. The standards are very acute trust centric and include:

- Mass counter measures
- Mass casualty
- Excess fatalities
- 10 standards relating to Hazardous materials and CBRN

Historically these standards were able to be self assessed 'in the context of mental health risk'. Through this new process this is no longer the case.

3.11 The self-assessment, attached as Appendix 1, shows the Trust to be fully compliant on 30 standards, partially compliant on 28 and not compliant with 0. The evidence which was gathered in carrying out the self-assessment is summarised within the table. It should be noted that there is no differential between a partially compliant and not compliant outcome against a particular standard.

3.3 The actions developed in order to work towards full compliance based on the initial self assessment are summarised within the table however following the significant changes in the process a more fundamental action plan is being developed in conjunction with the ICB's and other providers and will drive EPRR activity over the coming year. Progress against this plan will be monitored at the Emergency & Business Continuity Planning Working Group meetings that have been reestablished.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The EPRR Core Standards are not part of the CQC inspection framework, but they help us to plan and manage Trust arrangements to effectively deal with any internal or external incident and ensure continuity of our services.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS: - Should the Trust Board be concerned?

5.1 No, our internal self-assessment has demonstrated several key assurances within the core standards process and we can also demonstrate a number of examples during 2023 when we have successfully enacted our Business Continuity and EPRR plans.

5.2 Although there have been significant challenges within the revised core standards process and acknowledging this major change in expectations and requirements, the evidence provided within this report should assure the Board that the trust continues to anticipate; assess; prevent; prepare; respond and recover from any disruptive events or incidents.

6. CONCLUSIONS:

The self-assessment gives assurance to the Trust Board that the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst still maintaining provision to service users. However it is now recognised across the region that the environment is changing and more work needs to be done to improve resilience across the sector.

7. RECOMMENDATIONS:

Trust Board are requested to:

7.1 acknowledge the change in process, timelines for submission and the enhanced evidence requirements inherent in the new self-assessment process

7.2 acknowledge the way in which the self-assessment process has been conducted for 2023 resulting in a final self-assessed position of non-compliance

7.3 agree that the differential gap in evidential requirements will substantially inform the 2024 EPRR work plan

7.4 accept this report which gives assurance that although there have been significant challenges within the revised core standards process and acknowledging this major change in expectations and requirements, the evidence provided within this report should assure the Board that the trust continues to anticipate; assess; prevent; prepare; respond and recover from any disruptive events or incidents.

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Zoe Campbell
Managing Director North Yorkshire, York & Selby Car Group

Attachments:

Appendix ‘Core Standards Overview for Boards’ prepared by NHS England
Appendix 1 EPRR Core Standards Assessment including:
Core Standards Summary Evidence and Initial Core Standards Actions

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NHS England EPRR Core Standards Overview for Boards

Applicable to – NHS organisations in the North East & Yorkshire and North West regions

Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle

Version – 1.0 FINAL

Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

Publication reference: NEY&NWEPRRAssurance2023

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

The 2023/24 EPRR Assurance model

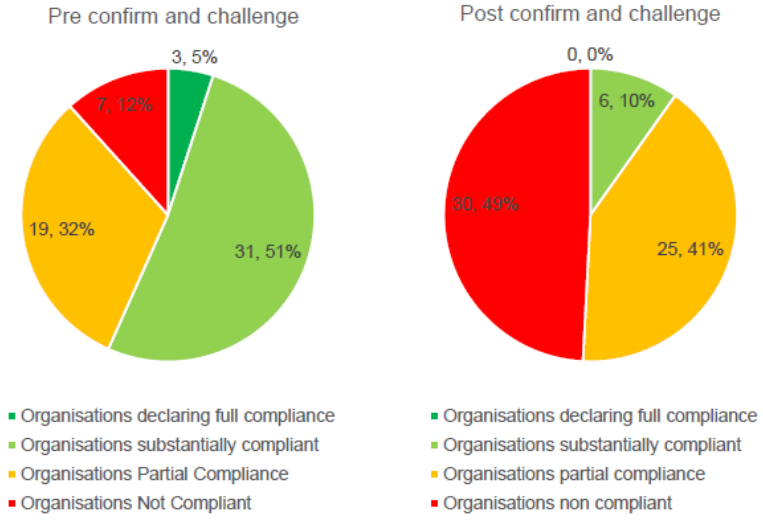
In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

This model required providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

NHS England Midlands

Levels pre and post confirm and challenge



The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

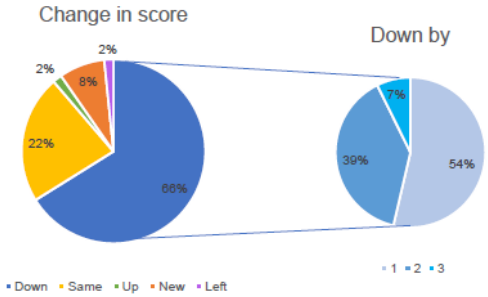
The maximum of accepted challenges to an organisational assessment was 30 standards.

OFFICIAL – SENSITIVE

Change from 2021/22

Breaking down the change into positive or reduced positions.

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
  - 7% dropped three compliance levels (full to non compliance)
  - 39% dropped two compliance levels (full to partial or Sub to non)
  - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year’s assurance cycle.

Version Control
1.3 13/06/23 -

Please choose your organisation type

Mental Health Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	5	6	0	0
Command and control	2	1	1	0	0
Training and exercising	4	1	3	0	0
Response	5	4	1	0	2
Warning and informing	4	2	2	0	0
Cooperation	4	3	1	0	3
Business continuity	10	7	3	0	1
Hazmat/CBRN	10	0	0	0	9
Total	**58**	**30**	**28**	**0**	**15**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	0	10	0	0
Total	**10**	**0**	**10**	**0**	**0**

Interoperable Capabilities for NHS Ambulance Service Providers only

Interoperable Capabilities	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant
HART Capability	3	0	0	0
HART Human Resources	8	0	0	0
HART Administration	10	0	0	0
HART Response time standards	4	0	0	0
HART Logisitics	7	0	0	0
SORT Capability	4	0	0	0
SORT Human Resources	10	0	0	0
SORT Administration	13	0	0	0
SORT Response Times	14	0	0	0
MassCas Capability	7	0	0	0
MassCas Equipment	7	0	0	0
Gen C2	4	0	0	0
Resource C2	6	0	0	0
Decision Making C2	3	0	0	0
Recording Keeping C2	3	0	0	0
C2 Learning Lessons	1	0	0	0
Competence C2	19	0	0	0
JESIP	13	0	0	0
Total	**136**	**0**	**0**	**0**

Percentage Compliance	52%
Overall Assessment	**Non-Compliant**

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non

Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non 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.	Check & Challenges rating	Accepted or challenged	Initial Submission Self Assessment	Action to be taken	Lead	Timescale	Comments
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 within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Managing Director (NY&Y&S) is the Board Level Director nominated as AEO. The Trust Board Audit and Risk sub committee provide governance. The AEO attends LHRP's at both NE&NC and H&NY 9 - BCP Command and Control plan, The Trust 13 - Business continuity policy, 14 - EPRR Policy Clearly identify the Managing Director (NY&Y&S) as the Board Level Director nominated as AEO 28 - EPRR Health leads details, 42 - LHRP Meeting documentation	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. 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.	Y	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 and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Appropriate EPRR Policy has been developed ratified and in place 9 - BCP Command and Control plan, 13 - Business continuity policy, 14 - EPRR Policy NB these documents were approved at the EBC Working group on the 29 September 2023 (previous submission did not include the latest version due to the timeframe)	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	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 and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	The board receives at least annual EPRR reports. 40 - Example of Board Submission - The Core Standards Assessment presented to the Board of Directors in September 22. 68 - Incident debrief 70 - Incident briefing	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an annual workplan that is informed by: • lessons identified from incidents and exercises • identified risks • outcomes of assurance processes in place 14 - EPRR Policy 72 - EPRR Work plan 68 - Incident debrief 70 - Incident briefing	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • 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/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The Trust has recently approved significant increase in the EPRR resouce. There are some challenges filling the posts. 14 - EPRR Policy defines roles of staff with key responsibilities, 13 - Business Continuity Policy, 9 - BCP-command-and-control-plan, The Trust has improved EPRR resilience through the creation of an additional post to support the EPRR lead 19 - Emergency Planning Resilience and Response Support Officer B5, 22 - EPRR Band 7 advert details.	Fully Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Ensure the vacant EPRR posts are filled	EPRR Lead	Jan-24	

Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non 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.	Check & Challenges rating	Accepted or challenged	Initial Submission Self Assessment	Action to be taken	Lead	Timescale	Comments
Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	EPRR Policy describes how Integrated Emergency Management (IEM) is used, together with capturing and sharing learning from incidents, exercises and regional meetings. 14 - EPRR policy, 4 - Industrial action debrief, 5 - Op silver puncture comms pack, 8 - Op arctic willow attendance, 15 - Covid inquiry responses, 17 - Digital and data excercise, 20 - energy questionnaire, 34 - industrial action briefing, 62 - incident debrief, 68 - IIC incident debrief 70 - Incident briefing 71 - on call log, 72 - work plan	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Risk Assessment template reviewed by E&BCP Working Group. Cross referenced to Datix. Individual NSRA Risk Assessment 2020 templates used as basis for shared risk working across all 4 LRFs. Outcomes are shared with the trust. 56 - risk report, 38 - Initial Operational Response (IOR) to Incidents Suspected to Involve Hazardous Substances or CBRN Materials 73 - Cleveland LRF Weekly Bulletin 74 - Care Group Board agenda	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	There is a Business Continuity sub category on Datix, the Trust centralised risk management system. Risks are reported with an assessmnet of likihoop and impact both before and after countermeasures. local, care group and trust reporting of risks is possible. High scoring risks are escalated ultimately to Trust board. Risk assessment as part of the Integrated Emergency Management cycle is described in the EPRR Policy. 14 - EPRR policy, 57 - safe staffing community, 58 - safe staffing inpatient, 56 - Risk report, 76 - Datix risk management guidance, 13 - Business continuity Policy	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Winter surge planning demonstrate collaboration. Procurement processes include resilience. The Trust participates in regional EPRR planning through the LRFs 27 - Hartlepool tall ships briefing, 42 - LHRP Meeting, 48 NYY System Surge escalation document, 77 - Winter Planning partnership Narrative, 78 Winter Planning updated TEWV input, 75 - LRF TNA Submission, 54 - Provider presentation - Mental Health Winter Planning Workshop	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non 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.	Check & Challenges rating	Accepted or challenged	Initial Submission Self Assessment	Action to be taken	Lead	Timescale	Comments
Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust policy and guidance in place along with escalation processes. The Trust has capability to respond both 'in hours' and 'out of hours' via the on call arrangements. 80 - Internal Emergency Plan (updated as at 29 September 23) , 50 - On call induction pack, 81 - External Major Incident Plan, 79 - The Therapies Staff Groups Business Continuity Plan outlines the process for providing a therapeutic intervention during a major incident, 9 - BCP Command and Control Plan (updated as at 29 September 23) , 31 - Secure Inpatient Service BCP, 46 - NYY BCP May 2023	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	Review all EPRR related policy, procedure and guidance to ensure it remains current			
Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has a joint summer and winter plan that contains direct links to the National plans (ensuring it remains current). BCPs contain action cards to support delvering services such as access to 4 wheel drive vehicles and provision of accomodation for staff. 3a - TEWV Summer and Winter Preparedness Plan (updated as at 29 September 23), linked to 3 - 2023.05.31 Adverse weather health plan, 57 - Safe-Staffing-Levels-Escalation-Procedure-Community, 58 - Safe-Staffing-Levels-Escalation-Procedure-Inpatient, 31 - Secure Inpatient Service BCP, 46 - NYY BCP May 2023	Fully Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Ensure all EPRR Policies are current, include changes to the Trust structure, new roles and governance arrangements.	EPRR Lead	Jul-24	
Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Trust policy and guidance in place along with escalation processes. Staff have recent experience of this kind of incident response. 53 - Pandemic-influenza-plan, 6 - Acute-respiratory-infection-patient-management, 7 - Admission-Transfer-and-Discharge-Policy, 10 CJD-Creutzfeldt-Jakob-Disease-and-Patient-Management, 11 - Controlling-access-to-and-exit-from-inpatient-areas-procedure, 35 - Infection prevention and control policy, 36 - Infectious disease procedure, 83 - Physical-Health-and-Wellbeing-Policy, 31 - Secure Inpatient Service BCP, 46 - NYY BCP May 2023	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust policy and guidance in place along with escalation processes. Staff have recent experience of this kind of incident response. 53 - Pandemic-influenza-plan, 6 - Acute-respiratory-infection-patient-management, 7 - Admission-Transfer-and-Discharge-Policy, 10 CJD-Creutzfeldt-Jakob-Disease-and-Patient-Management, 11 - Controlling-access-to-and-exit-from-inpatient-areas-procedure, 35 - Infection prevention and control policy, 36 - Infectious disease procedure, 83 - Physical-Health-and-Wellbeing-Policy, 31 - Secure Inpatient Service BCP, 46 - NYY BCP May 2023	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non 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.	Check & Challenges rating	Accepted or challenged	Initial Submission Self Assessment	Action to be taken	Lead	Timescale	Comments
Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Assessed as low risk in MH and LD services. The Trust as part of the Flu and Covid responses has plans to provide Mass Countermeasure arrangements including arrangements for administration, reception and distribution of mass vaccination which could also include mass prophylaxis . 53 - Pandemic-influenza-plan, 6 - Acute-respiratory-infection-patient-management, 7 - Admission-Transfer-and-Discharge-Policy, 10 CJD-Creutzfeldt-Jakob-Disease-and-Patient-Management, 11 - Controlling-access-to-and-exit-from-inpatient-areas-procedure, 35 - Infection prevention and control policy, 36 - Infectious disease procedure, 83 - Physical-Health-and-Wellbeing-Policy, 31 - Secure Inpatient Service BCP, 46 - NYY BCP May 2023, 84 - Staff vacination intranet page, 29 - Hotel services BCP page 42	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Mental health provision in place to provide support to providers and Psychosocial follow up. Escalation process in place based on increase in demand through access services such as liaison and crisis. Staff have access to the wellbeing hub. 9 - BCP Command and Control Plan, and the 79 - Therapies Staff Groups BCP (providing a therapeutic response) in conjunction with the relevant regional NHS England and Improvement mass casualty framework: 86 - Yorkshire & the Humber Mass Casualty Framework for Health or 85 - Mass Casualty Framework for Cumbria and the North East of England	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has options available across the geography for evacuation and shelter of patients at ward level. The Trust is also involved the planning for regioanl secure evacuation arrangements. 88 - Regional-Low-and-Medium-Secure-Adult-MH-Evacuation-Framework-Plan, 87 - Ridgeway-Security-Procedure, 31 - Secure-Inpatient-Service-BCP, 23 - Fire-Safety-Policy, 24 - Fire-Safety-Protocol , 11 - Controlling-access-to-and-exit-from-inpatient-areas-procedure, 9 - BCP-command-and-control-plan, 7 Admission-Transfer-and-Discharge-Policy, 46 NYY BCP May 2023,	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has hospital lockdown processes, wards have well managed access and egress arrangements. Buildings general areas locked down out of hours and security arrangements in place. Ongoing contractsfor secure transport. 87 - Ridgeway-Security-Procedure, 31 - Secure-Inpatient-Service-BCP, 46 NYY BCP May 2023, 7 - Admission-Transfer-and-Discharge-Policy, 9 - BCP-command-and-control-plan, 11 - Controlling-access-to-and-exit-from-inpatient-areas-procedure, 80 Internal-Emergency-Plan	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

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Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	For Royal Visits Police will take the lead and NEAS or YAS will confirm ambulance and emergency attendance with acute trusts. For high profile patients coming from detained settings the Prison Service will liaise directly with service. High Profile Visitor and High Profile Patient on Leave action cards in 87 - Ridgeway-Security-Procedure, 31 - Secure-Inpatient-Service-BCP, 46 NYY BCP May 2023, 7 - Admission-Transfer-and-Discharge-Policy, 11 - Controlling-access-to-and-exit-from-inpatient-areas-procedure	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. The Trust participated in a regional mass fatality exercise. No significant role required. Trust has support for mass casualty planning and plans through LHRP in relation to Trauma Network Activity low risk for MH / LD organisation, with pathway being for MH /LD deterioration death though urgent pathway. Link in to Pandemic planning 9 - BCP-command-and-control-plan. In the context of a mental health provider I am assessing as fully compliant	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 75 - LRF TNA Completion, 80 - Internal Emergency Plan	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

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Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 75 - LRF TNA Completion, 80 - Internal Emergency Plan	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	I addition to excercises the trust has run debrief exercises following live incidents and has drawn out and shared the appropriate learning. The Trust has also participated in regional exercises. 8 - Artic Willow attendees, 9 - BCP-command-and-control-plan, 4 - IA Hot Debrief NEY, 17 - Digital & Data Exercise 2023, 27 - Hartlepool Tall Ships Event Briefing, 62 - Dalesway (Rosebery Park) Incident Debrief Report, 68 - IIC Incident August 2022 - Reflections, 70 - Continuity of Patient Food Supply, 89 - Exercise Artic Willow Briefing, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 2024 (action 11)	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	

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Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, Dalesway (Rosebery Park) Incident Debrief Report, 68 - IIC Incident August 2022 - Reflections, 70 - Continuity of Patient Food Supply. In addition All Staff required to complete mandatory training Fire, health and safety, evacuation, IPC which is recorded via ESR	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The Trust has a Main ICC at Trust headquarters and a number of satalite IICs at other Trust main sites. Additionally the Trust utilises virtual ICC arrangements. 9 - BCP-command-and-control-plan, 13 - Business Continuity Policy, 14 - EPRR Policy, 30 - IA Update - Wednesday 20th September, 31 - Secure-Inpatient-Service-BCP, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP, 80 Internal-Emergency-Plan, 90a RE_ Foss Park ICC Check, 90b RE_ West Park ICC Check, 92 - internal comms request re IA, 80 - Internal Emergency Plan	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	All core services are supported by a BCPs that are available on the intranet via 1 click and in hard copy 9 - BCP-command-and-control-plan, 13 - Business Continuity Policy, 14 - EPRR Policy, 30 - IA Update - Wednesday 20th September, 31 - Secure-Inpatient-Service-BCP, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP, 80 Internal-Emergency-Plan, 90a RE_ Foss Park ICC Check, 90b RE_ West Park ICC Check, 92 - internal comms request re IA, 93 - Access to BCPs via the intranet (1 click),	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	All core services are supported by a BCPs. Trust safe staffing escalation processes provide staff with a range of pre BCP actions to mitigate against staffing challenges. 9 - BCP-command-and-control-plan, 13 - Business Continuity Policy, 14 - EPRR Policy, 30 - IA Update - Wednesday 20th September, 31 - Secure-Inpatient-Service-BCP, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP, 80 Internal-Emergency-Plan, 90a RE_ Foss Park ICC Check, 90b RE_ West Park ICC Check, 27 - Hartlepool Tall Ships Event Briefing, 25 - Go North East Industrial Action Briefing, 58 - Safe Staffing Levels Escalation Procedure-Inpatient, 57 - Safe Staffing Levels Escalation Procedure-Community	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

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Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	The Trust maintains a list of retained loggists. Loggists are paid an annual honarium subject to availability and training to be retained on the rota. 9 - BCP-command-and-control-plan, 13 - Business Continuity Policy, 14 - EPRR Policy, 31 - Secure-Inpatient-Service-BCP, 46 - NYY BCP, 80 Internal-Emergency-Plan, 93 - Access to BCPs via the intranet (1 click), 12 - Copy of honorarium. Loggists are paid an annual honarium subject to availability and training to be retained on the rota,	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	The requirement and process for submitting situation reports is detailed in the trust BCPs. 9 - BCP-command-and-control-plan, 13 - Business Continuity Policy, 14 - EPRR Policy, 31 - Secure-Inpatient-Service-BCP, 46 - NYY BCP, 80 Internal-Emergency-Plan, 93 - Access to BCPs via the intranet (1 click),	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Access to 'Clinical	Key clinical staff (especially emergency department) have access to		Guidance is available to appropriate staff either electronically or hard copies									
Access to 'CBRN	Clinical staff have access to the 'CBRN incident: Clinical		Guidance is available to appropriate staff either electronically or hard copies									
Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	For internal incidents the Communications Team send emails, update the itranet and reach out via social media. For external major incident ICB/NHSE Comms Teams lead. 13 - Business Continuity Policy, 14 - EPRR Policy, 17 - Digital & Data Exercise 2023, 25 - Go North East Industrial Action Briefing, 34 - industrial action briefing, 46 - NYY BCP, 47 - NYY out of hours - key contact telephone numbers, 64 - TEWV on call rota wc 22.9.23, 68 - IIC Incident August 2022, 80 - Internal-Emergency-Plan, 91 - internal and external comms request, 96 - Communications intranet page	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Communications Team Member is part of response team. Communications staff have a process to monitor and log information requests and inform via website and social media. Incident communication plans in place. On call arrangements are throug the strategic (Director) on call. Support material is available. BCP's include communication. 13 - Business Continuity Policy, 14 - EPRR Policy, 17 - Digital & Data Exercise 2023, 25 - Go North East Industrial Action Briefing, 34 - industrial action briefing, 46 - NYY BCP, 47 - NYY out of hours - key contact telephone numbers, 64 - TEWV on call rota wc 22.9.23, 68 - IIC Incident August 2022, 80 - Internal-Emergency-Plan, 91 - internal and external comms request, 96 - Communications intranet page,	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

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Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Communications Team Member is part of response team. Communications staff have a process to monitor and log information requests and inform via website and social media. Incident communication plans in place. On call arrangements are throug the strategic (Director) on call. Support material is available. BCP's include communication. 13 - Business Continuity Policy, 14 - EPRR Policy, 17 - Digital & Data Exercise 2023, 25 - Go North East Industrial Action Briefing, 34 - industrial action briefing, 46 - NYY BCP, 47 - NYY out of hours - key contact telephone numbers, 64 - TEWV on call rota wc 22.9.23, 68 - IIC Incident August 2022, 80 - Internal-Emergency-Plan, 91 - internal and external comms request, 96 - Communications intranet page	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Communications Team Member is part of response team. Communications staff have a process to monitor and log information requests and inform via website and social media. Incident communication plans in place. On call arrangements are throug the strategic (Director) on call. Support material is available. BCP's include communication. 13 - Business Continuity Policy, 14 - EPRR Policy, 17 - Digital & Data Exercise 2023, 25 - Go North East Industrial Action Briefing, 34 - industrial action briefing, 46 - NYY BCP, 47 - NYY out of hours - key contact telephone numbers, 64 - TEWV on call rota wc 22.9.23, 68 - IIC Incident August 2022, 80 - Internal-Emergency-Plan, 91 - internal and external comms request, 96 - Communications intranet page	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The Trust AEO and EPRR Lead attend LHRP meetings for both Humber and North Yorkshire and North East and North Cumbria. The EPRR lead attends LHRP sub group meetings. The Trust participates in both planned and unplanned LRF meetings and is a member of LRF sub groups. The ICB EPRR teams hold regular less formal EPRR sessions where health providers share knowledge understanding. The EPRR lead attends other regional and national EPRR meetings. 9 - BCP-command-and-control-plan, 42 - LHRP Papers for this afternoon's Meeting, 73 - Cleveland LRF Weekly Bulletin Official Sensitive, 97 - LHRP Papers - 15th May 2023, 98 - LHRP Operational Group, 21 - EP Planners Workshop Allocated Places - TEWV	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Ensure attendance at both ICB LHRP meetings is planned throughout the year between bot AEO and the EPRR lead	EPRR Lead	Nov-23	
LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The Trust AEO and EPRR Lead attend LHRP meetings for both Humber and North Yorkshire and North East and North Cumbria. The EPRR lead attends LHRP sub group meetings. The Trust participates in both planned and unplanned LRF meetings and is a member of LRF sub groups. The ICB EPRR teams hold regular less formal EPRR sessions where health providers share knowledge understanding. The EPRR lead attends other regional and national EPRR meetings. 9 - BCP-command-and-control-plan, 42 - LHRP Papers for this afternoon's Meeting, 73 - Cleveland LRF Weekly Bulletin Official Sensitive, 97 - LHRP Papers - 15th May 2023, 98 - LHRP Operational Group, 21 - EP Planners Workshop Allocated Places - TEWV, 100 - Cleveland LRF Training and Exercising Group meeting 2023 03 21 - Agenda and papers	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant				

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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. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Mutual aid through MOU in Forensic Services. There is a working partnership with Local authorities and LHRP. The trust could access voluntary services support during emergencies via the LRF. MACA can be requested through the relevant LRF but the trust must make the request via NHSE/I and show that all other alternatives have been exhausted. The request must be for a definite need and tasks explicit. Other options including mutual aid must have been discounted with the trust either lacks capability, or too expensive, not available or can't meet the scale and / or urgency. Recharge for this support. Mutual aid across Tust care groups are detialed in BCPs and Safe staffing escalation processes. The latest Trust excercise included aspects of mutual aid. The Trust has fed back to the covid inquiry on mutual aid. 9 - BCP-command-and-control-plan, 15 - covid inquiry questionnaire response. 17 - Digital & Data Exercise 2023, 27 - Hartlepool Tall Ships Event Briefing, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 55 - Regional-Low-and-Medium-Secure-Adult-MH-Evacuation-Framework-Plan, 58 - Safe-Staffing-Levels-Escalation-Procedure-Inpatient, 85 - Cumbria and North East LHRPs Mass Casualty Framework, 101 - mutual aid planning, 102 - example of mutual iad request.	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Arrangements for multi	The organisation has arrangements in place to prepare for and		• Detailed documentation on the process for coordinating the response to incidents affecting two									
Health tripartite working	Arrangements are in place defining how NHS England, the		• Detailed documentation on the process for managing the national health aspects of an									
LHRP Secretariat	The organisation has arrangements in place to ensure that the Local		• LHRP terms of reference									
Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Protocol outlined in section 4 in External Major Incident plan. Signatory to Durham and Darlington LRF Information Sharing Protocol. Process in place for sharing details of vulnerable patiets by postcode in the event of an incident where this is required. TEWV is also working with the ICB to develop new process for Vulnerable Persons in information sharing. 9 - BCP command and control plan, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 81 - External-Major-Incident-Plan, 103 - Vulnerable Persons Working Group - Papers and Next Meeting	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
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) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 NYY BCP,	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Business Continuity Management Systems (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. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	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 • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Business Continuity Policy, EPRR Policy. All BCP's are accessible electrocically (via the internet) and stored locally in hard copy. The Trust has a centralsised system of recording, scoring and monitoring risks this has board oversight. Previous incidents are considered. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 NYY BCP, 56 risk report, 68 - IIC Incident August 2022 - Reflections, 70 - Continuity of Patient Food Supply, 76 - TEWV - User guide -Datix risk management module, 77 - Winter Planning partnership Narrative, 73 - Cleveland LRF Weekly Bulletin Official Sensitive	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

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Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Business Continuity Policy, EPRR Policy. All BCP's are accessible electrocically (via the internet) and stored locally in hard copy. The Trust has a centralsised system of recording, scoring and monitoring risks this has board oversight. Previous incidents are considered. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 NYY BCP, 56 risk report, 68 - IIC Incident August 2022 - Reflections, 70 - Continuity of Patient Food Supply, 76 - TEWV - User guide -Datix risk management module, 77 - Winter Planning partnership Narrative, 73 - Cleveland LRF Weekly Bulletin Official Sensitive, 17 Digital & Data Exercise 2023, 89 - Exercise Artic Willow Briefing, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 2024	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Business Continuity Plans and associated action cards developed and held locally (hard copies available). 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 93 - Access to BCPs via the intranet (1 click), 94 - Digital-and-Data-Contract-Management-Policy, 57 - Safe-Staffing-Levels-Escalation-Procedure-Community, 58 - Safe-Staffing-Levels-Escalation-Procedure-Inpatient, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 2024	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Ensure all BCP's are current, include changes to the Trust structure, new roles and governance arrangements. Ensure the on call arrangements are current and where appropriate include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Jul-24	
Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Testing of BCPs has been undertaken through discussion based excercises, scenario excercises, simulation excercises with debrief. In addition BCPs have also been stress tested through live incidents. BCPs have been updated (are are currently being updated) as a result. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 32 - DTVF AMH MHSOP BCP - DRAFT, 27 - Hartlepool Tall Ships Event Briefing, 89 - Exercise Artic Willow Briefing, 17 - Digital & Data Exercise 2023, 70 - Continuity of Patient Food Supply, 68 - IIC Incident August 2022 - Reflections	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
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	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	The Trust Complies with the Data Protection and Security toolkit. 104 - Data Protection and Security Toolkit, 104a DPS toolkit action plan	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

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BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	EPRR working group with annual update on EPRR performance to the Audit and Risk Committee with an annual report to the board. In addition post incident debriefs reported to board/board sub groups. 40 - Item XX EPRR assurance process for 2022 23 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 2024, 68 - IIC Incident August 2022 - Reflections, 70 - Continuity of Patient Food Supply 180523, 30 - IA Update - Wednesday 20th September, 69 - Inpatient Food_ Continuity of supply cell	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	EPRR is included in the Trust internal audit Schedule. Board receive reports relating to all internal audit activity. 14 - EPRR Policy, 105 - Internal audit details	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
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	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Testing of BCPs has been undertaken through discussion based excercises, scenario excercises, simulation excercises with debrief. In addition BVPs have also been stress tested through live incidents. BCPs have been improved (and are are currently being updated) as a result. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 32 - DTVF AMH MHSOP BCP - DRAFT, 27 - Hartlepool Tall Ships Event Briefing, 89 - Exercise Artic Willow Briefing, 17 - Digital & Data Exercise 2023, 70 - Continuity of Patient Food Supply, 68 - IIC Incident August 2022 - Reflections, 69 - Inpatient Food_ Continuity of supply cell	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
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 align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 94 - Digital-and-Data-Contract-Management-Policy, 68 - IIC Incident August 2022 - Reflections, 69 - Inpatient Food_ Continuity of supply cell, 70 - Continuity of Patient Food Supply 180523	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Computer Aided	Manual distribution processes for Emergency Operations Centre /		• Exercising Schedule									

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Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

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Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Decontamination capability availability 24	The organisation has adequate and appropriate wet decontamination		Documented roles for people forming the decontamination team - including Entry Control/Safety									
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. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed 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	Y	This inventory should 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). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				
Waste disposal arrangements	The organisation has clearly defined waste management processes		Documented arrangements for the safe storage (and potential secure holding) of waste									

Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non 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.	Check & Challenges rating	Accepted or challenged	Initial Submission Self Assessment	Action to be taken	Lead	Timescale	Comments
Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Review of HBRN risk to MH / LD organisation with support from ICS / NHS E	EPRR Lead	Jun-24	
Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Review of HBRN risk to MH / LD organisation with support from ICS / NHS E	EPRR Lead	Jun-24	
PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Fully Compliant				

Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non 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.	Check & Challenges rating	Accepted or challenged	Initial Submission Self Assessment	Action to be taken	Lead	Timescale	Comments
Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialst advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. EWV participate in regional exeicising with acute and ambulance trusts. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS-CoV-2-and-Influenza, 107 - Standard-Infection-Control-Precautions, 108 - Infectious-Diseases, 109 - Resuscitation-Policy	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant	Review of HBRN risk to MH / LD organisation with support from ICS / NHS E	EPRR Lead	Jun-24	
Capability	NHS Ambulance Trusts must support designated Acute Trusts		Evidence predominantly gained through assessment and verification of training syllabus (lesson									
Capability Review	NHS Ambulance Trusts must undertake a review of the		Documented evidence of that review, including:									
Capability Review	NHS Ambulance Trusts must formally review the CBRN/HazMat		Documented evidence of that review, including:									
Capability Review report	Following each formal review of the capability within a designated		Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of									
Train the trainer	NHS Ambulance Trusts must support each designated hospital in		Written statement as to how this is achieved, which can then be further investigated during									
Aligned training	Training provided by the NHS Ambulance Trust for this purpose must		NARU can provide the latest version number of associated training packages. This can then be									
Training sessions	Provision of training sessions will be arranged jointly between the		Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is									

Deep Dive question	Further information	Mental Health Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas	EPRR Lead	Jul-24	
The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	

Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24
The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24
Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Include copliance with EPRR training in the annual board report	EPRR Lead	Jul-24
The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24
In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements. Continuous improvement trackers.	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Report lessons learned to the EPRR group including a statement if training should be ammended as a result	EPRR Lead	May-24

The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	Y	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24

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
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials (HazMat) • Chemical, Biological Radiological, Nuclear, Explosives (CBRN) • High Consequence Infectious Disease (HCID) • Marauding Terrorist Attack • Water Operations • Safe Working at Height • Confined Space • Unstable Terrain • All-Terrain Vehicle Operations • Support to Security Operations These represent both local and national capabilities that mitigate risks within the National Risk Register. They must be maintained even through periods of significant local or regional demand pressure.	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain the HART capabilities in compliance with the scope and interoperable specification defined within the National HART Capability Matrices.	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. It is the personal responsibility for each member of HART staff to access and know the content of the National Standard Operating Procedures (SOPs)	Y						
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies.	Y						
H5	**HART**	**Protected training hours**	I Training Information Sheets for HART. Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies. 1 – 4 H5 H5 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 (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). 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 (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). If HART staff are given additional local skills and training requirements outside of the scope defined within the National HART Matrices, that local training must be provided in addition to the 37.5 hours protected for core HART training.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for each member of HART in their establishment. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets. It must also include any restrictions in practice and corresponding action plans. Individual training records must directly cross reference the National Training Information Sheets.	Y						

H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered pre-hospital clinician. This will normally be an NHS paramedic, but this standard does not preclude the use of other NHS clinical professionals providing the Trust ensures the individuals have an appropriate level of pre-hospital experience and training. To ensure the appropriate clinical standard of care is maintained in accordance with the original DHSC mandate, the expectation is that the clinical level will be equivalent to or exceeding that of an NHS Paramedic.	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 (24/7)	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must be recruited in accordance with the minimum requirements set out in the national HART recruitment and selection manual. Local recruitment provisions can be added to this mandatory minimum as required by NHS Ambulance Trusts.	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. The Trust must then implement appropriate support for individuals on a restriction of practice.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any HART staff returning to work after a period of absence which exceeds 7 weeks must be subject to a formal review to ensure they receive sufficient catch up training and to ensure they are sufficiently fit (evidenced through the successful completion of a Physical Competency Assessment) and competent to continue with HART operational activity. It is the responsibility of the employing Trust to manage this process.	Y						
H12	**HART**	**Effective deployment policy**	Organisations must 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						
H13	**HART**	**Identification appropriate incidents / patients**	Organisations must maintain an effective process to identify incidents or individual patients, at the point of receiving a 999 call, that may benefit from the deployment of HART capabilities. Organisations must also have systems in place to ensure unreasonable delays in HART deployments are avoided.	Y						
H14	**HART**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the HART capabilities safely or if consideration is being given to locally reconfigure HART to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the HART capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y						
H15	**HART**	**Recording resource levels**	Organisations must record HART resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily at shift change over even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where HART staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y						
H16	**HART**	**Record of compliance with response time standards**	Organisations must monitor and maintain accurate local records of their level of compliance with all HART core standards defined in this document. That must include accurate records of compliance with staffing levels and responses time standards for every HART deployment. Organisations must comply and fully engage with any audits or inspections of the HART capabilities that are commissioned by NHS England. Compliance records must be made available for annual audits or inspections conducted by NHS England or NARU and must be made available to NHS commissioners or regulators on their request.	Y						

H17	**HART**	**Local risk assessments**	Organisations must maintain a set of local specific HART risk assessments which supplement the national HART risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation must also ensure there is a local process to determine how HART staff should conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H18	**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						
H19	**HART**	**Safety reporting**	Organisations must have a robust and timely written 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 24 hours of the risk being identified.	Y						
H20	**HART**	**Receipt and confirmation of safety notifications**	Organisations must have a written process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU or other relevant national body within 2 days of the notification being issued.	Y						
H21	**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						
H22	**HART**	**Initial deployment requirement**	Four HART personnel must be available or released and mobilised 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. The standard will not apply if the nearest HART unit is already deployed dealing with a higher priority incident requiring HART capabilities. If the HART team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y						
H23	**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. Confirmation of this requirement would usually come from; the HART Team Leader based on information from the call, one of the four HART Operatives already mobilised or from other emergency service personnel (including Ambulance personnel) in attendance at the scene. Delays in the deployment of all six HART staff could create a direct risk to the application of a safe system of work at the scene.	Y						
H24	**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 were initially determined through the Model Response Doctrine which led to the strategic placement of HART units. The 45 minute standard is therefore primarily associated with key transport infrastructure and densely populated areas. Where a Trust through their LRF have identified additional strategic sites of interest which may be beyond a 45 minute HART response, the Trust must have local multi-agency plans to act as a contingency for a potentially delayed HART response. A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region. If the HART Team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y						

H25	**HART**	**HART Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30-minute notice to move to anywhere in the United Kingdom following a mutual aid request endorsed by NHS England or NARU. Trusts can also maintain the 30-minute notice to move by way of a recall to duty or on-call process (i.e. where members of the on-duty team are unable to deploy due to child care or personal commitments at the time of the notification). A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region	Y						
H26	**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. This must include maintaining capital provisions of at least £1.9 million depreciated over 5 years to maintain the HART fleet and incident ground equipment. Internal HART budgets and expenditure must be in accordance with the reference costs set nationally for HART units. Given that the HART capabilities are national as well as local, HART funding provision must not be reallocated internally away from HART within the express permission of NHS England (the National EPRR team).	Y						
H27	**HART**	**Interoperable equipment**	Organisations must procure and maintain minimum levels of interoperable equipment specified in National Equipment Data Sheets. To maintain minimum levels of interoperability, national interoperable equipment that has not be specified within National Equipment Data Sheets should not be utilised as part of the HART capabilities.	Y						
H28	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks (where applicable) coordinated by NARU unless they can provide assurance that the local procurement is interoperable and meets the requirements of the National Equipment Data Sheets. Any locally procured equipment that does not have a National Equipment Data Sheet which has been procured locally to support the delivery of training, sits outside of the national safe system of work. Trusts must ensure that they have local risk assessments and governance provisions in place to manage the use of such equipment. Any such equipment must not be deployed at incidents in support of HART capabilities.	Y						
H29	**HART**	**Fleet compliance with national specification**	Organisations must ensure that the HART fleet and associated incident ground technology remain compliant with the national specification. Nationally specified vehicles must conform to the national loading lists for each vehicle and the vehicles state of readiness must be updated on the national monitor systems. This will include national location tracking.	Y						
H30	**HART**	**Equipment maintenance**	Organisations must ensure that all HART equipment is maintained according to applicable standards and in line with manufacturers recommendations. This will include standards specified in the National Equipment Data Sheets and relevant associated BS or EN related standards (or equivalent).	Y						
H31	**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						
H32	**HART**	**Capital estate provision**	Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.	Y						
S1	**SORT**	**Maintenance of national specified MTFA capability**	NHS Ambulance Trusts must maintain a combined MTA (Marauding Terrorist Attack) and CBRN (Chemical Biological Radiological Nuclear) capability in accordance with national specifications. These capabilities operate in support of Hazardous Area Response Team deployments when required.	Y						
S2	**SORT**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain compliant with the national safe system of work specified by the National Ambulance Resilience Unit (NARU).	Y						

S3	**SORT**	**Interoperability**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain nationally interoperable and confirm the scope of operational practice defined within national capability matrices published by NARU.	Y						
S4	**SORT**	**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. All Commanders and NILOs / Tactical Advisors must be able to access this advice at all times (24/7).	Y						
S5	**SORT**	**SORT establishment**	NHS Ambulance Trusts must maintain a minimum establishment of 290 SORT trained staff. For compliance purposes this must be for at least 90% of the calendar year. Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily (365 days per year). Recall to duty programmes must be in addition to this on duty requirement. For compliance monitoring and reporting the following provisions apply: • Trusts will not be penalised or deemed to be non-compliant if the number of SORT staff fluctuates between 30 and 35 during any given shift. • Less than 35 but more than 25 on up to 3 occasions per month = compliant. • Less than 30 and more than 25 on more than 3 occasions in any given month = non-compliant. • Less than 25 at any time = non compliant.	Y						
S6	**SORT**	**Completion of a Physical Competency Assessment**	All active SORT staff within each NHS Ambulance Trust must successfully complete a physical competence assessment every 12 months (annually). The physical competence assessment must be conducted to the nationally specified standard (as specified by the National Ambulance Resilience Unit). 'Active' staff means staff that are undertaking operational shifts where their numbers are being included within SORT staffing level data for the Trust. SORT staff that have not successfully completed a physical competency assessment within a 12 month period must be placed on a restriction of practice. They must not respond to an incident as a SORT operative whilst on such a restriction of practice and the Trust must have robust processes in place to ensure compliance with this provision. Staff on a restriction of practice for SORT must not be counted as part of the SORT on-duty staffing levels.	Y						
S7	**SORT**	**Staff competency**	NHS Ambulance Trusts must ensure that each individual SORT member of staff remains compliant with the competency standards defined within national Training Information Sheets (TIS's) published by NARU for SORT staff and CBRN training is aligned to Skills for Health occupational standard EC25 – Decontaminate individuals affected by chemical, biological, radiological or nuclear incident. This training requirement includes providing a minimum of 7 days training (minimum of 52.5 hours) every 12 months. This training must be split into at least two separate sessions per operative per annum (it cannot be delivered in a single consecutive training session or period).	Y						
S8	**SORT**	**Training records**	NHS Ambulance Trusts must ensure that comprehensive training records are maintained for all SORT personnel in their establishment. These records must include; a record of mandated training completed aligned to the national Training Information Sheets (TISs), when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the SORT skill sets. It must also include any restrictions in practice and corresponding action plans.	Y						
S9	**SORT**	**Provision of clinical training**	NHS Ambulance Trusts are required to provide supportive training to statutory Fire and Rescue Services within their Trust geography that have a declared MTA capability. That supportive training must cover the clinical elements of the response and working jointly with Ambulance HART and SORT deployments for MTA incidents.	Y						

S10	**SORT**	**Staff training requirements**	NHS Ambulance Trusts must ensure that all frontline operational staff have received familiarisation training or briefing on how non-specialist / non-protected Ambulance responders should deal with an MTA incident. This should be included as part of annual mandatory training requirements. It is recognised that Ambulance Trusts have various staff in training or on alternate duties at any point in time. Therefore, for compliance purposes, the Trust will be deemed to be compliant with this requirement providing it can evidence that over 80% of frontline staff have received the required familiarisation training when audited or inspected.	Y						
S11	**SORT**	**Arrangements to manage staff exposure and contamination**	NHS Ambulance Trusts must ensure they have robust procedures in place to document all staff who may have become exposed or contaminated during incidents involving CBRN or hazardous materials. These procedures must include attendance at scene monitoring, exposure monitoring and post exposure management.	Y						
S12	**SORT**	**CBRN Lead trainer**	NHS Ambulance Trusts must have sufficient capacity of dedicated training or instructional staff for SORT to enable the Trusts to deliver and maintain the nationally specified training requirements each year.	Y						
S13	**SORT**	**FFP3 access**	NHS Ambulance Trusts must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent such as a Powered Respirator Protective Hood PRPH) and that they have been appropriately fit tested (where applicable). The specification and standards for this protection (including the Air Particulate Filtration) must comply with the provisions set out in the relevant national Equipment Data Sheet (EDS).	Y						
S14	**SORT**	**IOR training for operational staff**	NHS Ambulance Trusts must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR) principles of Remove Remove Remove. Organisations must maintain records to demonstrate how many staff are trained (and when the training occurred).	Y						
S15	**SORT**	**Effective deployment policy**	NHS Ambulance Trusts must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the SORT capability. These procedures must be aligned to the MTA Joint Operating Principles (produced by JESIP).	Y						
S16	**SORT**	**Identification appropriate incidents / patients**	NHS Ambulance Trusts must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of SORT personnel to an incident requiring the MTA or CBRN capability. This must include specific mechanisms to identify on-duty SORT staff and make them available to response to the incident as quickly as possible. These procedures must be aligned to relevant Joint Operating Principles (JOPs, produced by JESIP).	Y						
S17	**SORT**	**Change Management Process**	NHS Ambulance Trusts must use the national Change Management Process coordinated by NARU before reconfiguring (or changing) any SORT procedures, equipment or training that has been specified as nationally interoperable.	Y						
S18	**SORT**	**Record of compliance with response time standards**	NHS Ambulance Trusts must monitor their compliance with the SORT core standards set out in this document. The Accountable Emergency Officer in each Trust is responsible to their Board for the levels of compliance against these standards. Each NHS Ambulance Trust must maintain accurate records of their compliance with the core standards set out in this document and make those records available during annual audits or inspections commissioned by NHS England. These records should also be made available to NHS commissioners and regulators on request.	Y						

S19	**SORT**	**Notification of changes to capability delivery**	SORT is both a national and regional capability. It provides critical mitigation to risks articulated in the risk register for the United Kingdom. NHS Ambulance Trusts must not take the SORT capability offline or reconfigure it locally without first obtaining permission from the National Ambulance Resilience Unit or NHS England's national EPRR team. In the first instance, the discussion needs to be with the NARU On-Call Duty Officer. In any event that the organisation is unable to maintain the SORT capability safely or if consideration is being given to locally reconfigure SORT to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the SORT capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y						
S20	**SORT**	**Recording resource levels**	NHS Ambulance Trusts must record SORT resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where SORT staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y						
S21	**SORT**	**Local risk assessments**	NHS Ambulance Trusts must maintain a set of local specific SORT risk assessments which supplement the national SORT risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation may determine what locations are considered high-risk (often in conjunction with the LRF), but the assessment must be for/or include MTA and CBRN specific risks. The organisation must also ensure there is a local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
S22	**SORT**	**Lessons identified reporting**	NHS Ambulance Trusts must have a robust and timely process to report any lessons identified following a SORT deployment or training activity that may affect the interoperable service to NARU within 12 weeks using the nationally approved lessons database. Note: the 12 weeks starts from resolution of the incident.	Y						
S23	**SORT**	**Safety reporting**	NHS Ambulance Trusts 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 SORT service as soon as is practicable and no later than 24 hours of the risk being identified. Reports must be made using the national safety alert system managed by NARU.	Y						
S24	**SORT**	**Receipt and confirmation of safety notifications**	NHS Ambulance Trusts have a process to acknowledge and respond appropriately to any national safety notifications issued for SORT by NARU within 2 days.	Y						
S25	**CBRN**	**HAZMAT / CBRN plan**	NHS Ambulance Trusts must ensure that their major or complex incident plans include specific provisions to manage a MTA or CBRN incident. These provisions must align to the national SORT matrices and operating procedures published by NARU. All SORT staff must have access to both the Trust plans and the national safe system of work provisions (including procedures, generic risk assessments etc) published by NARU and should be familiar with their contents. These plans must also be aligned to the relevant JESIP / JOP provisions.	Y						
S26	**SORT**	**SORT Audit and inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the SORT capability that are commissioned by NHS England.	Y						
S27	**SORT**	**SORT capability funding**	NHS Ambulance Trusts must ensure that the national funding provided to support the SORT capability within Trusts is used to support the maintenance of that capability. The Trust must not redirect these funds and use them for other internal purposes within the express permission of NHS England or NARU.	Y						

S28	**SORT**	**SORT Readiness to deploy**	NHS Ambulance Trusts must ensure their SORT capability remains at a high state of readiness to deploy to MTA or CBRN related incidents between the hours of 0600 and 0200 daily. On receipt of an emergency call or notification by a partner agency of a potential incident involving CBRN or a marauding terrorist attack, NHS Ambulance Trusts must immediately identify all SORT staff on duty within their system and prepare to deploy those that are not committed or that can be made available from lower priority calls.	Y						
S29	**SORT**	**SORT response time**	Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. Any SORT staff available to respond in less than 60 minutes, must be responded as quicky as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders must be assigned to the incident. The NHS Ambulance Trust can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident must be approved by a Tactical or Strategic Commander and must be clearly documented. The decision will be subject to external review post incident.	Y						
S30	**SORT**	**SORT Mutual Aid**	NHS Ambulance Trusts must maintain their SORT capability at a state of readiness which is able to support a national deployment under mutual aid with reference to the national mutual aid policy. As an interoperable capability, it is nationally expected that Trusts provide SORT mutual aid when requested by NHS England, NARU or the National Ambulance Coordination Centre.	Y						
S31	**SORT**	**PPE availability**	NHS Ambulance Trusts must ensure that the nationally specified personal protective equipment is available for all operational SORT personnel and that the equipment remains compliant with the relevant national Equipment Data Sheets (EDSs).	Y						
S32	**SORT**	**Equipment procurement via national buying frameworks**	NHS Ambulance Trusts must procure SORT (MTA and CBRN) equipment specified in the SORT (MTA and CBRN) related Equipment Data Sheets and where applicable through the buying frameworks maintained by NARU. NHS Ambulance Trusts must also ensure sufficient financial provisions are in place to replace SORT equipment as specified by the relevant national Equipment Data Sheets. For MTA equipment, this should include an annual programme of rolling replacement.	Y						
S33	**SORT**	**Equipment maintenance**	All SORT equipment must be maintained in accordance with the manufacturer's recommendations and applicable national industry standards. This must include a programme of regular inspections and preventative maintenance as specified in relevant national Equipment Data Sheets.	Y						
S34	**SORT**	**SORT asset register**	NHS Ambulance Trusts must maintain an asset register of all SORT (MTA and CBRN) assets specified in the relevant national capability matrices and associated national 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 and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
S35	**SORT**	**PRPS - minimum number of suits**	NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. Trusts must also ensure they have a financial / revenue replacement plan in place to ensure the minimum number of suits is maintained and replaced as required by the national Equipment Data Sheets.	Y						
S36	**SORT**	**Individual / role responsible for SORT assets**	NHS Ambulance Trusts must have a named individual or role that is responsible for ensuring SORT assets are managed appropriately.	Y						

S37	**SORT**	**CBRN countermeasures**	NHS Ambulance Trusts must ensure that they make CBRN countermeasures available for use by frontline Ambulance staff. This must include distribution of countermeasures across frontline assets in accordance with the specification and requirements defined within the relevant national matrix and Equipment Data Sheets (EDSs).	Y							
S38	**SORT**	**Water supply for clinical decontamintion**	NHS Ambulance Trusts must ensure they have local or regional agreements and procedures in place to facilitate access to water supplies to carry out clinical decontamination. This may be achieved in conjunction with Fire and Rescue Services.	Y							
S39	**SORT**	**Equipment Vehicles**	Organisations must maintain a minimum of four vehicles to provide the MTA pooled equipment These vehicles should be replaced at a maximum of every 7 years. A minimum of 160 sets of pooled ballistic PPE and associated medical consumables must be available split over the organisations geographical area based on a local Trust assessment of risk.	Y							
S40	**SORT**	**Equipment vehicle readiness**	In conjunction with standards S29 and S30, MTA pooled equipment vehicles must be maintained at a high state of readiness to deploy. At least one asset must be mobilised within 15 minutes of a SORT response being confirmed as being required for an incident. Failure to rapidly mobilise the equipment on these vehicles will delay the deployment of responders at the scene.	Y							
S41	**SORT**	**Vehicle Tracking**	NHS Ambulance Trusts must ensure that vehicles used to deploy interoperable capabilities can be tracked nationally by NARU via nationally approved systems. This includes the vehicles associated with the SORT capability that are used to transport either pooled MTA equipment or CBRN resources to the scene of an incident.	Y							
M1	**MassCas**	**Mass casualty response arrangements**	NHS Ambulance Trusts must ensure they have plans and procedures in place that specifically cater for a mass casualty incident and that those provisions are aligned to the national framework or concept of operations for managing mass casualty incidents published by NHS England.	Y							
M2	**MassCas**	**Arrangements to work with NACC**	NHS Ambulance Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) in the event that national coordination is required or activated.	Y							
M3	**MassCas**	**EOC arrangements**	NHS Ambulance Trusts must have effective and tested arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving medical facilities (including designated Acute Trusts) within the first hour of mass casualty or major incident being declared.	Y							
M4	**MassCas**	**Casualty management arrangements**	NHS Ambulance Trusts must have a Casualty Management Plan (CMP) (including patient distribution model) which has been produced in conjunction with Regional Trauma Networks and / or individual receiving facilities. These plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise.	Y							
M5	**MassCas**	**Casualty Clearing Station arrangements**	NHS Ambulance Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station or multiple Casualty Collection Points at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation / evacuation.	Y							
M6	**MassCas**	**Management of non-NHS resource**	NHS Ambulance Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources, as part of the patient distribution model: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y							
M7	**MassCas**	**Mass Cas Audits and Inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the mass casualties capability that are commissioned by NHS England.	Y							
M8	**MassCas**	**MCV accommodation**	NHS Ambulance Trusts must maintain the number of mass casualty vehicles assigned to them by the National Ambulance Resilience Unit. These vehicles must be maintained in compliance with the national specification and any guidance produced by NARU to ensure effective interoperability.	Y							

M9	**MassCas**	**Maintenance and insurance**	NHS Ambulance Trusts must insure, mechanically maintain and regularly run the mass casualty vehicles. Each nationally specified mass casualty vehicle must be securely accommodated undercover (garaged) when not deployed and must be maintained with an appropriate shoreline / electrical feed. The vehicle must be parked in a way that would facilitate rapid mobilisation and a high state of readiness. In the event of a mass casualty vehicle being unavailable, within 2 hours the national electronic dashboard must be updated and the NARU On Call Duty Officer informed.	Y						
M10	**MassCas**	**Mobilisation arrangements**	NHS Ambulance Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents or events which may benefit from the deployment of the asset(s). Trusts must ensure that their mass casualty vehicle (MCV) 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 MCV is already deployed at a local incident or is non operational.	Y						
M11	**MassCas**	**Mass oxygen delivery system**	NHS Ambulance Trusts must maintain the mass oxygen delivery system on the vehicles, in accordance with the manufacturers guidance (including regular servicing and maintenance).	Y						
M12	**MassCas**	**Drug and pharmaceutical stock management**	In accordance with agreements and instructions from NHS England and local Pharmacy Leads, the drugs and pharmaceuticals which form part of the minimum nationally specified stock for each MCV must be appropriately and effectively maintained by the NHS Ambulance Trust.	Y						
M13	**MassCas**	**Fleet compliance with national specification**	NHS Ambulance Trusts must ensure that the minimum contents for each MCV (specified through the national load list) are maintained on the vehicle and remain fit for operational deployment / utilisation.	Y						
M14	**MassCas**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that each MCV is managed in accordance with national procedures and other associated national safe system of work provisions.	Y						
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. Each NHS Ambulance Trust must comply and fully engage with any audits or inspections of the command and control capability that are commissioned by NHS England.	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 National Command and Control Guidance published by NARU.	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 (strategic commander down to functional roles) and utilisation of the Trusts interoperable capability assets to manage an 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 Trust is responsible for ensuring compliance with these core standards and the provisions set out within the National Command and Control Guidance published by NARU. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
C5	**C2**	**Command role availability**	NHS Ambulance Trusts must ensure that the command roles defined within the National Command and Control Guidance published by NARU are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Trusts must ensure that there is sufficient resource in place to provide each command level (strategic, tactical and operational) with the dedicated support roles set out in the National Command and Control Guidance published by NARU standards at all times.	Y						

C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Trusts 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. Those skills and the mandatory levels of competence are defined within the National Training Information Sheets for Command and the National Occupational Standards for 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**	Staff expected to discharge strategic, tactical, and operational command functions must have those responsibilities explicitly defined within their individual contracts of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Trust 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. To ensure interoperability at a national incident, this must include access to tabards that are compliant with the specification defined within the National Command and Control Guidance published by NARU.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Trust 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						
C11	**C2**	**Risk management**	NHS ambulance commanders must manage risk in accordance with the method prescribed in the National Command and Control Guidance published by NARU and the JESIP principles.	Y						
C12	**C2**	**Use of JESIP JDM**	NHS ambulance commanders at all levels 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 National Command and Control Guidance published by NARU. Tactical and operational commanders must utilise the national Standard Operating Procedures (SOPs) for command and associated safe system of work provisions.	Y						
C14	**C2**	**Retaining records**	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**	Commanders at all three levels (strategic, tactical and operational) must have access to an appropriate system of logging their decisions which conforms to national best practice. Ambulance Trusts are under a legal, professional and contractual obligation to ensure their commanders maintain appropriate decision logs.	Y						
C16	**C2**	**Access to loggist**	Each level of command (strategic, tactical and operational) must be supported by a trained and competent loggist. A minimum of three loggists 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 additional logs to be kept by non trained loggists should the need arise.	Y						
C17	**C2**	**Lessons identified**	NHS Ambulance Trusts must ensure they maintain an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards and that such learning is shared on the national systems produced by NARU and/or JESIP.	Y						
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the strategic commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Strategic commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Strategic commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions.	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). Individuals must not be placed on an active command rota or fulfil strategic commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the tactical commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Tactical commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Tactical commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service tactical commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to a tactical commander understanding the capabilities under their command.	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. Individuals must not be placed on an active command rota or fulfil tactical commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the operational commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Operational commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Operational commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service operational commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to an operational commander understanding the capabilities under their command.	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. Individuals must not be placed on an active command rota or fulfil operational commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						

C24	**C2**	**Commanders - maintenance of CPD**	All strategic, tactical and operational commanders must maintain appropriate Continued Professional Development (CPD). This CPD must be aligned to the relevant National Training Information Sheet for Command and the NHS England Minimum Occupational Standards for EPRR. The core competency requirements defined within the relevant Training Information Sheet must be specifically referenced within the CPD portfolio maintained by the individual commander. Individual CPD portfolios must demonstrate sufficient maintenance of skill and competence against the minimum requirements for the role.	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. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger multiagency exercises, including table top exercises. The requirement to attend an exercise in any 18 month period can be negated by discharging the individuals specific command 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 in their command role as part of the incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. Failure to demonstrate and document these command functions at an exercise or live incident within an 18 month period must result in the individual being immediately suspended from their command duties until such time as they are able to fulfil this mandatory competency requirement.	Y						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any ambulance service strategic, tactical or operational commander that has not maintained the competency requirements specified in the National Training Information Sheet applicable to their role, or that has not maintained the relevant continued professional development (CPD) obligations, must be immediately suspended from their command duties. They must be removed from any active command rota and must not discharge their command functions at an incident until such time as the minimum level of mandated competence can be fully demonstrated.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Each NHS Ambulance Trust must have a process in place to check and verify that strategic, tactical and operational commanders are maintaining appropriate levels of CPD evidence and that they are maintaining the minimum levels of competence defined within the National Training Information Sheets. As a minimum, this must include obtaining an annual signed declaration from all active commanders that they understand the obligations defined within these core standards and that they have maintained the minimum levels of competence and CPD defined within the relevant National Training Information Sheet. Further to these annual declarations, each Ambulance Trust must undertake 'dip sampling' of multiple CPD portfolios from the strategic, tactical and operational command levels to verify the declarations being made. This assessment of randomly selected CPD portfolios should be undertaken by a suitably competent person, such as an Emergency Preparedness professional. The Accountable Emergency Officer in each Ambulance Trust is responsible for ensuring that any commander at any level who has not been able to maintain the minimum competency requirements is immediately suspended from discharging command functions at an incident.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge a NILO or 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 or 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 or 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 and requirements defined by the National Ambulance Service Command and Control Guidance published by NARU.	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 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 National Ambulance Service Command and Control Guidance published by NARU).	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 involving ambulance service interoperable capabilities every 18 months. Attendance at these exercises will form part of mandatory continued professional development 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 and 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 compliance 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 (or equivalent) must be aware of the ambulance service's operational capabilities, including the interoperable capabilities, and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the National Command and Control Guidance published by NARU to enable the initial steps to be taken (e.g. notifying the Trust command structure, wider alerting mechanisms, following action cards etc.)	Y						
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line ambulance responders will often be, by default, the interim first commander at scene. So, all frontline operational ambulance staff must be aware of basic major incident principles, including their Trust's major incident plan and the need to follow major incident action cards. They must all have access to such cards. All frontline operational ambulance staff must be sufficiently competent to provide accurate information back to the control room and take the initial steps detailed on relevant major incident action cards safely and effectively.	Y						
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine must be incorporated into all organisational policies, plans and procedures relevant to a multi-agency 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**	**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						
J4	**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						
J5	**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.	Y						
J6	**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.	Y						
J7	**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						
J8	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.	Y						

J9	**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						
J10	**JESIP**	**Commanders - interoperability command course**	All active commanders (strategic, tactical and operational) are required to ensure that JESIP forms part of their ongoing continued professional development portfolios and evidence. This must include reflective practice that includes specific JESIP principles from an exercise or live incident every 18 months.	Y						
J11	**JESIP**	**Participation in multiagency exercise**	At least 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						
J12	**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						
J13	**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 M/ETHANE message.	Y						

Action Plan				Overall Assessment	Non-Compliant					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • 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/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The Trust has recently approved significant increase in the EPRR resouce. There are some challenges filling the posts. 14 - EPRR Policy defines roles of staff with key responsibilities, 13 - Business Continuity Policy, 9 - BCP-command-and-control-plan, The Trust has improved EPRR resilience through the creation of an additional post to support the EPRR lead 19 - Emergency Planning Resilience and Response Support Officer B5, 22 - EPRR Band 7 advert details.	Partially Compliant	Ensure the vacant EPRR posts are filled	EPRR Lead	Jan-24	
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has a joint summer and winter plan that contains direct links to the National plans (ensuring it remains current). BCPs contain action cards to support delvering services such as access to 4 wheel drive vehicles and provision of accomodation for staff. 25 - TEWV Summer and Winter Preparedness Plan, linked to 3 - 2023.05.31 Adverse weather health plan, 57 - Safe-Staffing-Levels-Escalation-Procedure-Community, 58 - Safe-Staffing-Levels-Escalation-Procedure-Inpatient, 31 - Secure Inpatient Service BCP, 46 - NYY BCP May 2023	Partially Compliant	Ensure all EPRR Policies are current, include changes to the Trust structure, new roles and governance arrangements.	EPRR Lead	Jul-24	
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 18 - Easter 2023 on call template complete - TEWV, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 45 - NENC ICC Details - BMA IA 13 - 22 July 2023, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, Dalesway (Rosebery Park) Incident Debrief Report, 68 - IIC Incident August 2022 - Reflections, 70 - Continuity of Patient Food Supply. In addition All Staff required to complete mandatory training Fire, health and safety, evacuation, IPC which is recorded via ESR	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	

Action Plan				Overall Assessment	Non-Compliant					
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37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The Trust AEO and EPRR Lead attend LHRP meetings for both Humber and North Yorkshire and North East and North Cumbria. The EPRR lead attends LHRP sub group meetings. The Trust participates in both planned and unplanned LRF meetings and is a member of LRF sub groups. The ICB EPRR teams hold regular less formal EPRR sessions where health providers share knowledge understanding. The EPRR lead attends other regional and national EPRR meetings. 9 - BCP-command-and-control-plan, 42 - LHRP Papers for this afternoon's Meeting, 73 - Cleveland LRF Weekly Bulletin Official Sensitive, 97 - LHRP Papers - 15th May 2023, 98 - LHRP Operational Group, 21 - EP Planners Workshop Allocated Places - TEWV	Partially Compliant	Ensure attendance at both ICB LHRP meetings is planned throughout the year between bot AEO and the EPRR lead	EPRR Lead	Nov-23	
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has 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. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Business Continuity Plans and associated action cards developed and held locally (hard copies available). 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 93 - Access to BCPs via the intranet (1 click), 94 - Digital-and-Data-Contract-Management-Policy, 57 - Safe-Staffing-Levels-Escalation-Procedure-Community, 58 - Safe-Staffing-Levels-Escalation-Procedure-Inpatient, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 2024	Partially Compliant	Ensure all BCP's are current, include changes to the Trust structure, new roles and governance arrangements. Ensure the on call arrangements are current and where appropriate include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Jul-24	
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialist advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS	Partially Compliant	Review of HBRN risk to MH / LD organisation with support from ICS / NHS E	EPRR Lead	Jun-24	

Action Plan				Overall Assessment	Non-Compliant					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialist advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP, 106 - Acute-respiratory-infection-patient-management-including-SARS	Partially Compliant	Review of HBRN risk to MH / LD organisation with support from ICS / NHS E	EPRR Lead	Jun-24	
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Assessed as low risk in MH and LD services. TEWV is reliant on accessing specialist advice through NHS E/UKHSA, local acute trusts and YAS/NEAS. Risk assessments have taken place to determine likely location, type of contaminant and associated treatment resulting in TEWV reception areas have BCPs in place with an action card specifically dealing with Hazmat/CBRN in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread. Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. As per regular clinical processes, resus team members have been provided with fit testing. FFP3 Masks are held on wards and in resus rucksacks. Escalation through NHS E as appropriate. EWV participate in regional execising with acute and ambulance trusts. 13 - Business Continuity Policy, 14 - EPRR Policy, 9 - BCP command and control plan, 29 - Hotel-Services-BCP, 31 - Secure Inpatient Service BCP, 46 - NYY BCP	Partially Compliant	Review of HBRN risk to MH / LD organisation with support from ICS / NHS E	EPRR Lead	Jun-24	
DD1	EPRR Training	EPRR TNA	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	

Action Plan				Overall Assessment	Non-Compliant					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
DD2	EPRR Training	Minimum Occupational Stan	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas	EPRR Lead	Jul-24	
DD3	EPRR Training	EPRR staff training	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
DD4	EPRR Training	Senior Leadership Training	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	

Action Plan				Overall Assessment	Non-Compliant					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
DD6	EPRR Training	Training Data	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
DD7	EPRR Training	Monitoring	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Include copliance with EPRR training in the annual board report	EPRR Lead	Jul-24	
DD8	EPRR Training	JESIP doctrine	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	
DD9	EPRR Training	Continuous Improvement pr	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements. Continuous improvement trackers.	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Report lessons learned to the EPRR group including a statement if training should be ammended as a result	EPRR Lead	May-24	

Action Plan				Overall Assessment	Non-Compliant					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
DD10	EPRR Training	Evaluation	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	The Trust needs to ensure that the EPRR national occupational standards are embedded in all EPRR roles and associated training. The Trust needs to ensure that the principles oh health command training is taken up by all on call staff and is made available of new staff coming onto the on call rotas. Trust EPRR processes and on call arrangements prepare staff for their role in an incident. 9 - BCP-command-and-control-plan, 31 - Secure-Inpatient-Service-BCP, 41 - JCC paper - Change of participants trustwide oncall, 46 - NYY BCP v2.8 May 2023, 50 - On call induction pack v2, 59 - SPD - maintenance of the combined on call workbook, 64 - TEWV on call rota wc 22.9.23. 71 - On-call log September 2023, 72 - EMERGENCY AND BUSINESS CONTINUITY WORK PLAN 2023 202, 75 - LRF TNA Completion, 99 - Training Alerts (compliance)	Partially Compliant	Fully implement the EPRR National Occupational Standards Framework for all staff involved in EPRR including on call staff, business managers and others coming into EPRR roles. (TNA, training, evaluation, portfolios and record keeping)	EPRR Lead	Jul-24	

Over arching changes:	Domain 10 - CBRN renamed to Domain 10 - HazMat/CBRN Domain 10 standards reordered amd renumbered

Previous standard detail					New standard detail			
Ref	**Domain**	**Standard**	**Detail**	**2023 Changes**	**Ref**	**Domain**	**Standard name**	**Standard Detail**
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 within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	No change	**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 within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. 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.	No change	**2**	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. 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.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	No change	**3**	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	No change	**4**	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.

5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	No change	**5**	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	No change	**6**	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
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 all relevant risk registers including community and national risk registers.	No change	**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 all relevant risk registers including community and national risk registers.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	No change	**8**	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Standard detail has been updated to emphasise the importance of joint working and collaborative planning with emergency services and health partners following lesson identified through JOL working group.	**9**	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	No change	**10**	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	No change	**11**	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	No change	**13**	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	No change	**12**	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	No change	**14**	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	No change	**15**	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	No change	**16**	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	No change	**17**	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.

18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	**18**	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	No change	**19**	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control								
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.	No change	**20**	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	No change	**21**	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising								
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	No change	**22**	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	No change	**23**	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	No change	**24**	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
25	**Training and exercising**	**Staff Awareness and Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	No change	**25**	**Training and exercising**	**Staff Awareness and Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
Domain 6 - Response								

26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	No change	**26**	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	No change	**27**	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
28	**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).	No change	**28**	**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).
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	No change	**29**	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	No change	**30**	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
31	**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.	No change	**31**	**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.
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	No change	**32**	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)
Domain 7 - Warning and informing								
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	No change	**33**	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.

34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	No change	**34**	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	No change	**35**	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	No change	**36**	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation								
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.	No change	**37**	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	No change	**38**	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.
39	**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. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	No change	**39**	**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. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
40	**Cooperation**	**Arrangements for multi-area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	No change	**40**	**Cooperation**	**Arrangements for multi-area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	No change	**41**	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	No change	**42**	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.	No change	**43**	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity								

44	**Business Continuity**	**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) that aligns to the ISO standard 22301.	No change	**44**	**Business Continuity**	**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) that aligns to the ISO standard 22301.
45	**Business Continuity**	**Business Continuity Management Systems (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. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	No change	**45**	**Business Continuity**	**Business Continuity Management Systems (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. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	No change	**46**	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
47	**Business Continuity**	**Data Protection and Security Toolkit (DPST)**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change	**47**	**Business Continuity**	**Data Protection and Security Toolkit (DPST)**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
48	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has 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	No change	**48**	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has 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
49	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	No change	**49**	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	No change	**50**	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	No change	**51**	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
52	**Business Continuity**	**BCMS continuous improvement process**	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 align and are interoperable with their own.	No change	**52**	**Business Continuity**	**BCMS continuous improvement process**	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 align and are interoperable with their own.
53	**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.	No change	**53**	**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.
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	No change	**54**	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon

Domain 10 - HazMat/CBRN								
				New Standard	**56**	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented
55	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Amended wording of standard so not specific to telephony advice.	**58**	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents
56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Standard detail amended to include specific elements of Hazmat/CBRN plan	**59**	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders
57	**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.	Standard detail amended and supporting information developed with evidence of risk assessments.	**57**	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type
58	**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.	Standard detail amended to incroporate wet, dry, interim and improvised decontamination where necessary and availibilty of staff.	**60**	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be deployed within 30 mins to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s)
59	**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/ourwork/eprr/hm/ • 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/	Standard detail amended to reflect need to ensure equipment is in line with organisational Hazmat/CBRN risk assessments	**61**	**Hazmat/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. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed 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

60	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Standards merged.	**66**		**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7
68	**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.					
61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Standards merged.	**62**	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for
62	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment					
63	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Standard detail amended to reflect need to ensure the organisation has processes in place to manage waste, including but not limited to PPE.	**63**	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans
64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Hazmat/CBRN Training standards have been consolidated from four into two standards	**64**	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.					
66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		**65**	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles of 'Remove, Remove, Remove' and isolation when necessary. (This includes (but is not limited to) acute, community,
67	**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.					
				New standard	**67**	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme

New Core Standards applicable to NHS ambulance services and developed by NARU in consultation with all NHS Ambulance Services in England to standardise the approach and support offer to acute Trusts	**68**	**CBRN Support to acute Trusts**	**Capability**	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response.
	69	**CBRN Support to acute Trusts**	**Capability Review**	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.
	70	**CBRN Support to acute Trusts**	**Capability Review Frequency**	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).
	71	**CBRN Support to acute Trusts**	**Capability Review report**	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.
	72	**CBRN Support to acute Trusts**	**Train the trainer**	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.
	73	**CBRN Support to acute Trusts**	**Aligned training**	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.
	74	**CBRN Support to acute Trusts**	**Training sessions**	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 June 2024**
Title:	**Register of Interests of the Board of Directors**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:

Assurance		***Decision***	
Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: To advise the Board of the updating of the Register of Interests of Members of the Board of Directors pending publication.

Proposal: The Board is asked to receive and note this report.

Overview: The Trust is required to compile and publish a Register of Interests of Members of the Board of Directors under para. 20 (1)(e) of Schedule 7 of the National Health Service Act 2006.

An updated version of the Register is attached to this report. It includes those interests held by Directors in the two years prior to appointment as agreed with the Council of Governors.

The Board is asked to note that the Register will be published on the Trust's website as required by NHS England.

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

Recommendations: The Board is asked to note this report.

Tees, Esk and Wear Valleys NHS Foundation Trust

Register of Interests of Members of the Board of Directors

Date: May 2024

Note: 1 - This Register has been established in accordance with the National Health Service Act 2006 (as amended) and the Constitution
Note: 2 - Descriptions of the types of interests are provided in NHS England Guidance "Managing Conflicts of Interests in the NHS" (Publications Gateway Number 06419) and the Trust's Conflicts of Interest Policy
Note: 3 - Changes of interest should be recorded as notified
Note: 4 - The Register should be refreshed annually
Note: 5 - At the request of the Council of Governors, the Board agreed that material interests held in the two years before appointment should also be registered

Name	Position		Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
David Jennings	Chair	Present	**None**	**None** *(but for transparency:* *CIPFA qualified accountant, though no longer a member of CIPFA* *Independent Non-Commissioner Member of Church Commissioner's Audit and Risk Committee since May 2022)*	**None**	**None** *(No direct financial interest for Mr Jennings or his relative, but for transparency a relative works for Barclays International, Barclays Corporate being the Trust's bankers)*
		Pre-Appointment	**Yes** Non-Executive Director/Vice-Chair South Tees, NHS FT January 2021 to August 2022 Non-Executive Director Bernicia Housing Group June 2017 to September 2021	**None**	**Yes** Chair of Audit One NHS Internal Audit Consortium: August 2019 to September 2021 Trustee and Honorary Treasurer Newcastle University Development Trust October 2020 to September 2022	**None**
Brent Kilmurray	Chief Executive	Present	**None**	**Yes** Mental Health, learning disability and autism partner representative of Humber North Yorkshire Integrated Care Board Member of the Mental Health, Learning Disability and Autism Sub-group of North East North Cumbria (NENC) Integrated Care Board Chair of the NENC Provider Collaborative Partnership Board	**None**	**Yes** Spouse is a senior clinician at Cumbria, Northumberland Tyne and Wear NHSFT
		Pre-Appointment	**None**	**None**	**None**	**Yes** Spouse is a member of clinical staff at Cumbria, Northumberland Tyne and Wear NHSFT
Roberta Barker	Non-Executive Director	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**None**	**None**	**None**

Name	Position		Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Charlotte Carpenter	Non-Executive Director	Present	**Yes** Executive Director at Karbon Homes. There is a slim chance of a conflict of interest arising from this position Independent Chair of North of Tyne Business Improvement Partnership	**None**	**None**	**None**
		Pre-Appointment	**Yes** Executive Director at Karbon Homes. Independent Chair of North of Tyne Business Improvement Partnership	**None**	**None**	**None**
Jill Murray	Non-Executive Director	Present	**None**	**Yes** President of the Chartered Institute of Housing (voluntary role)	**None**	**Yes** Husband is a solicitor and partner at Ward Hadaway who are a contractor of TEWV but he is not directly involved in this work
		Pre-Appointment	**None**	**Yes** President, Vice-President of the Chartered Institute of Housing. Fellow Member	**None**	**None**
John Maddison	Non-Executive Director	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**None**	**None**	**None**
Jules Preston	Non-Executive Director and Senior Independent Director	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**None**	**None**	**None**
Bev Reilly	Non-Executive Director & Deputy Chair	Present	**None**	**Yes** Member of Royal College of Nursing	**None**	**None**
		Pre-Appointment	**None**	**Yes** Member of Royal College of Nursing	**None**	**None**

Name	Position		Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Ann Bridges	Executive Director of Corporate Affairs and Involvement	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**Yes** CIPR North East Committee CIPR Health Committee	**None**	**None**
Mike Brierley	Assistant Chief Executive	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**None**	**None**	**None**
Zoe Campbell	Managing Director (NYYS)	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**None**	**None**	**None**
Hannah Crawford	Director of Therapies	Present	**None**	**None**	**None**	**Yes** Sibling is an Associate with DAC Beechcroft LLP (Leeds Office) specialising in financial services, consumer goods, insurance and health and social care (both public and independent sectors).
		Pre-Appointment	**None**	**None**	**None**	**Yes** Family connection of DAC Beechcroft LLP (see above)
Sarah Dexter-Smith	Director of People and Culture	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**Yes** Director of family company running four residential care homes for adults with MHDLA in the Teesside area. The business is no longer running	**None**	**Yes** Friend worked for the company that developed Oxehealth. Not direct contact about the system except for them linking the Trust with the research team at the time who were trying the system in different settings

Name	Position		Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Dr Kedar Kale	Medical Director	Present	**None**	**Yes** Member of the Royal College of Psychiatrists, British Medical Association, British Indian Psychiatry Association, British Association of Physicians of Indian Origin, British Newsopsychiatry Association	**None**	**Yes** Spouse has a private medical practice and both are joint shareholders in the company. The Board Member does not undertake private medical practice
		Pre-Appointment	**None**	**Yes** Member of the RCPsych, BMA, BNpA, BAPIO	**None**	**Yes** Jointly held company where his spouse was involved in private medical practice. The Board Member did not undertaken private practice
Beverley Murphy	Chief Nurse	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**None**	**None**	**None**
Liz Romaniak	Director of Finance and Estates/Facilities Management	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**Yes** Executive Director of Finance, Contracting and Facilities at Bradford District Care NHS FT to October 2020	**None**	**None**
Patrick Scott	Managing Director (DTVF)	Present	**None**	**None**	**None**	**None**
		Pre-Appointment	**None**	**None**	**None**	**None**

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**

Date: **13 June 2024**

Title: **Register of Sealing**

Executive Sponsor(s): **Brent Kilmurray, Chief Executive**

Report Author: **Phil Bellas, Company Secretary**

Report for:				
	Assurance		***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: To advise the Board of the use of the Trust's seal in accordance with Standing Order 15.2.

Proposal: The Board is asked to receive and note this report.

Overview: The Trust's seal has been used as follows:

Ref	**Document**	**Sealing Officers**
432	Contract for the provision of additional parking at 163 Durham Road, Stockton on Tees	Mike Brierley, Assistant Chief Executive Phil Bellas, Company Secretary
433	Lease relating to the Hawthorn Unit, Briary Wing, Harrogate Hospital	Mike Brierley, Assistant Chief Executive Phil Bellas, Company Secretary

Prior Consideration and Feedback	None relating to this report.
Implications:	None relating to this report.
Recommendations:	The Board is asked to note this report.

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