Board of Directors meeting - in Public

Wed 06 April 2022, 13:30 - 15:30

Via MS Teams

Agenda

1. Welcome and apologies for absence

Ken Jarrold, Chairman

2. Declarations of interest

Ken Jarrold, Chairman

3. Service user / carer / staff story

4. Minutes of the meeting held 2 March 2022

Ken Jarrold, Chairman

4. Board Public Minutes 2 March 2022 FINAL KA 003.pdf (11 pages)

5. Action log and matters arising from previous meeting

Ken Jarrold, Chairman

5 BoD Action Log PUBLIC as at 6.4.22.pdf (1 pages)

6. Chairman's Update

Ken Jarrold, Chairman

7. Chief Executive's Update

James Duncan, Chief Executive

7. CEO Report April 2022.pdf (4 pages)

Quality, Clinical and Patient Issues

8. COVID-19 Responses Update

Gary O'Hare, Chief Nurse

8. Covid 19 Board Update - Apr 2022.pdf (6 pages)

8.1. COVID-19 National Inquiry Update

Gary O'Hare, Chief Nurse

8.1 National Inquiry Covid 19 Board Update - Apr 2022.pdf (4 pages)

9. Commissioning and Quality Assurance Update (Month 11)

Lisa Quinn, Executive Director of Finance, Commissioning and Quality Assurance

9. Monthly Commissioning Quality Assurance Report - Month 11.pdf (9 pages)

Workforce Issues - no issues to report

Strategy, Planning and Partnership Updates

10. Annual Planning 2022-2023

Lisa Quinn, Executive Director of Finance, Commissioning and Quality Assurance

10. 22-23 Annual Plan Board paper for approval 220406 v1.5.pdf (25 pages)

11. Operational and Financial Planning update 2022/23

Lisa Quinn, Executive Director of Finance, Commissioning and Quality Assurance

11. Financial Planning & Budgeting 22-23 Final Submission (TB).pdf (8 pages)

12. Quality Account - Quality Priorities 2022/23 update

Lisa Quinn, Executive Director of Finance, Commissioning and Quality Assurance

12. Quality Account Update - Quality Priorities for 2022-23.pdf (9 pages)

13. Nursing Strategy

Gary O'Hare, Chief Nurse

13. Nursing Strategy Update - April 2022 Board.pdf (10 pages)

14. Armed Forces Update

James Duncan, Chief Executive

14. Armed Forces Update April 2022.pdf (3 pages)

15. Integrated Care System North East and North Cumbria update

James Duncan, Chief Executive

15. i ICS Update for Board April 2022.pdf (1 pages)
15. ii Report_Joint_Management_Executive_Group_on_ICS_Development.pdf (16 pages)

Regulatory Items

16. Modern Slavery Act Annual Statement

Debbie Henderson, Director of Communications and Corporate Affairs

16. Modern Slavery Statement April 2022.pdf (4 pages)

Board Sub-Committees and Governor issues for information

17. Quality and Performance Committee

Alexis Cleveland, Chair

18. Audit Committee

David Arthur, Chair

19. Resource and Business Assurance Committee

Paula Breen, Chair

20. Mental Health Legislation Committee

Michael Robinson, Chair

21. Provider Collaborative Committee

Michael Robinson, Chair

22. People Committee

Darren Best, Chair

23. Charitable Funds Committee

Louise Nelson, Chair

24. Council of Governor issues

Ken Jarrold, Chairman

25. Any other business

Ken Jarrold, Chairman

26. Questions from the public

Ken Jarrold, Chairman

Date and time of next meeting - 2 May 2022 via MS Teams

Minutes of the Board of Directors meeting held in Public
Held on 2 March 2022 1.30pm – 3.30pm
Via Microsoft Teams

Present:
Ken Jarrold, Chairman
David Arthur, Non-Executive Director
Darren Best, Non-Executive Director
Paula Breen, Non-Executive Director
Alexis Cleveland, Non-Executive Director
Louise Nelson, Non-Executive Director
Brendan Hill, Non-Executive Director
Michael Robinson, Non-Executive Director

James Duncan, Chief Executive
Ramona Duguid, Executive Chief Operating Officer
Rajesh Nadkarni, Executive Medical Director
Gary O'Hare, Executive Chief Nurse
Lisa Quinn, Executive Director of Finance / Commissioning & Quality Assurance
Lynne Shaw, Executive Director of Workforce and Organisational Development

In attendance:
Margaret Adams, Lead Governor, Public Governor for South Tyneside
Kirsty Allan, Corporate Governance Manager (Minute Taker)
Evelyn Bitcon, Public Governor for North Cumbria
Daniel Briggs, Patient Involvement Facilitator
Allan Brownrigg, Staff Governor, Clinical
Victoria Bullerwell, Staff Governor, Non-Clinical
Danny Cain, Staff Governor, Non-Clinical
Revell Cornell, Staff Governor, Non-Clinical
Anna Foster, Trust Lead for Strategy and Sustainability *(Item 15)*
Terry Haley, Service User *(for item 3)*
Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary
Thomas Lewis, Staff Governor – Medical
Darren McKenna, Director of Digital *(Item 16)*
Anne Moore, Group Director for Safer Care/Director Infection Prevention and Control
Leyton Rahman, Public Governor for Northumberland
Raza Rahman, Staff Governor, Clinical
Jayne Simpson, Corporate Affairs Officer
Russell Stronach, Service User Governor for Learning Disabilities and Autism
Tom Rebair, Service User, Adult Services
Sam Volpe, Health Correspondent

1. Welcome and apologies for absence
Ken Jarrold welcomed everyone to the meeting. There were no apologies for absence received.

2. Declarations of Interest
There were no new declarations of interest to note.

3. Service User/Carer Story

Ken Jarrold extended a warm welcome and thanks to Terry Haley who attended the Board to share his story and journey of becoming the first paid Peer Support Worker in the Trust.

4. Minutes of the meeting held 2 February 2022

The minutes of the meeting held on 2 February 2022 were considered.

Approved:

- **The minutes of the meeting held 2 February 2022 were approved as an accurate record.**

5. Action log and matters arising not included on the agenda

Item 01.12.2021 (5) Committee Reporting – Lynne Shaw confirmed work has now been completed and a paper will be provided to the People Committee in April 2022 outlining the statutory and regulatory requirements of the workforce papers. It was agreed the action could be closed.

Item 04.08.21 (21) North Cumbria Patient Advice and Liaison Service (PALs) - Evelyn Bitcon requested an update on the development of a PALs service for the North Cumbria locality. Ken Jarrold advised that the action log confirmed a report would be provided to the April Board meeting. Ramona Duguid offered a one-to-one discussion with Evelyn in the meantime.

6. Chairman's update

Ken Jarrold referred to the increased demand within services particularly within Children and Young People services, noting that the mental health implications of the pandemic will be with us for many years to come. With regards to staffing levels, Ken confirmed there has been a decline in Covid-related absence, but workforce capacity remains very challenging.

Ken expressed concern regarding the financial challenge the Trust was facing reflecting on the transition from the pandemic financing regime to the post-pandemic financing regime. Ken stated that Lisa Quinn would be leading on work over the next couple of months with the Board to develop the Trust operational and financial planning framework.

Ken referred to recent media coverage regarding mental health services provided by a neighbouring Trust and advised that discussions had taken place regarding the issues, the support CNTW can provide in terms of the Trust's role as the Commissioner of some services from Tees, Esk and Wear Valley NHS FT as well as the Trust's role as a partner in the delivery of regional services.

Ken referred to the current conflict and crisis in Ukraine and acknowledged the significant impact this will have on some members of our workforce, service users and members of the local community. The Trust is supporting those people directly affected by the conflict and the wider workforce as well as providing support to service users. Ken conveyed his thoughts to all the people of Ukraine who have been affected by the situation.

Resolved:

- **The Board noted the Chairman's verbal update**

7. Chief Executive's Report

James Duncan referred to national updates with the first amendments agreed to the Health and Care Bill announced last week. This was led by Lord Hunt to ensure that mental health has a very clear place within the new system with agreement that Integrated Care Boards (ICBs) must have mental health input into those Boards, representing an important step forward for parity between physical and mental health.

James referred to a statement delivered in the House of Commons by Gillian Keegan, Minister for Care and Mental Health announcing plans to develop a cross-government mental health strategy and increased support for suicide prevention. A public discussion paper will be launched this Spring to inform the development of the strategy.

James noted that the Department of Health and Social Care has published the Integration White Paper, which sets out the Government's plans for the integration of health and care and the levelling up of health and care access, experience, and outcomes across the country. This emphasises the position of place, defined as local authority boundaries and the requirement of each place having a single leader across health and local authorities.

James highlighted the recently published Levelling Up White Paper which sets out its ambition to end geographical inequality in the UK. The paper commits the government to publishing an annual report on progress towards the targets set and suggests the establishment of local advisory panels and a series of ministerial visits to support the Levelling Up agenda.

Michael Robinson referred to the Integration White Paper and asked if there was anything to stop the ICS taking that step towards embedding place based governance arrangements now, regardless of whether there is legislation in place. James Duncan confirmed that detailed discussions on place based governance were progressing across each local authority area and that the Trust was fully engaged in those discussions.

Ken Jarrold mentioned being present at the LGBT+ celebration day which was a very full day with a lot of learning with some truly remarkable speakers.

Resolved:

- **The Board received the Chief Executive's update.**

Quality, Clinical and Patient Issues

8. COVID-19 Response update

Ken Jarrold welcomed Anne Moore to provide an update on the COVID-19 response which will be Anne's last report in her present role due to retirement and thanked Anne for all the work she has done for the Trust and the NHS over many years. Ken mentioned Anne will be returning for a short period to work on the national pandemic inquiry and looks forward to Anne's help and support with this piece of important work.

Anne Moore presented the report and referred to the unprecedented impact of the surge in Omicron cases, which led the Trust to return to OPEL 3. Over the last three weeks the situation has changed with reduced cases and the move back to Government's Plan A and the Trust position improving back down to OPEL 2. During the last four weeks CNTW positive case rates in staff have continued to reduce dramatically.

Outbreak management continues to be a significant factor with patients continuing to test positive either in the community coming in, as a new admission, or who are taking leave out of the ward into community settings and returning and testing positive. At the time of the report CNTW currently has five outbreaks which reflects the reduction in community prevalence and is mirrored across most Trusts in the North East and Cumbria.

Anne noted that Infection, Prevention and Control (IPC) national guidance was still forthcoming in relation to any changes to NHS IPC practice.

Gary O'Hare thanked Anne Moore for the phenomenal work Anne has undertaken over the years and as Director of Infection Prevention wishing Anne well in her retirement.

Ken Jarrold thanked Anne for the report provided to the Board as well as the work Anne has done throughout her time with the Trust and indeed her whole NHS career.

Resolved:

- **The Board received the COVID-19 Response update**

9. Commissioning and Quality Assurance update (Month 10)

Lisa Quinn presented the report and noted the Trust continued to remain in Segment 1. At the end of Month 10, the Trust was able to forecast a break-even position in terms of revenue with a continued underspend against capital programme of approximately £10m.

Due to current pressures, the Trust continued to see some out of area placements (OAPs), resulting in 12 OAPs during January.

Lisa referred to a Mental Health Act Reviewer visit which took place in January 2022 to a forensic unit and a unit in Sunderland and noted that actions have taken place to address the issues identified.

Lisa noted that the majority of contractual requirements were met during the period, with a continued pause noted against some of the organisation's internal metrics in relation to training and appraisals. Lisa referred to the level of absence being significant due to the Omicron variant. As of 2 March, there had been a 30% reduction in the overall absence position.

Louise Nelson referred to the Mental Health Act Reviewer visits and asked whether managers within that area highlight learning to others across the patch. Lisa Quinn advised that there are individual action plans for every visit as well as a review of themes. Reporting and assurance is provided via the Quality and Performance Committee and the Mental Health Legislation Committee to review themes and trends to support learning across the organisation.

David Arthur queried the approach to reinstating activity relating to training. Lisa advised that a review of trajectories was taking place as part of the Annual Planning process. PMVA, Mental Health Act and Information Governance training were identified as key priority areas. Trajectories would be provided as part of the Annual Plan submission to the Board in April 2022.

Resolved:

- **The Board received the Month 10 Commissioning and Quality Assurance update**

10. Safer Care Report (Quarter 3)

Damian Robinson presented the report and provided a detailed overview of all incidents and activity during the quarter. The Trust has identified several safety priorities for the next financial year: suicide in inpatient units; reducing restrictive practice; improving sexual safety on inpatient wards; reducing incidents and consequences of choking; reviewing high dose antipsychotic therapy; and Valproate in women of childbearing age.

Within Safer Care, Damian mentioned an additional priority ,which is the implementation of national patient safety strategy. This will introduce new methods and processes for reporting and investigating incidents.

Evelyn Bitcon referred to page 8 of the report, which highlights five long-term segregation cases in North Cumbria and asked if they were local or out of area. Evelyn also referred to page 10 of the report asking what action is taken within the localities when safeguarding numbers are not decreasing. Rajesh Nadkarni noted that Trust-wide Children and Young People's services are also managed within the North Cumbria locality and advised that the number of long-term segregation cases may not all relate to the North Cumbria patch. With regard to safeguarding, Damian mentioned an increase in number of reports may reflect high compliance with reporting or reflect an increase in number of incidents.

Resolved:

- **The Board received and noted the Safer Care Report**

11. Annual Quality Priorities update

Lisa Quinn provided an update on this year's Trust priorities and requested Board approval for three priorities to be carried forward from this year into next year in the areas of: improving the inpatient experience; improving waiting times; increasing time staff can spend with service users and carers; and Equality, Diversity, Inclusion and Human Rights.

Lisa mentioned this year's priority was around 'time spent with your clinicians' which has been a priority being a common theme throughout the previous 12 months. The theme has now changed for next year which is a consequence of the action teams have taken as well as the change of time when COVID started.

Lisa mentioned feedback themes have now been reviewed from service users and carers and the common theme is 'being listened to' and recommended to the Board to change the quality priority for next year on this basis. Alexis Cleveland referred to a discussion which took place at Quality and Performance Committee and noted that the Committee was happy to support this change.

Darren Best queried whether the quality priority goes far enough but asked if there was something more fundamental about the way service users and carers are recognised in services. Lisa Quinn referred to the actions to be taken to develop the quality priority to respond to the feedback to see carers and service users in the delivery of care and will explore further in the action planning against the quality priorities.

Brendan Hill referred to Terry Haley's story and the need for some analysis looking at the time spent on quality, and time spent on interaction with patients and the impact of non-professionally aligned roles and the difference these make to people's recovery.

Resolved:

- **The Board received the Annual Quality Priorities update.**

Approved:

- **The Board approved three priorities for next year as well as the change in quality priority to adjust the feedback quality priority to focus on being heard and communicated to from service users.**

Workforce Issues

12. Annual Report on safe working hours: doctors in training

Rajesh Nadkarni referred to the annual report on safe working hours which focuses on junior doctors and referred to the new contract being offered to new trainees' as they take up training posts. Although the Trust hosts over 160 trainee posts, they do not directly employ most of these trainees, also due to current recruitment challenges a number of the senior posts remain vacant.

There are currently 152 trainees working into CNTW with 142 on the new Terms and Conditions of Service via the accredited training scheme via Health Education England. There are an additional 10 trainees employed directly by CNTW working as Trust Grade Doctors or Teaching/Clinical/Research Fellows.

Rajesh mentioned the number of exception reports have remained stable with the majority in 2021 closed through payments. Work will continue to increase the level of completeness of reporting. There has been a substantial fall in the number of reports of insufficient medical handover which will continue to be encouraged.

There has been an increase in the number of occasions where the emergency cover rota was necessary. This will continue to be monitored and reviewed to include the impact of the new training rota.

Michael Robinson asked if there was an underreporting with exception reports and asked what is being done to encourage people to complete a report. Rajesh referred to a change of culture following the implementation of the new junior doctor's contract. The issue is regularly discussed within the junior doctor forum and remains an area of focus.

Darren Best advised that the Board should take an active interest in working time directive across the Trust considering staff absence, COVID burnout etc., and to look at all the working time directive of all our staff not just junior doctors. Darren Best and Lynne Shaw will discuss further through the People Committee.

Resolved:

- **The Board received and noted the Annual Report on safe working hours: doctors in training**

13. Gender Pay Gap Report

Lynne Shaw referred to two papers relating to Gender Pay Gap; one for CNTW and the other NTW Solutions. Lynne referred to points 5 and 6 for the bonus payments, noting both gaps have increased due to the local clinical excellence awards and the way in which they have been apportioned during covid. It is expected there will be a similar picture next year in terms of the local clinical excellence awards and the bonus side of the gender pay gap.

Lynne noted that CNTW are committed to addressing the gender pay gap and subject to approval will incorporate actions from the report into the Trust's Equality, Diversity and Inclusion action plan.

Lynne mentioned the Gender Pay Gap Report for NTW Solutions has already been approved by the NTW Solutions Board. Lynne stated that both mean and median figures have had a reduction in figures since the previous report and confirmed NTW Solutions do not have bonus payments or excellence awards therefore their bonus pay gap is zero.

Resolved:

- **The Board received and noted the Gender Pay Gap Reports for CNTW and NTW Solutions**

Strategy and Partnerships

14. Integrated Care System / Integrated Care Board

James Duncan reminded the Board that Sam Allen has now taken up post as Chief Executive designate of the ICS at the beginning of February 2022. James mentioned Sam Allen is already engaged in the work across the ICS including looking at the recovery across mental health LD and autism.

Recruitment to the ICB Executive Director posts is expected to be concluded by the end of February. Sam Allen has acknowledged the outstanding questions relating to the development of place-based arrangements within the ICS governance structure, confirming that more guidance is expected in relation to these arrangements and highlighting the importance of co-production.

James confirmed the Trust belongs to a Provider Collaborative which is a collection of all of the provider organisations across the North East and Cumbria ICS. James acknowledged the use of the term 'Provider Collaboratives' for many different types of arrangements and hoped that the language around this would change over time. The ICS Provider Collaborative is continuing to develop, and a memorandum of understanding would be brought to a future Board meeting.

The North East and North Cumbria ICS has been awarded Flexible Apprenticeship Status by the Education and Skills Funding Agency (ESFA) and James referred to the link to the Trust Academy on how apprenticeships can work across organisations across the health and care system.

Michael Robinson referred to the system wide Provider Collaborative and its purpose. James Duncan noted there are areas where collaborative working is needed and indeed the ICB is

asking the Provider Collaborative to develop solutions to some key issues including clinical and estates strategies across the footprint.

Brendan Hill was pleased to receive the update regarding apprenticeships and also asked if there is a requirement to have a named lead across the health and care system by April 2023. James advised it was expected that the ICS will be required to have individual leads, but the initial expectation is that they will emerge from place.

Ken Jarrold raised the issue of public engagement in the context of the developing draft operating framework. As part of regional discussions, Ken highlighted that the ICB/ICS will be unlikely to succeed in engaging directly with the public itself, as it is too distant and new and it will require provider organisations to engage on its behalf, crucially the third sector.

Resolved:

- **The Board noted the Integrated Care System / Integrated Care Board update**

15. Progress on CNTW2030 engagement

James Duncan provided an update on the developing Trust-wide strategy. Anna Foster spoke to the report and provided the Board with an update of the strategy development progress and feedback to date. Anna explained the strategy is defined as people with a shared purpose, working together and towards a shared vision for the future.

Anna mentioned while the listening exercise was undoubtedly affected by the Omicron variant, a significant amount of feedback was received and summarised into four overarching themes which are highlighted within the report.

Brendan Hill thanked Anna Foster for the report mentioning it is good to see in a summary form and highlighted the honesty and humility particularly the ‘what do we do best’ to ‘what do we do well’ and what can we improve on the things we do less well.

Ken Jarrold explained some of the most important descriptions within the paper are an honest description of the present and mentioned in his experience most strategies fail not because of a problem in describing a hope for the future but because of a lack of honesty of where you are now.

Resolved:

- **The Board received the progress on CNTW2030 Engagement Report**

16. Global Digital Exemplar Accreditation

Darren McKenna mentioned in 2017, Northumberland, Tyne and Wear NHS FT (NTW) was selected to bid for Global Digital Exemplar status. Bids were assessed by an international panel and NTW was selected as one of 7 digitally advanced Mental Health organisations to develop and deliver a digital programme leading to formal accreditation as a Global Digital Exemplar. The Trust received £5m over 3 years to deliver the programme and develop a series of blueprints to spread the adoption of digital innovations.

Following the successful delivery of the programme in 2022, the Trust has now been formally recognised as an Accredited Global Digital Exemplar.

Darren Best referred to the accreditation achieving £5m of funding and asked how to keep the accreditation as the funding is now finished and is there a need to identify money to assist with the accreditation. Darren McKenna mentioned the team is very skilled at sustainability and developments and mentioned where schemes have a revenue consequence a business case has been put forward within the Trust.

Darren Best referred to the Great North Care Record as it is not discussed enough at Board level and asked if an update could be provided how the Great North Care Record are being used at an operational level.

Paula Breen mentioned accreditation is fantastic particularly considering the challenges faced over recent years. The Trust has been fortunate to have a £5m investment in IT and given the level of excellent IT, Paula felt this may present the Trust with an opportunity particularly at ICB level as with the level of accreditation and achievement the Trust has achieved in IT and given the money invested in the Trust to be a digital champion.

Ken Jarrold thanked Darren for his personal role in leading the Digital Team and mentioned that this is the best IT Department he has ever encountered within the NHS.

Resolved:

- **The Board received and noted the GDE Accreditation Report. The Board have agreed for an update at a future Board on the Great North Care Record.**

Regulatory Items

17. CEDAR Programme Board – review of governance

Debbie Henderson spoke to the enclosed paper which refers to a proposed change in reporting arrangements for the CEDAR Programme Board following some actions and changes. Following the decision of Peter Studd, Non-Executive Director to step down from his role at the end of last year, a decision was taken at that time to split the role, which was previously a combined role of Chair of NTW Solutions and Non-Executive of CNTW.

Debbie mentioned as part of the appointment process engagement discussions took place regarding the status of CEDAR Programme Board. The paper recommends that the CEDAR Programme board should not be considered as a formal sub committee of the Board but should fall within the remit of the Trust's Resource and Business Assurance Committee in terms of providing the assurance through to the Board.

Resolved:

- **The Board received the CEDAR Programme Board review of governance Report.**

Approved:

- **The Board approved the recommendations to revise the Terms of Reference of the CEDAR Programme Board to report to report to the Resource and Business Assurance Committee.**

Board sub-committee minutes and Governor issues for information

18. Quality and Performance Committee

Alexis Cleveland provided an update following the recent meeting, which reviewed the North Cumbria locality. Alexis mentioned the ongoing concern relating to recruitment but was encouraged to note there had been more clinicians and staff recruited within the period. The new operating model has been introduced in , which went live in November and will be kept under review. A Street Triage Team has also been introduced showing to be a great success.

The Committee also reviewed the Medicines Optimisation Report, the pilot within North Cumbria on Sodium Valproate and the annual recall of women of childbearing age because of the effect the drug can have on the foetus.

A clinical audit report was also discussed and whilst there has been a reduced programme during COVID the clinical audit report has gone forward with people have been implementing the recommendations of those clinical audits.

19. Audit Committee

David Arthur highlighted there will be a meeting in April and in May taking into consideration the timeframe of annual accounts and production of the external audit work.

20. Resource and Business Assurance Committee

Nothing to report.

21. Mental Health Legislation Committee

Nothing to report.

22. Provider Collaborative Committee

Nothing to report.

23. People Committee

Nothing to report.

24. Charitable Funds Committee

Nothing to report.

25. CEDAR Programme Board

James Duncan mentioned the Trust is progressing the land sale on Northgate site and further details will be provided to a future Board.

James highlighted some slippage in cashflow but, with agreement with the Central Team to carry over the slippage into next year there is no impact on the scheme. A new model of care for Ferndene is under review and the trust will reflect in terms of the build and model of care.

26. Council of Governors issues

Ken Jarrold mentioned the Governors Steering Group met recently and because of the widespread concerns about Children and Young People's Services there will be a focus on March 17th Governors meeting.

Ken highlighted Governor Bi-Elections pending for three constituencies, Neuro-Disability Carer Governor, Adult Carer and Public Governor for Sunderland.

Ken referred to very early discussions regarding the composition of the Council with consideration by the Governors Steering Group to review separation of Learning Disability and Autism Governor roles and an update will be provided to the Council of Governors meeting on 17th March.

27. Any Other Business

None to note.

28. Questions from the public

Russell Stronach raised a question however due to the bad quality connection was not able to be heard. Debbie Henderson and Kirsty Allan agreed to meet with Russell separately.

Date and time of next meeting

Wednesday, 6 April 2022, 1.30pm venue, Microsoft Teams.

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Board of Directors Meeting held in public

Action Log as at 6 April 2022

RED ACTIONS – Verbal updates required at the meeting
GREEN ACTIONS – Actions are on track for completion (no requirement for discussion at the meeting)

Item No.	Item	Action	By Whom	By When	Update/Comments
Actions outstanding					
04.08.21 (21)	North Cumbria PALs service	Provide an update on progress to establish a PALs service across the Trust footprint	Ramona Duguid	April 2022	Verbal progress update at April meeting
Completed Actions					
01.12.21 (5)	Committee reporting	Clarification regarding which workforce-related reports are statutory and non-statutory – to be reported into the People Committee	Lynne Shaw	March 2022	Complete – discussed at March meeting

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting
Chief Executive's Report
Wednesday 6th April 2022

Title of report	**Chief Executive's Report**
Report author(s)	**Jane Welch, Policy Advisor to the Chief Executive**
Executive Lead (if different from above)	**James Duncan, Chief Executive**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	N/A
Audit	N/A
Mental Health Legislation	N/A
Remuneration Committee	N/A
Resource and Business Assurance	N/A
Charitable Funds Committee	N/A
CEDAR Programme Board	N/A
Other/external (please specify)	N/A

Management Group meetings where this item has been considered (specify date)	
Executive Team	N/A
Corporate Decisions Team (CDT)	N/A
CDT – Quality	N/A
CDT – Business	N/A
CDT – Workforce	N/A
CDT – Climate	N/A
CDT – Risk	N/A
Business Delivery Group (BDG)	N/A

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Meeting of the Board of Directors
Chief Executive's Report
Wednesday 6th April 2022

Trust Updates

CNTW awarded Stonewall 'Silver' employer status

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) has received a Silver Employer award for their commitment to LGBTQ+ inclusion at work. The award comes as part of LGBTQ+ equality charity Stonewall's Bring Yourself to Work campaign which highlights the importance of inclusive work environments. CNTW has received the accolade for its commitment to inclusion of lesbian, gay, bi, trans and queer people in the workplace. Key achievements include integrating LGBTQ+ inclusion into the syllabus for all nursing students at Northumbria University and first year psychology students at Newcastle University, with plans in development to roll this out to nursing students at the University of Cumbria. The Trust plays a significant role in supporting the Northumberland Pride event, where it will be the official sponsor of the Pride village. Work has also been undertaken with services to ensure LGBTQ+ inclusion for service users, and the Trust's LGBTQ+ Network provides scaffolding support across the Trust for all service user areas who might need advice and guidance on any LGBT+ issues as well as support for LGBT+ staff. LGBTQ+ inclusion training is offered to all CNTW staff in partnership with Northumbria University. On 31st March the Trust celebrated the Transgender Day of Visibility; the Trust would like to thank the LGBTQ+ network for its hard work organising the event.

Cumbrian students complete Dream Placement with CNTW

Over February half-term, two ambitious young people from Cumbria took part in their 'Dream Placement week' with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). The Trust welcomed two students as part of the Centre for Leadership Performance's 'Dream Placement' programme. This unique leadership and work experience programme is designed to showcase the breadth of career opportunities within Cumbria to 16 –18 year-olds, whilst also providing them with an insight into leadership capability and the opportunities to develop their own skills and confidence over the 6-month programme. On their placement, students were tasked with researching and recommending how the Trust could work with schools and encourage more young people to consider a career in the NHS. They also met with various teams within the Trust to learn about the different career paths available. The Dream Placement Showcase event took place on 17th March giving the students an opportunity to share their experiences, highlight their achievements and continue to build their networks.

National updates

Integrated Care Partnerships to have interim integrated care strategies in place by December 2022

The Department of Health published a summary of engagement with stakeholders linked to the development of Integrated Care Partnerships (ICPs) delivered jointly with NHS England and Improvement and the Local Government Association. The document suggests that ICPs should have an interim integrated care strategy in place by December 2022 in order to influence the first 5-year Integrated Care Board Forward Plan due to be published by April 2023. The document also attempts to clarify the role of Health and Wellbeing Boards in relation to the new ICS governance structures.

King's Fund research highlights barriers to successful implementation of the ARRS scheme

King's Fund published *'Integrating additional roles into primary care networks'*, an evaluation of the implementation of the Additional Roles Reimbursement Scheme (ARRS). The report focuses on four roles – social prescribing link workers, first contact physiotherapists, paramedics and pharmacists, suggesting that while PCNs have recruited quickly into these roles, the ARRS are not being implemented and integrated into primary care teams effectively. The report makes several recommendations including the development of a shared vision for multi-disciplinary care; a comprehensive package of support for implementation of the scheme including improved support for clinical and managerial supervision; a focus on future sustainability, including funding, estates strategy and career progression; and leadership and management skills development embedded in GP specialist training.

4% of NHS leaders believe race equality is core business for Boards

NHS Providers published *'Race 2.0 – Time for real change'*, a report summarising the current views of member providers around progress towards race equality. Despite areas of progress, only 4% of respondents – which included Chairs, CEO's and NEDs – felt that race equality was fully embedded as a core part of their Board's business. All respondents shared an ambition to listen more closely to staff about their experiences, 63% said they had progressed in building a more diverse Board however only 32% have incorporated race equality into their Board assurance framework. Despite a large proportion of respondents having made progress in relation to workforce wellbeing, only 22% agreed they had made progress with the retention of ethnic minority staff. The report highlights several barriers to achieving race equality, as reported by members.

The economic case for the prevention of poor mental health

The Mental Health Foundation in partnership with the Care and Policy Evaluation Centre at the London School of Economics published *'The economic case for investing in the prevention of mental health conditions in the UK'*. The report estimates that mental health problems cost the UK economy at least £117.9 billion annually in 2019 – approximately 5 per cent of the UK's GDP. The majority of the cost of poor mental health falls outside the care sector; almost three quarters of the cost (72%) is due to the lost productivity of people living with mental health conditions and costs incurred by unpaid informal carers who take responsibility for providing mental health support. The report concludes that investment in the prevention of mental health conditions has the potential to be highly cost-effective and makes the case for a prevention-based approach to mental health.

Regional updates

North East and North Cumbria Integrated Care System update

The North East and North Cumbria Integrated Care System (NENC ICS) has appointed to the majority of its executive leadership positions and is currently finalising details with regards to start dates for individuals. Appointments so far include:

Executive Medical Director - Dr Neil O'Brien

Executive Chief Digital and Information Officer - Professor Graham Evans

Executive Director of People - Annie Laverty

Executive Director of Corporate Governance, Communications and Involvement - Claire Riley

Executive Director of Innovation - Aejaz Zahid

Executive Director of Finance - Jon Connolly

Executive Director of Place-based Partnerships (Central and Tees Valley) - Dave Gallagher

Executive Director of Place-based Partnerships (North and North Cumbria) - Mark Adams

Two executive leadership roles have not yet been recruited to. The ICS is still aiming to establish the Integrated Care Board (ICB) in shadow form in April 2022 in anticipation of the ICS becoming an NHS statutory organisation in July 2022. The ICS has also been engaging with partners to inform the development of its operating model which will shape how organisations work together, where decisions are made and by whom, and ways of working and structures.

James Duncan
Chief Executive
April 2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
Wednesday 6th April 2022

Title of report	COVID-19 update
Report author(s)	Anne Moore, Director of Infection Prevention Control (DIPC), Deputy Chief Nurse
Executive Lead (if different from above)	Gary O'Hare, Chief Nurse / Accountable Executive Officer

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention, and resilience	X
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	N/A
Audit	N/A
Mental Health Legislation	N/A
Remuneration Committee	N/A
Resource and Business Assurance	N/A
Charitable Funds Committee	N/A
CEDAR Programme Board	N/A
Other/external (please specify)	N/A

Management Group meetings where this item has been considered (specify date)	
Executive Team	N/A
Corporate Decisions Team (CDT)	N/A
CDT – Quality	N/A
CDT – Business	N/A
CDT – Workforce	N/A
CDT – Climate	N/A
CDT – Risk	N/A
Business Delivery Group (BDG)	N/A

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	X
Workforce	X	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience, and effectiveness	X	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to
N/A

Coronavirus (Covid-19)
Report for the Board of Directors meeting
Wednesday 6th April 2022

1. Executive Summary

This report provides an exception report in response to the Covid-19 pandemic since the last Trust Board. For this month the report focus is on:

- Covid-19 Prevalence, Surge and Business Continuity
- Nosocomial & Outbreak Management
- CNTW changes to asymptomatic and symptomatic testing
- Vaccination as a condition of redeployment update

2. COVID-19 Prevalence, Surge and Business Continuity

The report to the last Trust Board indicated an improved position following the December / January Omicron Surge in cases and escalation of Business Continuity. We also reported a reduction in both staff and patient confirmed cases, and there was a move back to government's Plan A, and the Trust position improving back down to OPEL Level 2.

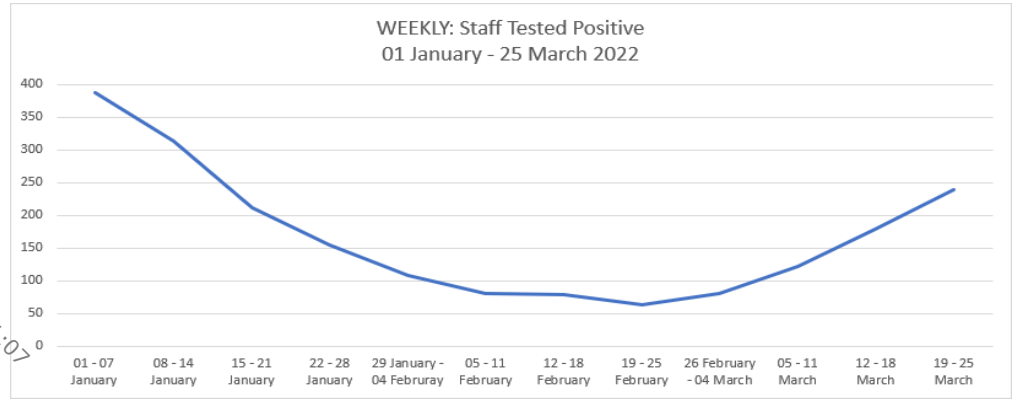
However, the last four weeks has seen another rapid increase in cases as easing of restrictions for the general public has progressed.

The Omicron sub-variant BA.2 whilst milder, is still a serious illness for those who are unvaccinated e.g. notable in Hong Kong / China with increased deaths where vaccination programme has been less developed. No new variant of concern to date, but UKHSA is monitoring closely.

The rise in cases is reported to be mirroring the January / February surge – Southeast and Southwest and Scotland are highest currently and over the last two weeks the rest of the country has followed, it is expected to peak early April going into the Easter break. In the North East the Acute hospital cases have increased but most cases of Covid are secondary to reason for hospitalisation. Critical care bed usage for Covid cases remains low. Staff absence has increased dramatically.

2.1 CNTW Position

During the last four weeks CNTW positive case rates staff have increased as per chart below



- Daily sitreps have been reintroduced as part of service continuity surge planning alongside Surge Meetings with Executive Director oversight
- Reviewed staffing levels and planned level loading over the Easter break in preparation for increased staff absence in services.
- Absence line and test and trace contingency plan is in place to manage increase in calls, testing and close contact review of positive cases.

3. **Nosocomial and Outbreak Management and changes in guidance**

National guidance notes that outbreaks must be 28 days free without a further positive case linked in time and place before it can be closed. It was proposed by the DIPC and agreed by Executive Directors that CNTW would move to close outbreaks at 14 days from the last positive case, following a risk assessment of standard IPC control measures. Post outbreak debriefs still take place. The outbreaks continue to be open on the national system until 28 days.

Introduction of LFD Testing with Inpatients

This was approved for day 5/6, i.e. risk assessed, and if two consecutive negative tests and no symptoms the patient can come out of isolation. This has improved patient experience of isolation and is in line with the direction of travel for the general population and care homes.

Since the last report the Trust has seen a significant increase in inpatient confirmed cases, this is currently standing at 27 with **7** active outbreaks.

3.1 New Outbreaks at the time of the report

Newton: Day 7, last positive case 23.03.22
Springrise: Day 8, last positive case 21.03.22
Ruskin: Day 9, last positive case 22.03.22
Roker: Day 7, last positive case 23.03.22
Oakwood: Day 3, last positive case 27.03.22

3.2 Dormant Outbreaks:

The following outbreaks are dormant, and 14 days or over. Learning debriefs are arranged prior to closing on the national system at 28 days. This is an opportunity for the Outbreak Control Group members including the clinical team, IPC, Absence Line, Facilities, Agency / Bank lead to reflect on the root cause hypothesis and learning including patient reflections of their experience of the outbreak.

Cuthbert: Day 14, last positive case 16.03.22
Redburn: Day 26, last positive case 04.03.22

3.3 Learning/themes from Outbreak areas

Each Outbreak gives us the opportunity to review with the clinical Team and Outbreak Management Group the key themes relating to practice and trust processes which can be improved or reaffirmed. A summary of the learning since the last report is included below:

- Staff coming into work whilst symptomatic with head cold symptoms, sore throat and not contacting the absence line leading to patient and staff transmission.

- Night Duty – inpatient feedback suggested they struggled to sleep due to restrictions on daytime activities and exercise off the ward and more engagement from night staff would have been appreciated when isolating.
- Importance of MDT engagement in Outbreak management to ensure the wider therapeutic needs of patients continued to be met and were not unnecessarily restricted due to perceptions of keeping footfall to a minimum and PPE.
- MDT to consider working flexibly at a weekend during an outbreak to increase engagement with patients and support nursing colleagues.
- Patient Information – patient information board suggested by patients and an updated patient information leaflet to include why restrictions are different in hospital settings.
- Importance of regular staff LFT testing – reinforce staff awareness of QR code to scan and record on CNTW portal.
- Local induction of new staff to include IPC measures – IPC developing a video to support.
- Examples of good patient engagement whilst cohorting / isolating – including access to Peer support workers and Occupational Therapy.
- Twice weekly staff LFD testing and recording on CNTW portal is not embedded in Outbreak areas.
- Good practice has demonstrated proactive support to prioritise Agency and Bank staff in outbreak areas where staffing is diminished due to Covid positive staff.
- Domestic support has been invaluable, and support acknowledged by clinical teams.
- Lack of planning when planned works on ward will have an impact on patient access to space which impacts on social distancing, increasing transmission risk.

3.4 North East and Cumbria

As described above the North East and Cumbria localities and overall Trust position has changed significantly since the last report, however Health Protection Boards (HPBs) continue their plans to move to a 'Living with Covid' approach, standing down Covid HPBs and integrating into general HPB's including Covid. CNTW representation expected.

External Testing Sites for the general public will close on 31st March 2022. Due to reduction in national testing, data is no longer a reliable indicator of case rates.

3.5 Health and Social Care IPC Guidance

Revised National guidance is expected by 1st April 2022. Ruth May, CNO has stated that the proposed changes are to support a 'transition back to pre-pandemic practices and living with Covid'.

Details are still being worked through and will be confirmed by UKHSA – the following gives an indication of what is expected.

- Physical distancing: reduce to pre pandemic in all clinical (exception Emergency Depts) and non-clinical areas.
- Move to standard cleaning measures and enhanced cleaning in areas with suspected or confirmed positive cases only.
- Masks to continue for patients, staff, and visitors in clinical areas.
- No masks in non-clinical areas, i.e., Finance, HR, alongside local risk assessment.
- Review of isolation periods.
- Testing to continue of asymptomatic and symptomatic staff.
- Expect LFD kits to be made available to NHS.
- Care home guidance also being reviewed in tandem.
- Revised IPC BAF/IPC Manual.
- Outbreak Management Governance assurance.

4. CNTW Infection, Prevention and Control Measures, COVID testing or isolation guidance

4.1 Testing

As the current local surge is also impacting on CNTW staffing levels we know that covid illness is mild and hospitalisations low. Currently the direct impact on staff availability to provide non-covid care and treatment is affecting the therapeutic Mental Health and Disability outcomes for patients in addition to the potential safety of our patients. It has been agreed by the Executive Team in recommendation by the DIPC that we move ahead of the national guidance taking a risk based approach and modify our advice to staff and patients on testing.

Testing for Patients

- PCR testing will continue as usual on admission, day 3 and day 5 which will identify if this is a community acquired or Nosocomial case and if symptomatic.
- It has been agreed that routine asymptomatic 7 day testing will cease.
- Patients will continue to be tested 48 hrs prior to discharge to care homes as required.

Testing of Staff

- Asymptomatic staff testing via LFD is to stop, with the exception of staff who are Visiting Professionals into Care Homes.
- Those staff who are symptomatic are to test with LFD and contact absence line as usual practice.

This change is to be communicated at the time of the report. Any impact on patient or staff service will be closely monitored and any new guidance from the 1st April 2022 will also be reviewed and changes made.

4.2 **FFP3 Resilience in the MH and Community Setting**

MH & Community resilience principles have been developed for consideration and implementation and is a national NHSE instruction. The intention being that by the end of March 2022, standards, policies and processes are in place to underpin national FFP3 resilience. Furthermore, these principles will ensure that compliance is maintained against the NHS Core Standards for Emergency Preparedness, Resilience and Response, which will become mandatory in Mental Health, Learning Disability and Community settings in January 2022.

The plan recognises that frequency and likelihood to use FFP3 respirators is low in MH, Community and LD settings; compared to those within the Acute and Ambulance setting.

CNTW have been involved with the national reference group shaping the guidance outlining the plans for ongoing planning and assessment compliance with the plan was submitted to NHSEI by 14th March 2022.

5. Vaccination as a Condition of Deployment

The legal requirement for health and social care staff to be double jabbed was removed from 15th March 2022.

The Health and Social Care Secretary confirmed on 1st March 2022 that regulations making COVID-19 vaccination a condition of deployment in health and social care will be revoked on Tuesday 15th March 2022. Stated, the vast majority of NHS, social care and other healthcare staff have been double jabbed, the government is clear those working in health and social care who remain unvaccinated still have a professional responsibility to get vaccinated against COVID-19 and Get Boosted Now.

The government is continuing to work closely with royal colleges and professional regulators to strengthen guidance and consult on updating the code of practice on the prevention and control of infections in relation to COVID-19 requirements for CQC-registered providers of health and social care in England

6. Moving forward

The activity currently is focused on maintaining patient safety and staff health and wellbeing whilst we learn to live with Covid. The much-awaited IPC Guidance refresh will indicate if further practical changes can be made at clinical and non-clinical level. In the meantime the focus is on collating and reflecting on two years of learning both clinically and corporately, ensuring we embed the actions and are well prepared for any future escalation if new variants emerge.

7. Recommendation

The Board are asked to receive this report, noting the assurance on the measures taken to date, and significant collaborative response from the organisational teams to ensure the safe and effective delivery of care during another period of unprecedented surge in activity.

Anne Moore
Director of Infection Prevention and Control, Deputy Chief Nurse

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
Wednesday 6th April 2022

Title of report	COVID-19 National Inquiry update
Report author(s)	Anne Moore, Director of Infection Prevention Control (DIPC), Deputy Chief Nurse
Executive Lead (if different from above)	Gary O'Hare, Chief Nurse / Accountable Executive Officer

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention, and resilience	X
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	N/A
Audit	N/A
Mental Health Legislation	N/A
Remuneration Committee	N/A
Resource and Business Assurance	N/A
Charitable Funds Committee	N/A
CEDAR Programme Board	N/A
Other/external (please specify)	N/A

Management Group meetings where this item has been considered (specify date)	
Executive Team	N/A
Corporate Decisions Team (CDT)	N/A
CDT – Quality	N/A
CDT – Business	N/A
CDT – Workforce	N/A
CDT – Climate	N/A
CDT – Risk	N/A
Business Delivery Group (BDG)	N/A

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	X
Workforce	X	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience, and effectiveness	X	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to
N/A

COVID-19 National Inquiry Briefing
Report to the Board of Directors
Wednesday 6th April 2022

1. INTRODUCTION

The Government announced in December 2021 that the National Covid19 Inquiry will be chaired by Baroness Hallett.

It will be an independent public inquiry on a statutory basis with full powers under the Inquiries Act of 2005, including the ability to compel the production of all relevant materials and take oral evidence in public under oath.

It will examine, consider, and report on preparations and the response to the pandemic in England, Wales, Scotland, and Northern Ireland, up to and including the inquiry's formal setting-up date. In doing so, it will consider reserved and devolved matters across the United Kingdom.

2. TERMS OF REFERENCE

The draft terms of reference for the COVID-19 Public Inquiry were issued on the 10th of March, following consultation with the Chair and ministers in the devolved administration. Consultation closes on the 7th April 2022. These are wide-ranging and cover:

- Preparedness.
- The public health response including how and when decisions were made.
- The response in the health and care sector including issues or capacity and resilience.
- Our economic response.

3. AIMS OF THE INQUIRY

3.1 Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account. Including:

In relation to central, devolved, and local public health decision-making and its consequences:

- preparedness and resilience.
- how decisions were made, communicated, and implemented.
- intergovernmental decision-making.
- the availability and use of data and evidence.
- legislative and regulatory control.
- shielding and the protection of the clinically vulnerable.
- the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings.
- testing and contact tracing, and isolation.
- restrictions on attendance at places of education.
- the closure and reopening of the hospitality, retail, sport and leisure sectors, and cultural institutions.

- housing and homelessness.
- prisons and other places of detention.
- the justice system.
- immigration and asylum.
- travel and borders; and
- the safeguarding of public funds and management of financial risk.

3.2 The response of the health and care sector across the UK, including:

- preparedness, initial capacity, and the ability to increase capacity, and resilience.
- the management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels.
- the management of the pandemic in care homes and other care settings, including infection prevention and control, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, and changes to inspections.
- the procurement and distribution of key equipment and supplies, including PPE and ventilators.
- the development and delivery of therapeutics and vaccines.
- the consequences of the pandemic on provision for non-COVID related conditions and needs
- provision for those experiencing long-COVID

3.3 The economic response to the pandemic and its impact, including government interventions by way of:

- support for businesses and jobs, including the Coronavirus Job Retention Scheme, the Self-Employment Income Support Scheme, loans schemes, business rates relief and grants.
- additional funding for relevant public services
- benefits and sick pay, and support for vulnerable people.

3.4 Identify the lessons to be learned from the above, thereby to inform the UK's preparations for future pandemics.

In meeting these aims, the inquiry will:

- listen to the experiences of bereaved families and others who have suffered hardship or loss because of the pandemic. Although the inquiry will not investigate individual cases of harm or death in detail, listening to these accounts will inform its understanding of the impact of the pandemic and the response, and of the lessons to be learned
- highlight where lessons identified from preparedness and the response to the pandemic may be applicable to other civil emergencies

- consider the experiences of and impact on health and care sector workers, and other key workers, during the pandemic
- consider any disparities evident in the impact of the pandemic and the state's response, including those relating to protected characteristics under the Equality Act 2010 and equality categories under the Northern Ireland Act 1998, as applicable
- have reasonable regard to relevant international comparisons
- produce its reports (including interim reports) and any recommendations in a timely manner.

4. KEY ACTIONS TAKEN TO DATE

- Trust Inquiry team led by Executive Chief Nurse in place – includes representation from Information Governance, Caldicott, Gold Command key personnel, EPRR and Communications Team.
- Appointed an Inquiry Lead – confirmed that Anne Moore DIPC/Deputy Chief Nurse will be retiring and return to oversee the process.
- 'Stop notice' - has been issued to all staff to prevent the destruction of evidence.
- Processes in place for recording contact details for leavers and key personnel?
- Commenced collating and sequencing documentation "relevant" to the Terms of Reference for possible:
  - Disclosure to the Inquiry
  - Referencing in statements, reports or evidence

5. TRUST PLAN GOING FORWARD

- Evaluate how the Terms of Reference impact CNTW.
- Consideration of potential co-ordination and co-operation with partner organisations.
- Mapping who CNTW key decision makers were throughout the pandemic to date.
- Ensure key decision makers are on board and understand their duties:
  - Consider CNTW role may have beyond disclosure, including possible Core Participant status
  - Assess what "evidence" CNTW will have for disclosure to the Inquiry
  - Identification "relevant" documentation
- Plans in place to collate, catalogue and sequence information.
  - Plans being developed re storing information to ensure it will be safe from upgrades / data migration.
  - Confirming regular report/update reporting via the Trust governance structures.
- Regular briefings via Communications Team to be agreed to keep staff fully informed and supported

6. RECOMMENDATIONS

Trust Board to receive the update for information and assurance.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
6th April 2022

Title of report	**CNTW Integrated Commissioning & Quality Assurance Report**
Report author(s)	**Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Finance, Commissioning & Quality Assurance**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	30.03.2022
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	28.03.2022
Corporate Decisions Team (CDT)	
CDT – Quality & Safety	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	X
Workforce	X	Environmental	
Financial/value for money	X	Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to

CNTW Integrated Commissioning & Quality Assurance Report 2021-22 Month 11 (February 2022)

Executive Summary

Regulatory Requirement

1 The Trust remains assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework (SOF).

2 At Month 11, the Trust has a surplus of £0.1m which is in line with plan. Agency spend at Month 11 is £18.0m of which £11.2m (62%) relates to nursing support staff and forecast agency spend is £20.0m.

3 The Data Quality Maturity Index (DQMI) score is reported at 92.9% for November which is the latest published data available. The DQMI publication includes data from a number of datasets relevant to the Trust. The DQMI score relating to the Mental Health Services Dataset (MHSDS) only is reported at 91.9% (November 2021) for CNTW.

4 Information Governance training is reported at 85.7% at the end of February 2022 against a 95% standard across CNTW services.

5 There were 350 inappropriate adult out of area bed days due to the unavailability of adult acute and adult older persons beds reported in February 2022. This related to fifteen patients.

6 In Sunderland IAPT service, percentage of clients moving to recovery has decreased slightly during the month and is reported at 62.9%, 63.0% in January 2022. The North Cumbria IAPT service moving to recovery rate has increased to 55.1% for the month, 52.9% in January. The national standard is 50%.

7 At month 11, 92.3% of referrals to Early Intervention in Psychosis (EIP) started treatment within 2 weeks of referral against a 60% standard.

8 The number of follow up contacts conducted within 72 hours of discharge from an inpatient ward is reported above the 80% standard at 92.5% across CNTW. A total of ten patients were not seen within the required timescale trust wide.

9 Referral to treatment (RTT) incomplete pathways for consultant led services waiting 18 weeks or less are reported at 99.2%.

10 Children and Young Peoples Eating Disorder Services waiting times are reported nationally on a quarterly basis for both routine and urgent referrals. The national standard for both is 95%. The Trusts latest reported figures are:

- Waiting times for routine referrals (seen within 4 weeks) at Quarter 4 to date is reported at 69.0%, (at Quarter 3, 77.8% reported nationally for CNTW against 66.4% reported for England).

- Waiting times for urgent referrals (seen within 1 week) at Quarter 4 to date is reported at 90% (at Quarter 3, 97.3% reported nationally for CNTW against 59.0% reported for England).

11 There have been four Mental Health Act Reviewer visits since the last report to Longview, the KDU (Cheviot, Wansbeck, and Lindisfarne), Riding and Brooke House. Feedback from the visits include communication, environmental issues, staffing levels and delayed discharges or bed management issues.

The action plans relating to these visits are owned by the relevant service and the Associate Director is responsible for following up on actions until the action plan is complete through their CMT/CBU. The CQC Compliance Officer routinely receives updates on all outstanding action plans and these are collated and shared with the Mental Health Legislation Steering Group and Mental Health Legislation Committee on a quarterly basis. The Associate Director/CBU must provide evidence to the CQC Compliance Officer to support the closure of any action contained in the action plan. The CQC Reviewer Group considers all action plans and adds in any additional overarching information where relevant prior to sign off by the Group Director/Group Nurse Director for the relevant locality group.

The themes from these visits are taken to CQC Quality Compliance Group on a monthly basis and Mental Health Legislation Steering Group and Mental Health Legislation Committee on a quarterly basis.

Contractual Requirement

1 The Trust met all local CCG's contract requirements for month 11 with the exception of:

- CPA metrics for all CCGs.
- Delayed Transfers of Care within Newcastle/Gateshead, South Tyneside, Sunderland and North Cumbria.
- Current service users with a valid ethnicity completed within the Mental Health Services Data Set (MHSDS) in North Tyneside.
- 72 hour follow up in North Tyneside.
- IAPT numbers entering treatment in Sunderland and North Cumbria.

2 The Trust met all the requirements for month 11 within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (94.6% under performance relating to 3 patients against a 100% target).

3 All CQUIN schemes for 2021/22 are suspended due to the COVID-19 pandemic.

4 The overall FFT satisfaction score for February 2022 was reported at 89.5%, this was based on the number of responses received from service users and carers who stated their overall experience with CNTW services was either good or very good. The number of Points of You survey returns received was 173, of which 70% were from service users, 19% from carers, 8% were completed on behalf of a service user and 3% did not state their person type.

Internal Reporting

1 Adult and Older Persons waiting times are reported internally and are calculated from the referral received date to the first attended direct contact, the wait calculation will reset on the first did not attend (dna) appointment, any further dna's or cancelled appointments do not stop the waiting time.

As at 28th February 2022 there were a total 4992 people waiting to access services in non-specialised adult services across CNTW of which, 190 people have waited more than 18 weeks. This is an increase from 4383 people waiting to access non-specialised adult services last month of which 174 were reported waiting over 18 weeks.

2 CYPS waiting times from referral to treatment are reported in line with the national definition. The wait to treatment is calculated from referral received date to second contact and both contacts can be either direct (e.g. face to face, telephone) or indirect contacts (e.g. Multi-Disciplinary meeting where the service user is not present or a discussion with another care professional).

This month there has been an increase in the total number of CYP waiting more than 18 weeks to treatment, reported at 1834 as at 28th February 2022 compared to 1636 as at 31st January 2022. The number of young people waiting to access children's community services overall has increased in month 11.

3 Training topics below the required trust standard as at month 11 are listed below:

Training Topic	Month 11 position	Quarter 4 standard
Information Governance	85.7%	95%
PMVA Breakaway training	71.2%	85%
Mental Health Act combined	63.2%	85%
Clinical Risk and Suicide Prevention training	75.2%	85%
Clinical Supervision	77.7%	85%
Seclusion training	69.9%	85%
Rapid Tranquilisation	79.3%	85%
Safeguarding Children Level 2	77.3%	85%
Safeguarding Children Level 3 **For completion by all professionally registered staff*	76.5%	85%
Safeguarding Adults	81.2%	85%
PMVA Basic training	39.7%	68%
Fire Training	82.3%	85%
Medicines Management Training	83.7%	85%
MHCT Clustering	57.9%	85%

4 Appraisal rates are reported at 67.0% in February 2022 (67.1% last month) against a 85% standard Trustwide.

5 Clinical supervision training is reported at 77.7% for February (was 77.7% last month), showing a sustained position towards an 85% standard for Quarter 4. The percentage of staff with a completed clinical supervision record is reported at 40.7% as at 28th February 2022. At 28th February 2022 the proportion of staff with a management supervision recorded in the last 3 months is reported at 49.8%.

6 The confirmed January 2022 sickness figure is 9.8%. This was provisionally reported as 10.55% in last month's report. The provisional February 2022 sickness figure is 7.44% which is above the 5% standard. The 12 month rolling average sickness rate has increased to 6.94% in the month.

7 The quality priorities at month 11 have been internally assessed as:

- Improving the inpatient experience and improving waiting times for referrals to multidisciplinary teams have been assessed as not achieved.
- Increasing time staff are able to spend with service users and carers and Equality, Diversity & Inclusion and Human Rights have been assessed as partially achieved.

Other Reporting

1 There are currently 16 notifications showing within the NHS Model Hospital site for the Trust.

Regulatory	**Single Oversight Framework**			
	1	The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy).	Use of Resources Score:	2
	CQC			
	Overall Rating	Number of "Must Dos"	There have been four Mental Health Act Reviewer visits since the last report to Longview, the KDU (Cheviot, Wansbeck, and Lindisfarne), Riding and Brooke House. Feedback from the visits include communication, environmental issues, staffing levels and delayed discharges or bed management issues.	
	Outstanding	45		

Contract	**Contract Summary: Percentage of Quality Standards achieved in the month:**							
	NHS England	Northumberland CCG	North Tyneside CCG	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	North Cumbria CCG
	94%	90%	70%	70%	80%	86%	87%	50%

Contract Summary: Percentage of Quality Standards achieved in the month:									
Cirrhosis & fibrosis tests for alcohol dependant patients	Staff Flu Vaccinations	Use of specific Anxiety Disorder measures within IAPT	Routine outcome monitoring in CYPS & Perinatal MH Services	Routine outcome monitoring in Community Mental Health Services	Biopsychosocial assessment by Mental Health Liaison Services	Healthy Weight in Adult Secure Services	Achieving high quality 'formulations' for CAMHS inpatients	Mental Health for Deaf	Routine outcome monitoring in perinatal inpatient services
All CQUIN schemes are currently suspended for 2021/22									

Internal	**Accountability Framework**							
	North Locality Care Group Score: February 2022		Central Locality Care Group Score: February 2022		South Locality Care Group Score: February 2022		North Cumbria Locality Care Group Score: February 2022	
	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements

Quality Priorities: Month 10 internal assessment RAG rating

Improving the inpatient experience	Improve waiting times for referrals to multidisciplinary teams	Increasing time staff are able to spend with service users and carers	Equality, Diversity & Inclusion and Human Rights

Waiting Times

The number of people waiting more than 18 weeks to access services has increased in the month for non-specialised adult services and the number waiting for treatment has also increased. The number of young people waiting to access children's community services overall has increased in month 11. The number of young people waiting over 18 weeks has also increased. There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group have developed action plans which continue to be monitored via the Business Delivery Group and the Executive Management Team.

Workforce

Statutory & Essential Training:

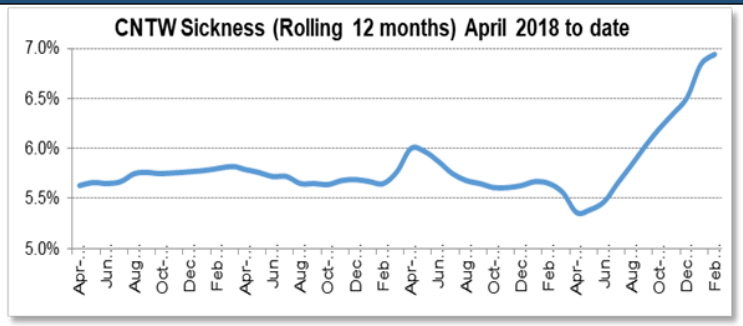
Number of courses Trajectory Achieved Trustwide:	Number of courses <5% below trajectory Trustwide:	Number of courses trajectory not achieved (>5% below standard):
5	3	11

Fire training (82.3%), Safeguarding Adults training (81.2%) and Medicine Management training (83.7%) are within 5% of the Quarter 4 standard. Safeguarding Children Level 3 (76.5%) Clinical Risk training (75.2%), Clinical Supervision training (77.7%), Safeguarding Children Level 2 (77.3%), Rapid Tranquilisation training (79.3%), PMVA basic training (39.7%), PMVA Breakaway training (71.2%), MHA combined training (63.2%), MHCT Clustering Training (57.9%), Seclusion training (69.9%) and Information Governance (85.7%) are reported at more than 5% below the Quarter 4 standard.

Appraisals:

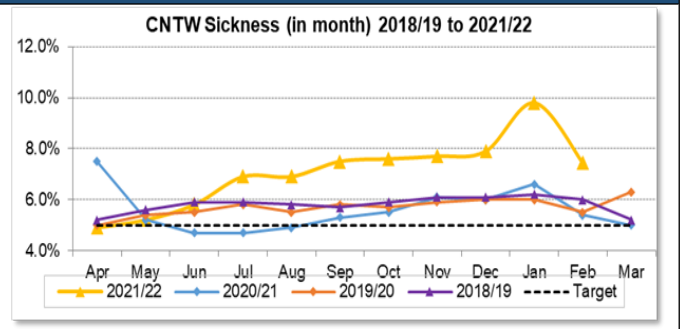
Appraisal rates have decreased in the month to 67.0% in February 2022 (was 67.1% last month).

Sickness Absence:



The provisional "in month" sickness absence rate is above the 5% target at 7.44% for February 2022

The rolling 12 month sickness average has increased to 6.94% in the month



Finance

At Month 11, the Trust has a surplus of £0.1m which is in line with plan and the forecast year-end position is breakeven which is also in line with plan. Agency spend at Month 11 is £18.0m of which £11.2m (62%) relates to nursing support staff and forecast agency spend is £20.0m.

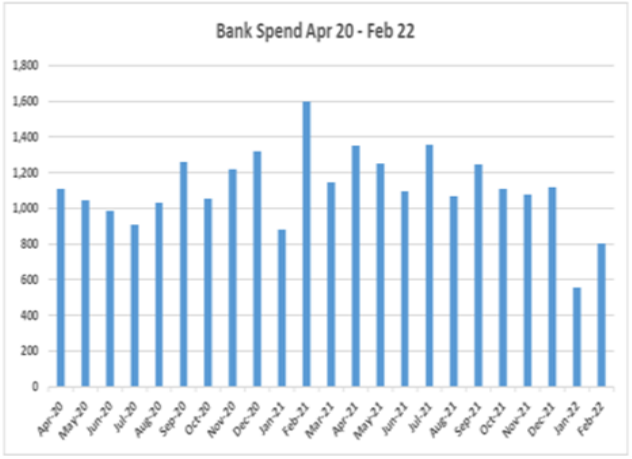
Financial Performance Dashboard

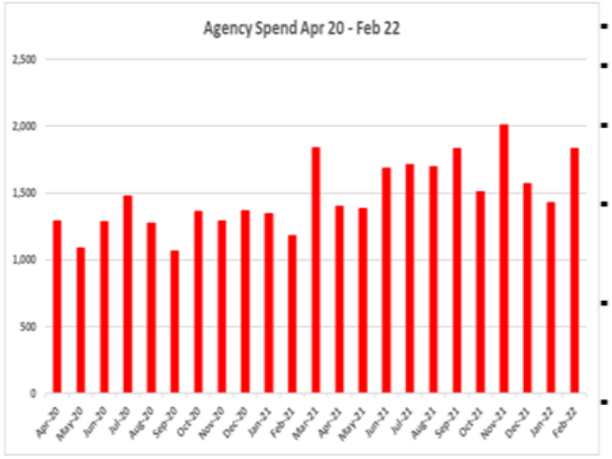
Income & Expenditure

	YTD			FORECAST		
	Plan £m	Actual £m	Variance (£)	Plan £m	Actual £m	Variance (£)
Income	453.0	471.6	(18.7)	495.2	520.4	(25.2)
Pay	(321.7)	(330.7)	8.9	(351.5)	(361.9)	10.4
Non Pay	(131.2)	(140.8)	9.7	(143.7)	(158.6)	14.9
Surplus / (Deficit)	**0.1**	**0.1**	**(0.1)**	**0.0**	**0.0**	**(0.0)**

Key Indicators

Key Indicators	Year To Date	Forecast
Surplus/ (Deficit)	£0.1m	£0.0m
Agency Spend	£18.0m	£20.0m
Cash	£68.4m	£65.0m
Capital Spend	£29.2m	£37.3m





Key Issues/Risks.

- At month 11 the Trust has a £0.1m surplus which is in line with plan.
- The plan and forecast for the year is to deliver break-even.
- Income arrangements for H2 are a continuation of the block contracts implemented in 2020/21 in response to COVID.
- Pay costs in month 11 have increased due to a significant increase in overtime payments. Over time has increased over the last 3 months by £1m a month with bank costs reducing by £0.3m.
- The Trust is the Provider Collaborative lead for the North East & Cumbria for Specialist CYPs services and Adult Secure services. As a result the Trust is managing an additional £53m income and expenditure in 2021/22.
- Cash – £68.4m at month 11 which is more than historical cash levels (pre-COVID) due to improved working balances, capital spend being less than plan both this year and in 2020/21 and increases in provisions.
- Capital Spend - £29.2m at month 11 which is £13.6m less than plan. Forecast spend is £37.3m which is £10.0m less than plan, of which £8.7m relates to the CEDAR programme. The Trust have agreement for PDC relating to this to be carried forward from 2021/22 to 2022/23.

Reporting to NHSI – Number of Agency shifts and number of shifts that breach the agency cap

	31/01/2022		07/02/2022		14/02/2022		21/02/2022	
Medical	153	110	129	80	118	81	128	91
Qual Nursing	196	142	160	109	153	95	174	119
Unq Nursing	1,942	144	1,885	96	2,002	80	2,111	102
A&C	65		55		43		43	
	2,356	**396**	**2,229**	**285**	**2,316**	**256**	**2,456**	**312**

In February the Trust reported an average of 312 price cap breaches (91 medical, 116 qualified nursing and 106 nursing support). At the end of February 15 medics were paid over the price cap.

Risks and Mitigations associated with the report

- There is a risk of non-compliance with CQC essential standards and the NHS Improvement Oversight Framework.
- The Trust did not meet all the commissioning standards across all local CCG's and NHS England at month 11.
- The trust moved to OPEL Level 3 on the 5th January 2022, leading to a further risk to compliance against trajectories and standards. On 7th February 2022 the Trust moved back to OPEL Level 2 but the performance management of training and appraisals with the exception of PMVA remain stood down.
- There continues to be over 18 week waiters across services. Work continues to monitor and improve access to services across all localities.
- Please note the change in requirement and reporting due to COVID-19 are not reflected in this report.
- Quality and training standards have been impacted as a consequence of responding to COVID-19.

Recommendations

The Board of Directors are asked to note the information included within this report

Allan Fairlamb	Lisa Quinn
Deputy Director of Commissioning & Quality Assurance	Executive Director of Commissioning & Quality Assurance
17th March 2022	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
Wednesday 6th April 2022

Title of report	**2022-23 Annual Plan**
Report author(s)	**Anna Foster** **Trust Lead for Strategy and Sustainability**
Executive Lead (if different from above)	**Lisa Quinn** **Executive Director of Finance, Commissioning & Quality Assurance**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	x	Work together to promote prevention, early intervention and resilience	x
To achieve "no health without mental health" and "joined up" services	x	Sustainable mental health and disability services delivering real value	x
To be a centre of excellence for mental health and disability	x	The Trust to be regarded as a great place to work	x

Board Sub-committee meetings where this item has been considered (specify date)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance		Executive Team	x
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board		CDT – Risk	
Other/external (please specify)		Business Delivery Group (BDG)	x

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability	x	Reputational	x
Workforce	x	Environmental	x
Financial/value for money	x	Estates and facilities	x
Commercial	x	Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, carer and stakeholder involvement	x

Board Assurance Framework/Corporate Risk Register risks this paper relates to
All

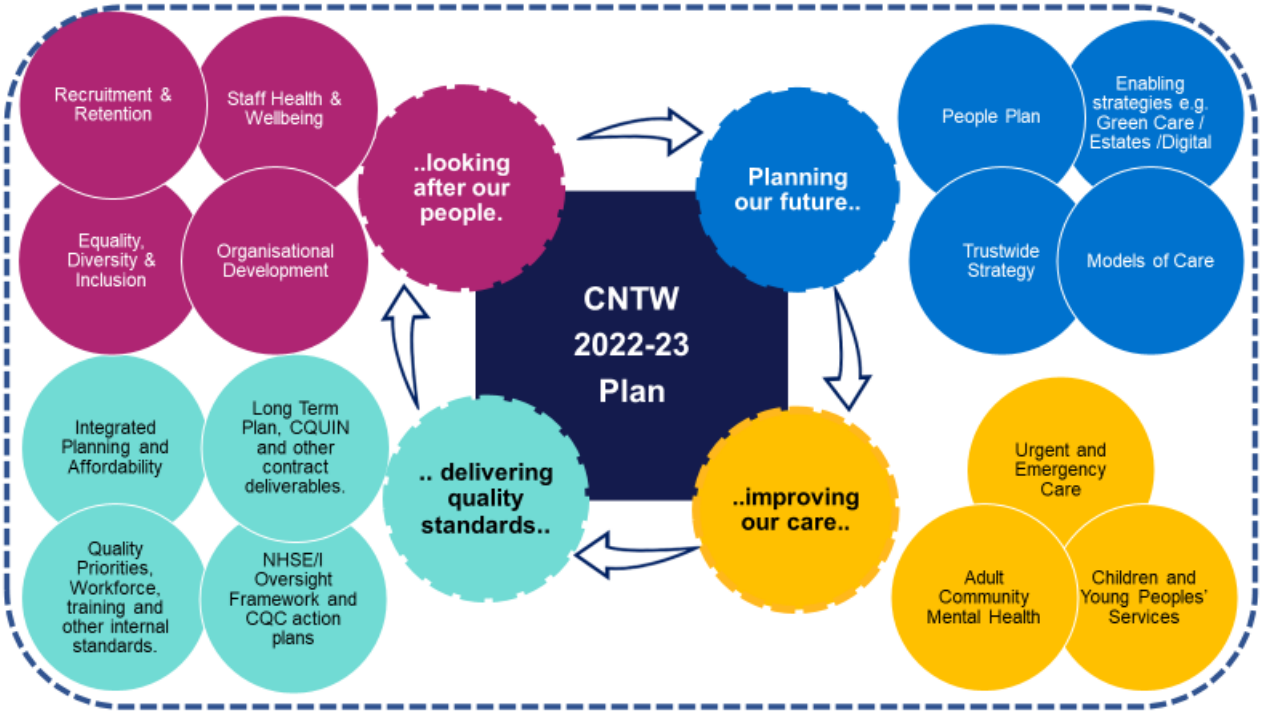
Board of Directors
Wednesday 6th April 2022
2022-23 Annual Planning

Overview

1. This paper serves as the CNTW 2022-23 Annual Plan which is presented to Board for approval, building upon the draft previously considered at Trust Board in March 2022. Contextually, this paper is ideally read in conjunction with the Board Quality Priorities and Finance updates.
2. The purpose of the Annual Plan is to articulate the organisation's key priorities for the year ahead to support decision-making throughout the organisation during what is likely to be a challenging, transitional year. Considerable uncertainty remains as the health and social care system attempts to restore operational capacity while learning to live with COVID.
3. On this basis it's important to note that the priorities and deliverables described in this paper are as at *this point in time.* Therefore, the plan is emergent rather than fixed and will adapt throughout the year in response to changing circumstances. For this reason, the plan's progress is best measured and reported based on evidence of impact.
4. Note that 'business as usual' activities are excluded from the planning.
5. The paper also contextualises the plan's *current* underpinning assumptions, drivers, risks and mitigations, which will be reviewed on an ongoing basis using an integrated planning approach spanning the four principles below.
6. The core principles guiding 2022-23 planning are:
    - Planning our future,
    - Improving our care,
    - Delivering quality standards, and
    - Looking after our people.
7. Also guiding the 2022-23 planning and challenges are our values, which are to be:
    - Caring and compassionate,
    - Respectful,
    - Honest and Transparent.

2022-23 Annual Planning Framework

8. The 2022-23 planning comprises 15 interconnected elements, grouped under four themes as shown in the diagram below:



2022-23 Annual Planning Key Aspirations

9. Continuing the organisation's ambition and longstanding commitment to high standards of care, the 22-23 Annual Plan aspires to:

   a. protect and improve workforce wellbeing and retention, attract new staff and tackle workplace discrimination and return to a collective, devolved leadership model;

   b. reduce temporary staffing and recruit to vacancies which have been exacerbated by 1) shortages of qualified staff and 2) large numbers of existing staff leaving established services to take-up newly funded posts which support delivery of the Long Term Plan;

   c. improve delivery of regulatory compliance and quality standards by existing services, working to improvement trajectories based on previous activity growth while also developing new models of care with new quality standards to support the Long Term Plan. Delivery of quality standards is dependent upon the re-establishment of improvement initiatives (see part 2 of the plan);

   d. achieve financial balance by returning to pre-COVID staffing and absence levels.

   e. agree and implement a new Trustwide strategy and made significant progress towards the development of an underpinning service strategy.

10. The next section of the report provides an overview of each of the four elements of the plan.

2022-23 Annual Planning Part One – Planning Our Future…

(Further detail in Appendix 1)

11. The management challenge currently faced by the organisation is how to manage differently today while planning for a better tomorrow. The immediate needs of improving care within the current system, keeping people safe, meeting minimum quality and financial standards must be balanced with activity to deliver longer-term improvements in care and strategic issues.
12. Successfully delivery of the NHS Long Term Plan is dependent on radical changes to models of care, a systems approach and relationship building to improve partnership working, both inter- and intra- organisations and across the whole sector including local authorities, patient groups and the independent/voluntary/charity sectors.
13. To facilitate the change in culture needed to adapt to the above challenges, the next CNTW strategy will be focussed on leadership, our role in the system and how we work together with all stakeholders across the system. A compassionate leadership approach will encompass the inclusive, collaborative, collective, learning approach that is needed to achieve this paradigm shift.
14. The CNTW2030 engagement campaign has explored stakeholder views on what matters to inform a future vision of the organisation. The feedback received has been themed and aligns with issues already identified through existing service user, carer and staff feedback mechanisms.
15. A draft Trust wide strategy will be brought to the Trust board for approval by the end of September 2022. Focussing on issues that all CNTW staff have in common, the strategy will set out values, vision and principles to describe the desired culture and ways of working. Following Board approval, stakeholder engagement will take place to ensure widespread understanding of the strategy and its aims, to ensure this awareness informs everyday behaviours and decision-making.
16. The culture focussed Trust wide strategy will be supported by range of key underpinning strategies. It is envisaged that the existing quality improvement programmes will develop into a service strategy which will in turn inform the development of refreshed workforce, estates, digital and other enabling strategies.
17. The strategic framework will be refreshed to complement the new strategy, to ensure that future priorities across the organisation align with the vision and strategic aims.

…

2022-23 Annual Planning Part Two – Improving Our Care…

(Further detail in Appendix 2)

18. Key existing programmes of work to be re-established are:
    a. Community adult mental health transformation
    b. Urgent and Emergency Care and adult mental health inpatient care.
    c. Services for Children and Young People
19. These are underpinned by cross-cutting themes including: Partnership Working, Learning Disability Needs, Autism and Neurodiversity, Substance Misuse.
20. All programmes acknowledge the need for core services to reset and stabilise post Covid and the need for clarity on the recovery position for a number of core community and inpatient pathways going into 2022-23.
21. Work is ongoing to look beyond immediate plans to set out the desired impact and change within the next 12 months, engaging and resonating with front line teams to deliver sustained improvement.
22. Appendix 2 describes key programme deliverables, which have been aligned with quality standards or proposed 2022-23 Quality Priorities. Contract service development improvement plans, which are currently being negotiated, should align with these programmes of work.

…

2022-23 Annual Planning Part Three – Delivering Quality Standards…

(Further detail in Appendix 3)

23. The requirement to meet internal workforce/training standards and external contractual requirements were largely suspended during the last two years to support the pandemic response. Despite this, operational services have on the whole maintained a high level of achievement against national requirements, although many internal standards are currently below standard in line with OPEL working.
24. Trajectories to improve from the current position against quality standards this year have been agreed and external NHS Standard contract requirements are being re-established, marking the return of CQUIN, service/data improvement schemes and external scrutiny of quality standards.
25. The Care Quality Commission have continued to regulate services throughout the pandemic and actions to address issues arising are detailed in the Board CQC Quarterly Report.
26. The Trust continues to be assessed as having no specific support needs via the NHS Improvement/England NHS System Oversight Framework.

27. A comprehensive list of all internal and external quality standards is included at **Appendix 3,** alongside a summary of current achievement/baseline and any agreed or draft improvement trajectories, recognising that some standards may not be achievable this year. There are seven separate elements to this section, reflecting the range of standards**.** NB Further details of Internal Quality Priorities are presented to Board for approval via a separate report.
28. Progress towards these standards will be reported via the monthly Board Commissioning and Quality Assurance Report and is partly dependent upon ongoing service improvement activity described in the next section.

...

2022-23 Annual Planning Part Four – Looking After Our People...

(Further detail in Appendix 4)

29. This element of the planning aligns with the NHS People Plan and focusses on:
    - workforce health and wellbeing,
    - recruitment and retention,
    - equality, diversity and inclusion and
    - organisational development.
30. Operational pressures remain significant due to underlying vacancies plus pandemic-related issues including elevated absence rates, COVID-safe working practices, outbreak management and general fatigue. The Recruitment and Retention programme seeks to alleviate some of these pressures (including international recruitment) and support for existing staff is to be bolstered via the continuing Health and Wellbeing initiatives.
31. Following the necessary Command-and-Control leadership approach to managing during the pandemic, the organisation is returning to a collective, devolved leadership model. The Organisational Development offer will be reviewed to support this shift and to ensure alignment with the Trust's next strategy.
32. Tackling all forms of discrimination remains a priority and implementing inclusive recruitment processes will support the staff recruitment and retention programme while seeking to increase the diversity of the workforce.
33. The EMPOWER programme to raise awareness among staff of approaches to protect human rights and reduce restrictive interventions is linked to this element of the plan. These form a quality priority relating to the Quality Safety Goal and further detail is provided separately via the Quality Priorities Board paper.

.

2022-23 Annual Planning Risks and Mitigations

35. Risks and mitigations based on risk appetite categories (see Appendix 5) are set out overleaf.

36. Workforce is not a category within the risk appetite framework. Therefore workforce-specific risks and mitigations include:

    f. Workforce overwhelm or demotivation if the links between the different elements of the plan, actions to achieve financial balance in-year or external system pressure to improve quality standards are not adequately articulated and understood by the wider workforce. This risk can be mitigated by clear communications and clarity of expectations to align all organisational objectives with the Annual Plan in alignment with workforce intrinsic motivation.

    g. Management capacity may be eroded by the requirement to achieve financial balance, reduce operational pressures and improve quality standards in existing services or models of care while also developing or supporting new services or models of care in line with the Long Term Plan. This risk will be mitigated by Business Delivery Group oversight of the improvement initiatives and the ongoing reestablishment of collective, devolved leadership.

Further risk, mitigations and any other relevant information by risk category

37. The table below highlights other issues and risks based on risk appetite categories:

Risk categories with LOW risk appetite:	Risk Categories with MODERATE or HIGH risk appetite:
Quality Effectiveness, Experience, Safety Continuing absence levels, vacancies and ongoing demand pressures risk all aspects of quality. Risks include safety implications arising from overoccupancy of inpatient beds, increases in both waiting times and numbers waiting, and general deterioration in care provision. These risks are mitigated via existing operational oversight and integrated planning by subject experts.	**Clinical Innovation** There is a risk that an emphasis on financial delivery or reduced workforce autonomy may inhibit clinical innovation. Lack of headroom to consider different ways of working may result in incremental change rather than significant, co-produced redesign of existing service models. This risk is mitigated by management oversight of the improvement programmes.
Compliance/Regulatory The quality risks outlined briefly above may risk achievement of new or existing quality standards, The risk of non-delivery of CQC standards or action plans is mitigated via the CQC Compliance Group. Reductions in quality standards could lead to increased scrutiny via NHS England/Improvement via the Oversight Framework – this risk is mitigated by the internal Accountability Framework.	**Financial/Value for money** There is a risk of financial pressure if services are unable to return to pre-COVID expenditure levels due to ongoing pandemic impact and demand. This risk is mitigated by 1) a revised approach to managing COVID and 2) delivery of the improvement programmes in inpatient and community services.
Climate and Ecological Sustainability There is a risk to the delivery of the Trust Green Plan objectives if stretched management capacity leads to deprioritisation of this agenda. This risk is mitigated by CDT subgroup oversight.	**Reputation / Commercial** There is a risk of reputational damage resulting from deterioration of quality or safety.
	Partnerships, including new system working (ICS, ICP and PLACE) Effective system working may be impaired by 1) lack of management capacity to work collaboratively, or 2) pressure on relationships with Primary Care/Commissioners due to quality issues. This risk is mitigated by CNTW Group leadership participation at Place.

2022-23 Annual Planning System Submissions and Integrated Planning

38. System level planning requires Trusts to submit planned 2022-23 activity, quality, workforce and finance data to NHS England/Improvement.

39. Draft finance, activity, quality and workforce planning summaries were submitted during March 2022. Please see Appendix 2 for more detail of improvement trajectories submitted to meet required quality standards and underlying assumptions about growth and improvement at ICS level and note that a separate Trust Board paper provides further detail of these submissions, which declare a breakeven financial position based on the information contained within this Annual Plan.

40. Based on anticipated 2022-23 expenditure levels, the net increase in workforce compared with January 2022 would be an additional c121 whole time equivalents (including a large shift from nursing support posts to registered nurses). Note: 1) this figure will reduce in line with reductions in planned expenditure to achieve financial balance and 2) there is a risk to achievement of this position as it assumes successful recruitment into vacant posts yet currently there are difficulties in recruiting qualified staff due to national shortages.

41. All final submissions to NHS England/Improvement are due in April 2022 alongside a separate workforce planning submission required by Health Education England. The delivery of these plans is dependent upon a number of factors including a return to pre-COVID staffing and absence levels, recruitment to vacancies and efficiency/productivity gains facilitated via the quality improvement programmes.

42. Following the submission of 'final' system plans in April 2022, integrated planning will continue within CNTW to assess and model delivery of ongoing finance, activity, workforce and quality standards, marking a shift towards annual planning becoming an ongoing, iterative process.

2022-23 Annual Planning Monitoring and Assurance Reporting

43. Existing Board reports will be complemented by a quarterly report to provide assurance to the Board of combined progress across all four interconnected elements of the Annual Plan, based on evidence of impact.

Next Steps

44. To reiterate, this plan should be considered ongoing and emergent. Work continues to:

- evaluate the organisation's ability to deliver requirements described in this paper, and
- ensure integrated planning processes facilitate the informed decision-making necessary in challenging times. This will support prioritisation where needed.

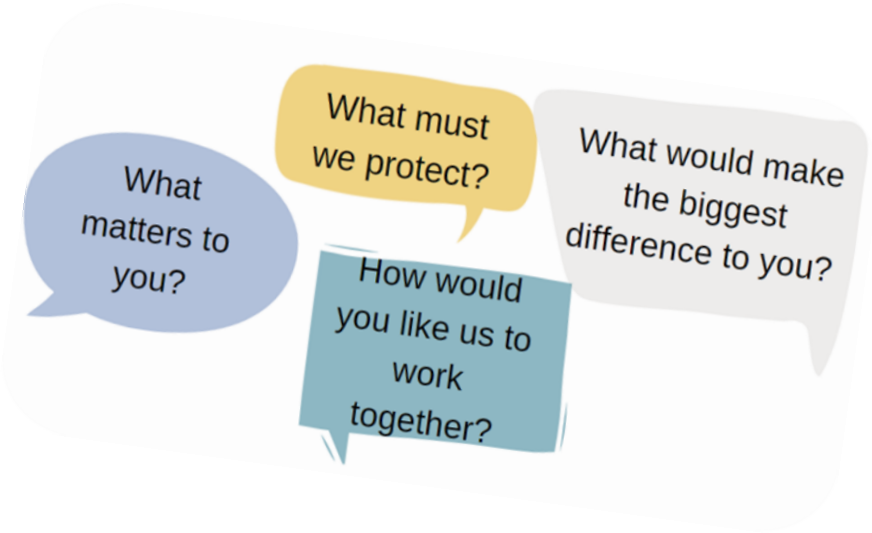
Recommendations

45. The Trust Board are asked to consider and approve this report as the starting version of the 2022-23 Annual Plan.

Anna Foster
Trust Lead for Strategy and Sustainability
29 March 2022

Appendix 1 Planning Our Future – CNTW Feedback to date:

We asked service users, carers, staff and anyone else who works with us:



Appendix 2 Improving Our Care 2022-23 Deliverables

MENTAL HEALTH EMERGENCY & HOSPITAL CARE	COMMUNITY MENTAL HEALTH	CHILDREN AND YOUNG PEOPLE
SCOPE: Improve the inpatient experience, enhance patient flow and maximise the effectiveness of urgent crisis and liaison services.	**SCOPE:** Development of integrated models of care with partners to improve access to assessment and treatment.	**SCOPE:** Improve access and experience of CNTW children's services, with a focus on waiting times, transitions, crisis and neurodevelopmental pathways.
✓ Quality standards for emergency access achieved. ✓ Goals for admission achieved. ✓ Reduction in DTOC (Adult & Older Persons) ✓ Reduction in readmission rates. ✓ Crisis alternatives to admission established. ✓ Reduction in Length of Stay. ✓ Reduction in bed occupancy. ✓ Reduction in OATs. ✓ Improved retention of staff. ✓ Reduction in vacant IP nursing positions. ✓ Reduction in bank and agency expenditure. ✓ Improved staff safety and security.	✓ Analysis of community capacity to clarify gaps in capacity & demand. ✓ Improved relationships with primary care. ✓ New CPA arrangements implemented. ✓ New access standards achieved. ✓ Redesign of primary care access to secondary care services. ✓ Easier access to 'step up care' ✓ Priority pathways for improvement agreed with stakeholders. ✓ Reduction in assessment & treatment waits. ✓ Reduction in DNA and Trust cancellations. ✓ Fewer patients admitted for medication titration.	✓ Reduction in length of time children and young people wait for assessment and treatment. ✓ Improvement in patient, family and carer feedback on transition planning. ✓ Successful implementation of CEDAR related changes to CYPS inpatient services. ✓ Reduction in CYPS DTOC. ✓ Reduction in eating disorder delays for admission.

Cross Cutting Themes	Working with our partners at place and across the system
	Learning Disability Needs
	Autism and Neurodiversity Needs
	Addictions Needs
Specialist Provider Collaboratives[1]	Secure Care Services

[1] The deliverables above span the 3 current specialist provider collaboratives – Children and Young People, Secure Care and Adult Eating Disorders.

Appendix 3 Quality Standards

Appendix 3.1 Relevant National Quality Requirements (Standard Contract 22-23)

Ref	Standard	Current Achievement
E.B.3	RTT Percentage of Incomplete (unseen) referrals waiting less than 18 weeks	Achieved
E.B.S.4	RTT 104 weeks wait - zero tolerance	Achieved
E.B.S.1	Mixed-sex accommodation breach >0	Achieved
E.B.S.3	80% 72 hour Follow up from Mental Health inpatient care (excluding specialised services commissioned by NHSE)	Achieved
E.H.4	Early Intervention in Psychosis programmes: 60% Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) to wait less than two weeks to start a NICE-recommended package of care	Achieved
E.H.1	Improving Access to Psychological Therapies (IAPT) 75% of Service Users referred to an IAPT programme to wait six weeks or less from referral to entering a course of IAPT treatment	Achieved
E.H.2	Improving Access to Psychological Therapies (IAPT) 95% of Service Users referred to an IAPT programme to wait 18 weeks or less from referral to entering a course of IAPT treatment	Achieved
TBC	Services for children and young people with an eating disorder, 95% of Service Users designated as routine cases to access NICE concordant treatment within four weeks.	Below Standard
TBC	Services for children and young people with an eating disorder, 95% of Service Users designated as urgent cases to access NICE concordant treatment within one week.	Achieved

Appendix 3.2 Long Term Plan Deliverables and delivery risks:

Assessed as achievable:	
IAPT	Maintain waiting times (75% within 6 weeks; 95% within 18 weeks)
	Maintain 50% recovery rate
EIP	Maintain 60% Activity standard
	70% Level 3 NICE concordance
	Continue to deliver against the 4WW Trailblazer initiative (Northumberland)
Crisis	100% coverage of 24/7 adult CRHT
MH liaison	100% coverage of Liaison Mental Health teams for all ages
Other adult and older adult inpatient mental health	50% of Liaison Mental Health Teams achieving 'core 24' standard
	80% Adult MH inpatients follow up within 72hrs of discharge
	Reducing long length of stay (LoS) for adults in acute inpatient services. No more than 8.0% of adult admissions per 100k to have a LoS over 60 days
	Reducing long length of stay (LoS) for older adults in acute inpatient services. No more than 10.75% of older adult admissions per 100k to have a LoS over 90 days.

Contract Long Term Plan deliverables assessed at risk:	
IAPT	Access rate
	In treatment pathway waits
	LTC service in place for each CCG
SMI Physical Health (adult and older adult)	60% people with SMI receive annual physical health check & follow up
Dementia Diagnosis	Maintain dementia diagnosis rate of 66.7% of prevalence & improve post diagnostic care
Perinatal Community	Access to services. Standard 8.6% live births.
PCN ARRS posts	Recruitment
IPS	People accessing IPS
Personality Disorder	Place-based service models
Adult ED Community	Establishment of new Eating Disorder Community teams
CYP Comm MH services	CYP accessing support by NHS funded services.
CYPS Eating Disorders	95% routine seen within 4 weeks
	95% urgent seen within one week
CYPS Crisis	35% coverage of 24/7 crisis provision for CYP
Alternatives to Crisis	Invest in crisis alternatives (by 2023/24)
Other adult and older adult - inpatient mental health	Improving therapeutic support in adult MH IP (by 2023/24)
	Eliminate OAPs for adult acute care
	Admissions with no previous contact with community MH services – standard 16.3%

Appendix 3.3 DRAFT Activity and quality standard improvement trajectories and assumptions as at March 2022
NB all figures are under feasibility review ICS-wide

Provider Level:

Measure	Average 2022-2023	Q1 2022-2023	Q2 2022-2023	Q3 2022-2023	Q4 2022-2023
Mental Health Services Dataset (DQMI) score	91.5%	90%	91%	92%	93%
72 Hour Follow up	91%	90%	90%	92%	92%
Inappropriate Out of Area Placements (bed days)	43.75	85	60	30	0

ICS level:

Measure	Q1 2022-2023	Q2 2022-2023	Q3 2022-2023	Q4 2022-2023	**ICS** Level trajectory projection assumptions
Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	TBC by ICS				
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	6,286	6,393	6,500	6,607	Projection based on proportional growth of standard line from actual
Dementia Diagnosis Rate	65.7%	66.1%	66.4%	66.7%	Projection based on linear growth to achieve standard by Q4 22/23
CYP Eating Disorders - % rate of routine referrals seen within 4wks	82%	87%	91%	95%	Projection based on linear growth to achieve standard by Q4 22/23. CYP Eating Disorder recovery will be an ICS priority in 2022/23
CYP Eating Disorders - % rate of urgent referrals seen within 1wk	79%	84%	90%	95%	

Measure	Q1 2022-2023	Q2 2022-2023	Q3 2022-2023	Q4 2022-2023	**ICS** Level trajectory projection assumptions
Number of people on the GP SMI registers who have received a physical health assessment in the 12 months	13,056	14,191	16,325	16,460	Projection based on linear growth from actual to 23/24 standard as growth during Covid is an unreliable measure and pre-pandemic no growth seen.
Number of women accessing specialist community Perinatal MH and MMHS services	481	961	1,442	1,923	(YTD figure) Projection based on similar growth rate to that seen in recent actual data
Number of people accessing Individual Placement Services as a rolling total each quarter	531	1,062	1,592	2,123	(YTD figure) Projection based on same growth rate to that seen in previous years
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses	35,914	36,357	36,801	37,244	Aligned to nationally set quarterly trajectories as currently on track
Early Intervention in Psychosis /At Risk Mental State Access Rate	60%	60%	60%	60%	As a minimum the ICS plans to continue to achieve the 60% access rate
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	51,136	51,871	52,606	53,341	Projection based on growth continuing at the same rate currently

Appendix 3.4 2022-23 Financially incentivised Commissioning for Quality and Innovation schemes (CQUIN).

Description	Standard	Newcastle Gateshead	South Tyneside	North Tyneside	Northumberland	Sunderland	North Cumbria
CCG1: Flu vaccinations for frontline healthcare workers	90%	✓	✓	✓	✓	✓	✓
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients	35%	✓	✓	✓	✓	✓	✓
CCG10a: Routine outcome monitoring in CYP and perinatal mental health services	40%	✓	✓	✓	✓	✓	✓
CCG10b: Routine outcome monitoring in community mental health services	40%	✓	✓	✓	✓	✓	✓
CCG11: Use of anxiety disorder specific measures in IAPT	65%					✓	✓
CCG12: Biopsychosocial assessments by MH liaison services	80%	✓	✓	✓	✓	✓	✓

NHS England:

Description	Standard
PSS6: Delivery of formulation or review within 6 weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings	80%
PSS7: Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings – MHSDS Restrictive Intervention Score	80%
PSS8: Outcome measurement in perinatal inpatient services	95% CROM 55% PROM

Appendix 3.5 NHS Improvement/England Oversight Framework metrics: Current Achieved Segment 1

Oversight Theme	Longterm Plan / People Plan headline area	2021/22 planning Guidance deliverable	Measure Name (Metric)	CCG	Trust	ICS
Quality, access and outcomes	Mental health	Deliver the mental health ambitions outlined in the NHS Long Term Plan, expanding and transforming core mental health services	NHS Long Term Plan metrics for mental health	✓	✓	✓
	Delivering safe, high quality care overall		Overall CQC rating (provision of high-quality care)		Outstanding	
			Acting to improve safety (safety culture theme in NHS Staff survey)		88.00%	
			Potential under-reporting of patient safety incidents		✓	
			Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		0	
			Clostridium difficile infection rate		0	
			E. coli bloodstream infections	✓	0	✓
			Venous thromboembolism (VTE) risk assessment		0	
Preventing ill health and reducing inequalities	Screening and vaccination programmes meet base levels in the public health agreement or national goals	First COVID-19 vaccination dose offered to all adults by the end of January	% of adults vaccinated		97.16%	✓
		Flu vaccination	Number of people receiving flu vaccination	✓	66.74%	✓
	Reducing inequalities	Restoring NHS services inclusively	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	✓	✓	✓
		Accelerating preventative programmes	COVID-19 vaccination uptake for black and minority ethnic groups and the most deprived quintile compared to the national average		698	✓
Leadership and capability	Leadership		Quality of leadership†	✓	✓	✓
			Aggregate score for NHS Staff Survey questions that measure perception of leadership culture††	✓	✓	✓

People	People Promise	Supporting the health and wellbeing of staff and taking action on recruitment and retention	People promise index††	✓	✓	✓
	Looking after our people		Health and wellbeing index††	✓	✓	✓
			Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a)	✓	a) 8.0% b) 11.6% c) 28.0%	✓
			Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	✓	43.40%	✓
			Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	✓	68.10%	✓
			% of jobs advertised as flexible	✓	✓	✓
			Staff retention rate (all staff)	✓	89.14%	✓
			Sickness absence (working days lost to sickness) in month	✓	23,824	✓
			Proportion of staff who say they have a positive experience of engagement	✓	✓	✓
			Number of people working in the NHS who have had a 'flu vaccination	✓	6185	✓
	Belonging in the NHS		Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women	✓	✓	✓
			Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	89.20%	✓
	Growing for the future		Number of registered nurses employed by the NHS (WTE)			✓
			Mental health workforce growth	✓		✓
Finance and use of resources	The NHS will return to financial balance: NHS in overall financial balance each year	Systems to manage within financial envelopes	Performance against financial plan	✓	✓	✓
			Underlying financial position	✓	✓	✓
			Run rate expenditure	✓	✓	✓
			Overall trend in reported financial position	✓	✓	✓

Appendix 3.6 Workforce Standards Trustwide Improvement Trajectories (as at 25.03.22)

Name of Training Course	Standard	Current	Q1	Q2	Q3	Q4
3001 - Clinical Risk and Suicide Prevention	85%	74%	77%	81%	84%	85%
3002 - Clinical Supervision	85%	79%	82%	83%	84%	85%
3004 - Equality & Diversity Introduction	85%	91%	85%	85%	85%	85%
3006 - Fire	85%	82%	85%	85%	85%	85%
3008 - Health & Safety	85%	92%	85%	85%	85%	85%
3015 - Infection Prevention & Control - Inoculation Incidents – Hand Hygiene	85%	89%	85%	85%	85%	85%
3018 - Medicines Management Training	85%	84%	85%	85%	85%	85%
3019 - Moving & Handling Awareness	85%	89%	85%	85%	85%	85%
3022 - PMVA Basic	85%	40%	46%	54%	63%	73%
3023 - Rapid Tranquilisation Training	85%	80%	85%	85%	85%	85%
3026 - Safeguarding Adults Level 1	85%	92%	85%	85%	85%	85%
3087 - Safeguarding Adults Level 2	85%	85%	85%	85%	85%	85%
3027 - Safeguarding Children Level 1	85%	91%	85%	85%	85%	85%
3047 - Safeguarding Children Level 2	85%	77%	80%	83%	85%	85%
3046 - Safeguarding Children Level 3	85%	76%				85%
3030 - Information Governance (Data Security Awareness)	95%	86%	95%	95%	95%	95%
3042 - Seclusion Training	85%	70%	75%	79%	82%	85%
3043 - PMVA Breakaway	85%	71%	76%	79%	82%	85%
3075 - MHA MCA DoLS Combined	85%	63%	69%	76%	81%	85%
3501 - Complete Appraisals (JDR's)	85%	66%	72%	77%	83%	85%
3514 - Management supervision recorded	85%	52%	61%	71%	80%	85%
1933 Clinical Supervision records	80%	47%	63%	71%	79%	85%
Dysphagia Awareness	85%	71%	74%	78%	82%	85%
Prevent Training	85%	76%				85%
3089 - Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	85%	54%	72%	77%	81%	85%
3091 - Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year	85%	0%	30%	50%	70%	85%
3092 - Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	85%	47%	58%	69%	81%	85%
3093 - Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	85%	40%				
3094 - Resuscitation - Level 3 - Paediatric Immediate Life Support - 1 Year	85%	0%	0%	85%	85%	85%
Sickness Corporate Induction Local Induction Turnover	<5% 100% 100% <10%					

Appendix 3.7 CNTW 2022-23 Quality Priorities co-produced with service users, carers and partners

Quality Priority 1: Safety **Improving the inpatient experience.**	**Quality Priority 2: Service User and Carer Experience** **Improving waiting times.**	**Quality Priority 3: Patient Care** **Support service users and carers to be heard.**	**Quality Priority 4: Clinical Effectiveness** **Equality, Diversity, Inclusion and Human Rights in relation to the core values of Fairness, Respect, Equality, Dignity and Autonomy (FREDA).**
Improving the inpatient experience by removing barriers to admission and discharge, and improving the therapeutic offer during treatment, through: • Embedding new ways of working relating to admission and discharge processes • Improved Inpatient ward quality standards • Ensuring the purpose of admission and therapeutic offer add value to patient care • Reducing restrictive practice, violence and aggression (EMPOWER)	Improving waiting times in areas where demand currently exceeds capacity through: • Working in partnership with Primary Care to enable better support for patients and carers sooner. • Delivery of a single point of access for North Cumbria CNTW services. • Improved transitions from CYPS to Adult services. • A review of Adult Autism Diagnostic Service (AADS) and Adult Attention Deficit Hyperactivity Disorder Service (AADHDS) pathways. • Gender – Increase capacity through recruitment and retention of staff, developing a community programme with peer support workers and the 3rd sector and develop a clinical model for a Primary Care Trans Health Service with key stakeholders (inc NHSE and GPs).	Support service users and carers to be heard by improving processes and promoting person-centred approaches through: • Promoting an inclusive approach to positive patient engagement and responsiveness. • Co-production of refreshed digital enablers for patients and carers • Monitor and respond to feedback themes	Implement a Trustwide approach working across Locality Groups. The Equality & Diversity Lead, CNTW Academy, Chaplaincy, Commissioning & Quality Assurance, Accessible Information Standard Group and Communications and Staff Networks. (EMPOWER programme)

Appendix 4 Looking after our people key deliverables:

Looking after our people Programme 1 Health and Wellbeing		
Workstream 1 Review staff psychological support & occupational health provision	Workstream 2 Embed CNTW Health & Wellbeing approach	Workstream 3 Safety and Effectiveness Quality Priorities
✓ Develop service specification & undertake tender process. ✓ Review management of sickness absence. ✓ Implement revised service.	✓ Equip line managers to support their own & team wellbeing through collective leadership & embedding wellbeing conversations. ✓ Interpret & adopt NHS HWBE Framework standards. ✓ Utilise workforce analytics to inform decision making. ✓ Support staff use of alternative modes of transport, e.g. cycle-to-work scheme. ✓ Support uptake of physical wellbeing initiatives & tools e.g. on site health checks. ✓ Proactively offer menopause support to staff through manager & staff training & informal network. ✓ Provide opportunities for all staff to increase their financial awareness & plan for the future. ✓ Analyse flexible working practices/requests (via ESR) to support improvement. ✓ Increase staff financial awareness & planning.	Keeping people safe through ✓ Reducing Violence and Aggression ✓ EMPOWER programme to reduce restrictive practice

Looking after our people Programme 2: Organisational Development			
Workstream 1 Review organisational development approach	Workstream 2 Collective Leadership & Devolution	Workstream 3 A learning culture	Workstream 4 Leadership & management development
✓ Review current OD offer in line with new Trust strategy.	✓ Establish framework for team development plus team coaching capacity & capability. ✓ Collective leadership management development programme rolled out Trust wide.	✓ Approval to develop /embed a learning culture programme (e.g. partnership with Centre for Public impact). ✓ Staff Surveys – collaborative identification of 3 shared Trust priorities & locality-based priorities. ✓ Implementation of locality-based staff survey engagement plans. ✓ Relaunch Trust Improvement Collaborative (TIC).	✓ Launch Springboard Development Programmes for staff with protected characteristics. ✓ Pilot bitesize Managing People programmes. ✓ Launch CNTW Development Forum to ensure leadership & development opportunities for all staff alongside career pathways, new roles & upskilling of staff.

Allan,Kirsty
04/01/2022 11:41:07

Looking after our people Programme 3: Equality, Diversity and Inclusion			
Workstream 1 A representative workforce	Workstream 2 Inclusive recruitment	Workstream 3 BAME leadership	Workstream 4 Tackling discrimination of all forms from all sources
✓ Review locality information (incl census) to better understand population demographics. ✓ Implement actions to attract applicants from under-represented groups.	✓ Implementation of Inclusive Recruitment measures. ✓ Monitor the efficacy of Inclusive Recruitment measures ✓ Report efficacy of Inclusive Recruitment measures, recommend appropriate adjustments.	✓ Implementation of Inclusive Recruitment measures. ✓ TBC 22-23 contract requirement to develop plan for ethnically representative Council of Governors and Trust Leadership (band 8A+) by 2027-28.	✓ Implement Respectful Resolution Pathway. ✓ Hate Crime Champion Staff Training. ✓ Mechanism established to capture reporting to the Police. ✓ Implement leading with values training. ✓ Roll out Disability Equality Training.

Looking after our people Programme 4: Recruitment and Retention		
Workstream 1 International recruitment	Workstream 2 Retention Plan	Workstream 3 Recruitment plan
✓ Continue to develop the international Fellows programme ✓ Review support & development available to international recruits ✓ Undertake international recruitment campaign for both medical staff & nursing staff.	✓ Explore the development of 'run through' posts. ✓ Review reward & benefits for all staff to support retention including Terms & Conditions review. ✓ Further development of career conversations linking into the CNTW development forum.	✓ Implement inclusive recruitment initiatives. ✓ Implement recommendations from the Recruitment & Retention Taskforce. ✓ Review advertising practice including general promotion & awareness. ✓ Engage with staff networks to develop methods for attracting a diverse workforce. ✓ Develop & maintain links with a wide variety of groups e.g. armed forces, community/under-represented groups, educational establishments

Appendix 5 Risk Appetite Statement

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust recognises that its long-term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust will not accept risks that materially provide a negative impact on quality (safety, experience and effectiveness).
However, CNTW has a greater appetite to take considered risks in terms of their impact on organisational issues. CNTW has a greater appetite to pursue Commercial opportunities, partnerships, clinical innovation, Financial/Value for Money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated and/or it is in the best interests of the population we serve.

Category	Risk Appetite	Risk Appetite Score
Clinical Innovation	CNTW has a **MODERATE** risk appetite for Clinical Innovation that does not compromise quality of care.	**12-16**
Commercial	CNTW has a **HIGH** risk appetite for Commercial gain whilst ensuring quality and sustainability for our service users.	**20-25**
Compliance/Regulatory	CNTW has a **LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**
Financial/Value for money	CNTW has a **MODERATE** risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.	**12-16**
Partnerships, including new system working (ICS, ICP and PLACE)	CNTW has a **HIGH** risk appetite for partnerships which may support and benefit the people we serve.	**20-25**
Reputation	CNTW has a **MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	**12-16**
Quality Effectiveness	CNTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	**6-10**
Quality Experience	CNTW has a **LOW** risk appetite for risks that may affect the experience of our service users.	**6-10**
Quality Safety	CNTW has a **LOW** risk appetite for risks that may compromise safety.	**6-10**
Climate and Ecological Sustainability	CNTW has a **LOW** risk appetite for risks that may result in the harming of the environment which could lead to harm to the health and safety of the service users, carers and staff and the population we serve	**6-10**

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
6th April 2022

Title of report	Operational and Financial Planning Update 2022/23
Report author(s)	Chris Cressey, Deputy Director of Finance & Business Development
Executive Lead (if different from above)	Lisa Quinn, Executive Director of Finance, Commissioning & Quality Assurance

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	/	Work together to promote prevention, early intervention and resilience	/
To achieve "no health without mental health" and "joined up" services	/	Sustainable mental health and disability services delivering real value	/
To be a centre of excellence for mental health and disability	/	The Trust to be regarded as a great place to work	/

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	4/4/22
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	/
Workforce	/	Environmental	/
Financial/value for money	/	Estates and facilities	/
Commercial		Compliance/Regulatory	/
Quality, safety, experience and effectiveness	/	Service user, carer and stakeholder involvement	/

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Financial Planning & Budgets 2022/23

1. Executive Summary

Purpose of the Report

- The Trust are required to provide a draft final financial plan as part of the ICB overall financial plan by 8th April. Following that any changes are to be agreed across the system by 19th April, with finalised plans at individual organisation level and ICB level being submitted to NHS E / I on 28th April.
- Further to the papers provided to the Trust Board on 2nd March, that showed an initial planned deficit of £38.5m deficit and 11th March, which showed a reduced deficit of £11.3m following the inclusion of spend reduction areas, the Trust is required to submit a final plan which shows delivery of financial break-even.
- The Trust has seen a £24.1m reduction in funding for 2022/23 from reductions in temporary COVID related funding, national efficiencies and the national convergence adjustment.
- The Trust has identified spend reduction areas of £17.8m and there is £6.9m still to identify to deliver financial break-even.
- The Trust are required to submit a 5 year capital programme as part of the plan. The proposed capital plan for 2022/23 to 2026/27 totals £70.2m with spend of £39.0m in 2022/23.
- The Trust's capital plans for 2022/23 and 2023/24 are almost fully committed. There is a minimal contingency of £0.8m and £0.5m in each of these years. As a result the Trust will have to clearly prioritise any capital requirements in these years not currently identified in the programme.
- The CEDAR project is forecast to spend £25.5m in 2022/23, the Trust will drawdown £11.1m in Public Dividend Capital (PDC) with the balance being funded from Trust cash. The Business Case assumed the Trust funded element of the scheme would be covered by central Department of Health and Social Care (DHSC) Capital Departmental Expenditure Limit (CDEL) allocation. However, the Trust has been advised there will be no central allocation provided to cover spend financed by the Trust in 2022/23 and this be met from within the ICB allocation. The Trust have asked the DHSC to re-consider this decision and if no central allocation is available the Trust is planning to breach its CDEL allocation for 2022/23.
- Based on delivery of the capital programme of £70.2m, the Trust cash position is forecast to reduce by £41.3m over the next 5 years. The cash forecast assumes financial break-even throughout the period.
- The information provided in this report is based on the figures included for the Trust in the final ICB planning submission and in the Trusts final individual organisation submission to be provided to the ICB by 8th April.

2. Final Financial Planning submission – 2022/23

The Trust Board received a paper on 2nd March providing the detail of the Trust's draft financial planning position and then an update paper on the 11th March providing the figures submitted to NHS E / I. The Trust is required to provide a final financial planning return for 2022/23, the table below provides the submission deadlines: -

Action	Deadline
Submit first cut final financial plan to ICB	8th April 2022
Submit final financial plan to ICB	19th April 2022
Individual Provider Finance Return uploaded to national portal ICB Financial Plan submitted	28th April 2022

Provider organisations have been instructed to plan on the basis of a return to an environment without COVID restrictions and based on pre-COVID service levels.

The Trust's draft financial planning return showed a £11.3m deficit broken down as per the table below: -

Income & Expenditure	2022/23 £m
Total Income	496.0
Total Expenditure	(534.5)
Deficit	**(38.5)**
National Efficiency Requirement (1.1%)	4.6
Deficit – Submission 1st March	**(33.9)**

Increased efficiency to 2%	3.8
Non recurrent flexibilities	5.0
Increase in income assumption based on SDF	0.7
Increase in NHS England offer	5.0
Deficit	**(19.3)**

Review of phasing of planned recruitment	8.0
Deficit – Submission 10th March	**(11.3)**

The Trust financial position for 2022/23 has seen a significant reduction in temporary funding, efficiencies applied in the national allocation of 1.1% and the impact of the convergence adjustment. The convergence adjustment has been applied to all ICBs nationally to move allocations towards a fair share funding distribution. The convergence adjustment differs across ICBs and depends on their distance from the target allocation. The table below shows the impact on the CNTW financial position of these changes.

Income & Expenditure	2022/23 £m
Reduction in temporary funding from 2021/22 to 2022/23	19.0
National Efficiency factor applied – 1.1%	4.6
CNTW allocation of convergence adjustment applied to ICB	0.5
Total Impact	**24.1**

National financial briefings have been clear that NHS Provider organisations are expected to deliver financial break-even in 2022/23. To support delivery of financial break-even the Trust is: -

- Continuing discussions with commissioners to identify the appropriate funding and investment to be provided to the Trust for 2022/23.
- Including any non-recurrent flexibilities available.
- Reviewing inpatient services with a plan to return to pre-COVID staffing levels by quarter 2 2022/23.
- Continuing to target investment at delivery of the Long-Term Plan objectives focused on Community Services. Community re-design work will support safe, efficient, affordable services.
- Reviewing all other services to return to pre-COVID levels of resources.

The table below summarises the Trust's plan to deliver financial break-even in 2022/23: -

Income & Expenditure	2022/23 £m
Total Income	496.0
Total Expenditure	(534.5)
Deficit	**(38.5)**
Reducing the financial gap	
Review of recruitment phasing	8.0
Increase in income agreed from draft submission	5.8
Total identified to reduce the financial gap	**13.8**
Spend reduction	
Non Recurrent Flexibilities	6.5
Return to pre-COVID inpatient staffing from Q2	6.3
Community Re-Design	3.0
Other Non-Group Spend	2.0
Total Identified	**17.8**
Unidentified required to deliver financial break-even	6.9
Total required	**24.7**
TOTAL	**0.0**

The Trust requires to reduce its planned spend by £24.7m to deliver financial break-even, this equates to 5.2% of planned spending levels. As identified above there are

£17.8m (3.7% of planned spending) identified with a further £6.9m (1.5%) still to be identified. It is proposed that the Trust submit a plan to deliver financial break-even highlighting the £6.9m of unidentified as a significant risk to financial delivery, along with the assumptions around returning to precovid levels whilst current pandemic management is still in place and affecting absence levels.

Underlying Income & Expenditure Position

Income based on pre-pandemic contract levels is insufficient to cover the Trust current spending profile. An extensive exercise is required to understand which costs can be reduced as services evolve to live with COVID in the future. An agreement is needed as to the future of services stood up through the pandemic, which services need to be maintained and what resources need to be deployed to new priorities identified against new investment.

Work will be prioritised to identify which elements of funding will be available on an on-going basis to establish the Trusts overall baseline funding. This work will be co-ordinated with the new commissioning arrangements from July 2022 as the Integrated Care Boards become legal bodies. It will also support the key work streams the Trust has begun to review Emergency & Hospital Care, Community Services, and Children's & Young Peoples Services. Funding levels will need to be correlated to spending plans at commissioned service level to show where the Trust has underlying financial pressures. Plans will be required as to how to deliver services within funding levels going forward.

3. Capital

The Trust are required to provide a 5 year capital programme as part of the 2022/23 planning submission. The Board approved a 5 year capital plan for 2021/22 to 2025/26 of £94.1m as part of the 2021/22 planning submission. The proposed capital plan for 2022/23 to 2026/27 totals £70.2m. The table below provides a reconciliation of the changes to the total programme: -

	2022/23 £m
2021/22 to 2025/26 Capital Programme	**94.1**
Remove forecast capital spend for 2021/22	(37.0)
Remove underspend on Eradicating Dormitories scheme – centrally funded	(0.3)
Remove underspend on Workforce Planning system – centrally funded	(0.4)
Additional scheme for CYPS Seclusion Suite – centrally funded	0.2
Additional scheme for Monkwearmouth / Boldon Clinic	3.0
Additional capital capacity from ICS CDEL allocation	2.5
Add 2026/27 capital plan	7.7
Add Digital Funding for 2022/23	0.5
2022/23 to 2026/27 Proposed Capital Programme	**70.2**

The table below provides a break-down of the proposed Trust draft capital plan for 2022/23 to 2026/27.

Description of scheme	2022/23 £m	2023/24 £m	2024/25 £m	2025/26 £m	2026/27 £m	Total £m
New Developments						
Secure/CYPS/Adult In-Patients	25.5	3.4	0.0	0.0	0.0	28.8
Hadrian Ward, Carlton Clinic	3.1	0.0	0.0	0.0	0.0	3.1
Monkwearmouth/Boldon Clinic	2.4	0.6	0.0	0.0	0.0	3.0
Eating Disorders, The Grange	0.3	0.0	0.0	0.0	0.0	0.3
Other Schemes	2.5	0.2	0.2	0.2	0.2	3.3
Total – New Developments	**34.4**	**4.2**	**0.2**	**0.2**	**0.2**	**39.1**
Maintenance Schemes						
Refurbishment Programme	0.5	0.5	0.5	0.5	0.5	2.5
Backlog / Other schemes	1.2	1.2	1.2	1.2	1.2	6.0
Total - Maintenance	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**8.5**
Other Schemes						
IM&T	0.8	0.8	0.8	0.8	0.8	4.0
Other Allocations	1.9	1.0	1.0	1.0	1.0	5.9
Contingency	0.8	0.5	4.0	4.0	4.0	12.7
Total - Other	**2.9**	**2.3**	**5.8**	**5.8**	**5.8**	**22.6**
Total Capital Expenditure	**39.0**	**8.2**	**7.7**	**7.7**	**7.7**	**70.2**
Funding						
Depreciation (excl IFRS16 adj)	6.0	6.0	6.0	6.0	6.0	30.0
PDC	11.6	0.0	0.0	0.0	0.0	11.6
Asset Sales / Trust Cash	21.4	2.2	1.7	1.7	1.7	28.7
Total Capital Funding	**39.0**	**8.2**	**7.7**	**7.7**	**7.7**	**70.2**

The table above shows the Trust capital plans for 2022/23 and 2023/24 are almost fully committed. There is a minimal contingency of £0.8m and £0.5m in each of these years. As a result the Trust will have to clearly prioritise any capital requirements in these years not currently identified in the programme.

The Trust Accounting Policy for IT was changed in 2021/22 to no longer class lap-tops as capital spend / fixed assets. Purchase of lap-tops will be managed in the Trust Income and Expenditure position. The capital allocation for IT has been reduced and the total planned depreciation has also reduced to reflect this change. The reduction in depreciation releases the funding for purchases from within Income & Expenditure.

Asset Sales Programme

The Trust reviews opportunities for asset sales on an on-going basis and for 2022/23 has identified the sales of land at St Georges Park (which was included in the 2021/22 plan, but the sale has slipped in to 2022/23) and the sale of Craigavon. The table below summarises the position included in the 2022/23 plan.

	Net Book Value £m	Planned Proceeds £m	Gain on Disposal £m
Land at St Georges	0.15	2.00	1.85
Craigavon	0.20	0.20	0.00
TOTAL	**0.35**	**2.20**	**1.85**

Capital Departmental Expenditure Limit – CDEL

An initial allocation of the ICS CDEL for 2022/23 identifies £10.2m for CNTW. There has been an agreement across the ICS in 2021/22 that an organisation that underspends against their CDEL will have their underspend re-provided in 2022/23. CNTW reported a £3.3m underspend against its ICS allocation at month 10.

The CEDAR programme is supported by £8.7m PDC carried forward to 2022/23 and £2.5m originally allocated to 2022/23. The CEDAR programme will spend £25.5m in 2022/23, with £14.3m to be funded from the Trust's cash balances and asset sales. The Trust expectation has always been that the Trust funded element of capital spend would be covered by DHSC central allocation. The CEDAR programme was approved before the current capital system was introduced. DHSC have advised that no central CDEL allocation is available in 2022/23 and their expectation is that the Trust funded element of capital spend needs to be supported from the ICS CDEL allocation. However, the ICS allocation is for 2022/23 is fully committed. The scheme is part of the 40 new hospitals promised by the government, therefore it was assumed DHSC had approved CDEL to cover the cost of this. The Trust have asked the DHCS to re-consider their position but if central allocation is not available the Trust is planning to breach its allocated CDEL limit for 2022/23.

The table below summarises the position.

	CDEL £m	Plan £m	Difference £m
Capital Plan (excl CEDAR)			
ICS Allocation 22/23	10.2	13.0	2.8
ICS Allocation 21/22 c/forward	3.3		(3.3)
PDC – IT	0.5	0.5	0.0
CEDAR			
PDC	11.2	11.2	0.0
Trust Funded		14.3	14.3
TOTAL	**25.2**	**39.0**	**13.8**

IFRS 16

As of 1st April 2022 the NHS is subject to the International Financial Reporting Standard (IFRS) 16. This change impacts on leases and is intended to ensure information for all leased assets is reported in a standardised way. From 2022/23 leases will be recognised on the Trust's balance sheet as right of use assets and the Trust's commitment to the lease will be recognised as a liability. Lease payments will be managed through the balance, similar to loan and PFI re-payments. The Trust Income & Expenditure account will see an increase in depreciation and a decrease in rent charges. The figures included in the financial planning for 2022/23 include adjustments for the estimated changes required through IFRS 16.

4. Liquidity

The table below provides an assessment of the Trust cash position for the coming 5 years. The plan assumes delivery of financial break-even throughout the period and delivery of the Capital Programme proposed above.

Cash Flow	2022/23 £m	2023/24 £m	2024/25 £m	2025/26 £m	2026/27 £m
Opening Cash Balance	**70.0**	**46.3**	**47.3**	**41.1**	**34.9**
Trust Surplus (excl asset sales)	0.0	0.0	0.0	0.0	0.0
Asset Sales	2.2	7.6	0.0	0.0	0.0
Capital Programme	(39.0)	(8.2)	(7.7)	(7.7)	(7.7)
Depreciation	9.5	9.5	9.5	9.5	9.5
PDC	11.6	0.0	0.0	0.0	0.0
PFI / Loan Repayments	(5.0)	(5.0)	(5.0)	(5.0)	(5.0)
Lease Repayments	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)
Closing Cash Balance	**46.3**	**47.3**	**41.1**	**34.9**	**28.7**

The Trust has taken steps to improve its underlying cash position in recent years, which has provided sufficient headroom to manage without a surplus over the next 5 years if a breakeven position is achieved. Based on the position above the Trust would see a reduction in cash balances of £41.3m by 2026/27.

Before COVID-19 the Trust had planned to deliver a £4m surplus in 2022/23. The CEDAR scheme was approved on the basis the Trust would deliver increasing surpluses of £2m in 2020/21 up to £5m in 2023/24 to maintain the Trust's cash balances throughout the scheme.

The Trust's financial obligations require the Trust to generate a surplus to fund the repayment of loans and support the Trust's capital programme. The Trust will have to return to delivering surpluses in the future to generate the cash required to repay around £5m a year of PFI / loans, to maintain the Trust cash balances.

Next Steps

- The Board are asked to approve the final financial planning submission due on 8th April based on the Income & Expenditure and Capital Programme included above, recognising delivery of financial break-even includes delivery of a £24.7m reduction in planned spending levels.
- The Board are asked to delegate responsibility to the Chief Executive and Executive Director of Finance, Commissioning and Quality Assurance to approve any changes to the Trust submission required by 19th April and before the further final submission on 28th April.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to Board of Directors

Title of report	**Quality Account update – Quality Priorities for 2022-23**
Report author(s)	**Paul Sams, Feedback and Outcomes Lead, Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Finance, Commissioning & Quality Assurance**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability	X	Reputational	X
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, carer and stakeholder involvement	X

Board Assurance Framework/Corporate Risk Register risks this paper relates to

CNTW Quality Account update

Quality Priorities for 2022-23

Executive Summary

The Board of Directors have agreed the Trust will have four Quality Priorities for 2022-23:

Quality Priority 1 – Improving the Inpatient Experience

Quality Priority 2 – Improving Waiting Times

Quality Priority 3 – Support Service Users and Carers to be Heard

Quality Priority 4 – Equality, Diversity, Inclusion and Human Rights

The Board of Direcors are asked to note the following:

1. The Quality Priorities discussed here will be included in the 2021-22 Quality Account that will be submitted to the Department of Health and Social Care by 30th June 2022, following approval by the Board of Directors.
2. All Quality Priority aims, objectives and milestones for 2022-23 are set out in draft in this report.

Update on the CNTW Quality Priorities for 2022-23

Our long-term Quality Goals are based on safety, service user and carer experience, and clinical effectiveness. Each year we set Quality Priorities to help us achieve our long-term Quality Goals as part of a robust process of engagement with stakeholders and exploring what we have been told and learned in the previous years.

Here is how the Quality Priorities for 2022-23 (on the right) align with our long term quality goals and which quality domain they support:

The Board of Directors have now approved the four Quality Priorities. Each Quality Priority is set out in this document with the agreed milestones for each quarter of 2022-23 as well as how each Quality Priority will be measured for effectiveness and impact.

These Quality Priorities will feature in the 2021-22 Quality Account which will be published on 30th June 2022.

Quality Priority 1: Safety - Improving the inpatient experience.	**Lead: Dr Patrick Keown**
Improving the inpatient experience by removing barriers to admission and	

discharge, and improving the therapeutic offer during treatment, through:

- Embedding new ways of working relating to admission and discharge processes
- Improved Inpatient ward quality standards
- Ensuring the purpose of admission and therapeutic offer add value to patient care

Planned future actions to be taken Trust-wide during Quarter 1 (April, May & June):

- Continue to build on the work started in 21/22 to improve efficiencies in the admission and discharge process, including further embedding the roles of enhanced bed management and crisis gate-keeping within Patient Flow Locality Teams.
- Carrying out a stocktake of ward quality standard measures and accreditations.
- Seek input from patients, carers, staff and wider professional groups, to gathering an evidence base on inpatient models of care within acute pathways.

Planned future actions to be taken Trust-wide during Quarter 2 (July, August & September):

- Evaluation of the impact of changes to admission and discharge processes to be undertaken.
- Consider the evidence base associated with inpatient ward quality standards and accreditations along with the feedback received to develop future actions and areas of focus.

Planned future actions to be taken Trust-wide during Quarter 3 (October, November & December):

- Delivery of agreed action plans relating to inpatient ward quality standards and models of care.

Planned future actions to be taken Trust-wide during Quarter 4 (January, February & March):

- Embedding and evaluation of agreed action plans relating to inpatient ward quality standards and models of care.

Evidence of Impact:

- Delivery of the Trust Out of Area trajectory.
- Reduction of occupancy rates on adult acute and older peoples inpatient wards.
- Improved inpatient experience.

Status:

Quality Priority 2: Service User and Carer Experience – Improving waiting times.	Lead: Andy Airey

Improving waiting times in areas where demand currently exceeds capacity through:

- Working in partnership with Primary Care to enable better support for patients and carers sooner.
- Delivery of a single point of access for North Cumbria CNTW services.
- Improved transitions from CYPS to Adult services.
- A review of Adult Autism Diagnostic Service (AADS) and Adult Attention Deficit Hyperactivity Disorder Service (AADHDS) pathways.
- Gender – Increase capacity through recruitment and retention of staff, developing a community programme with peer support workers and the 3rd sector and develop a clinical model for a Primary Care Trans Health Service with key stakeholders (inc NHSE and GPs).

Planned future actions to be taken Trust-wide during Quarter 1 (April, May & June):

- Completion of a detailed workforce plan for each locality.
- Go live with North Cumbria adult pathway planned care single point of access.
- Transitions project milestones and associated impact assessments developed to inform future quarter activities.
- AADHDS Exploring options of workers being directly in PCN setting.
- AASD – supporting Community Treatment Teams (CTT) – and other teams - to be skilled up to complete Autism assessments where client is open to more than one CNTW team.
- Gender: Recruitment of staff to increase capacity, identify estate for staff and clinics and contract under SLAs with 3rd sector to support service users on the waiting list.

Planned future actions to be taken Trust-wide during Quarter 2 (July, August & September):

- Continue to rollout of ARRS posts, and evaluation of those posts already in place.
- Expand North Cumbria's single point of access to include CAMHS and children's ADHD services.
- Delivery of agreed CYPS transitions project milestones, with benefits/impacts measured.
- Establish task and finish group to explore options around discharge pathway for ADHD, to include Clinical Commissioning Group (CCG) reps and General

Practitioner (GP) rep; to include consideration of referral routes (in relation to open referral in AASD). Scope out with Community Treatment Teams (CTT) around numbers of staff to be upskilled in Autism diagnostic assessment.

- Gender: Recruitment of medical staff to increase capacity, provide Gender training for new staff members, identify estate for staff and clinics, establish a task & finish group to develop the clinical model.

Planned future actions to be taken Trust-wide during Quarter 3 October, November & December):

- Continue to rollout of ARRS posts, and evaluation of those posts already in place.
- Expand North Cumbria single point of access to include older people's services.
- Delivery of agreed transitions project milestones, with benefits/impacts measured.
- Commence agreed delivery models within ADHD and ASD teams.
- Seek approval for estate for staff and clinics, provide Gender training for new staff members and agree the clinical model and business case for Primary care model with NHSE.

Planned future actions to be taken Trust-wide during Quarter 4 (January, February & March):

- The future of ARRS posts will be determined WITH PCNs.
- Remaining community services in North Cumbria will join the single point of access model.
- Conclusion of the evaluation of the change in approach to transitions across the trust, with continuous improvement actions agreed.
- Recruitment to any agreed Primary Care Network (PCN) posts and commence evaluation; commencement of training roll out for other teams to complete ASD assessment.
- Commission the new primary care model. Agree on going funding for 3rd sector peer support workers.

Evidence of Impact:

- All mainstream Adult and Older Peoples Services having first contact within 18 weeks.
- All CYPS referrals receiving treatment within 18 weeks.
- Reduction in ASD and ADHD waits
- Reduction in waits for Gender services.

Status:

Quality Priority 3: Patient Care – Support service users and carers to be heard.	**Lead: Elaine Fletcher**
Support service users and carers to be heard by improving processes and promoting person-centred approaches through: • Promoting an inclusive approach to positive patient engagement and responsiveness. • Co-production of refreshed digital enablers for patients and carers • Monitor and respond to feedback themes	
Planned future actions to be taken Trust-wide during Quarter 1 (April, May & June):	
• Develop action plan through engagement with peers and service users. • Respond to 'You Said – We Did' test feedback. Making changes to the process to promote easy user function, reducing the clinical time spent producing the poster.	
Planned future actions to be taken Trust-wide during Quarter 2 (July, August & September):	
• Implementation of actions. • Develop communication strategy for 'You Said – We Did' roll out, including through The Bulletin and through discussion in locality meetings.	
Planned future actions to be taken Trust-wide during Quarter 3 (October, November & December):	
• Implementation of actions. • Roll out 'You Said – We Did' poster process to all wards and teams.	
Planned future actions to be taken Trust-wide during Quarter 4 (January, February & March):	
• Implementation of actions. • Evaluate roll out of 'You Said – We Did', identifying teams not using it and offering support.	
Evidence of Impact:	
• Reduction in people offering negative feedback around feeling listened to/heard. • Increase in wards and teams using You Said - We Did poster.	
Status:	

Quality Priority 4: Clinical Effectiveness – Equality, Diversity, Inclusion and Human Rights (in relation to the core values of Fairness, Respect, Equality, Dignity and Autonomy (FREDA)).	**Lead: Lynne Shaw and Dr Rajesh Nadkarni**

Implement a Trustwide approach working across Locality Groups. The Equality & Diversity Lead, CNTW Academy, Chaplaincy, Commissioning & Quality Assurance, Accessible Information Standard Group and Communications and Staff Networks.

Planned future actions to be taken Trust-wide during Quarter 1 (April, May & June):

- Implementation of Inclusive Recruitment measures.
- Implementation of inclusive recruitment measures.
- Implement Respectful Resolution Pathway.
- Scope current activity and develop priority areas of engagement
- Trauma Informed Care presentation to take place at BDG.
- HOPEs proposal to be presented at BDG, focusing on training, communication and practice.
- Empower presentation to take place at CDT.
- Roll out of HOPEs training commencing in pilot areas.
- After Trauma Informed Care proposal is accepted, begin recruitment and develop the team, and identify pilot areas.
- Continued development of the communications strategy.
- Continued planning of raising awareness of FREDA/Rights Based Approaches across CNTW. Linking with other Trust initiatives and rolling-out communications and awareness materials.

Planned future actions to be taken Trust-wide during Quarter 2 (July, August & September):

- Review locality information (including census) to better understand population demographics.
- Train staff to be Hate Crime Champions.
- Mechanism to be established to capture reporting to the Police.
- Locality plans to improve engagement in these areas.
- Positive & Safe team to plan and deliver awareness sessions incorporating Human Rights and Trauma Informed Care.
- Trauma Informed Care pilots to commence in pilot areas.

Planned future actions to be taken Trust-wide during Quarter 3 (October, November & December):

- Implement actions to attract applicants from under-represented groups.
- Monitor the efficacy of the Inclusive Recruitment measures.
- Implement leading with Values training.
- Roll out of Disability Equality Training provided by Difference North East.
- HOPEs training rolled-out in all pilot areas, learning to be consolidated and shared.
- Development of a Trauma Informed Care network.

Planned future actions to be taken Trust-wide during Quarter 4 (January, February & March):

- Report on efficacy of Inclusive Recruitment measures, recommend adjustments where required.
- Implement Respectful Resolution Pathway.
- Training strategy for Trust-wide HOPEs plan of implementation in all areas.
- Trauma Informed Care roll-out of training in pilot areas completed, with learning consolidated and shared to inform a Trust-wide strategy.

Evidence of Impact:

Equality, Diversity and Inclusion

- Improvement in Workforce Race Equality Standard Metrics particularly in terms of 'appointment after shortlisting' and staff experience
- Reduction in disciplinary/grievance cases relating to bullying and harassment, values and behaviours
- Improvement in Workforce Disability Standard metrics in terms of staff experience
- Staff survey and Quarterly staff survey results

Empower

- Reduction in restrictive practices.
- Reduction in incidents, staff sickness absence and an increase in well-being.

Status:

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
Wednesday 6th April 2022

Title of report	**Nursing Strategy – Delivering Compassion in Practice Annual Report (covering the period April 2020 to April 2022)**
Report author(s)	**Anne Moore, Director of Infection Prevention Control (DIPC), Deputy Chief Nurse**
Executive Lead (if different from above)	**Gary O'Hare, Chief Nurse**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Nursing Strategy
Delivering Compassion in Practice Annual Report
Covering the period April 2020 to April 2022

Board of Directors Meeting
Wednesday 6th April 2022

Background

CNTW Nursing Strategy *Delivering Compassion in Practice 2019 – 2024* was launched at our sixth annual nursing conference, a "Call to Action" for the whole of our nursing workforce. The strategy is aligned to six strategic aims, each underpinned by key commitments which focus effort and energy in creating a positive impact on patient and service user care.

The 6Cs remain as our value base in all that we do, with strategic aims focused on the delivery of the 6Cs across the health arena. They are designed to enable us all to reach further both individually and collectively by focusing on what is important and through connecting with each other we can achieve more for service users, patients, and communities and for our profession.

Each strategic aim has several key commitments which are integrated into service strategy planning. It is aligned with the Trust's strategic ambitions and our workforce strategy and will enable us to make a significant contribution to the delivery of both.

Supporting the Pandemic

This report summarises the activity over the past two years. 2020 was designated as the Year of the Nurse and our intention was to facilitate several celebratory events throughout 2020 commencing with our Annual Nursing Conference in March 2020.

However together, alongside our colleagues, we have instead faced the challenge of the Covid 19 global pandemic. In meeting this challenge nurses in CNTW have been at the forefront in driving change, alongside other professionals we have adapted to new ways of working: in many cases taking on new roles and working in new environments to deliver our pandemic response.

During the pandemic together with our colleagues we have:

- Seen nurses return to clinical practice to support front line services.
- Continued to deliver student placements including employment of over 300 nursing students during the first national lockdown, boosting staffing levels and enabling students to complete training on time and enter our nursing workforce.
- Created robust communication channels with particular emphasis on IPC, designed to keep both staff and patients informed and safe.
- Implemented a PPE Team to source and manage supplies, implementing a rolling plan for FFP3 Risk assessment and fit testing
- Set up a Staff PCR Testing and Mobile Team with the aim of testing staff and households to enable them to return safely back to work – delivering over 24,000 PCR and Antibody tests.

- Implemented Surveillance Patient testing and isolation for new admissions and transfers from care homes / hospital to reduce risk.
- Created a Covid Vaccination Hospital Hub delivering over 29,000 Covid and Flu vaccinations to both staff and patients.
- Handled over 84,000 calls in our single point of access absence call line.
- Set up a welfare call system delivered by absence line staff.
- Undertaken over 8,000 covid risk assessments through our Senior Nurse test and trace team with the aim of reducing transmission, supporting return to work, and providing guidance and support to staff.
- Learnt valuable lessons through outbreak management processes which has informed guidance and reinforced IPC practices to keep staff and patients safe.

Throughout this period we have continued to deliver our nursing strategy objectives as outlined below:

Strategic Aim 1	**Linked to Leading Change, Adding Value – Chief Nursing Officer for England Strategy. Commitments**
Helping people to stay independent, maximising well-being and improving health outcomes	Promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery, and care staff. Increase the visibility of nursing and midwifery leadership and input in prevention. Work with individuals, families, and communities to equip them to make informed choices and manage their own health.

Physical health and wellbeing remain a key priority with focus on working collaboratively and building capacity and capability to ensure the best possible outcomes for service users.

We have

- Provided easy read leaflets in a variety of subjects including COVID and Covid vaccination.
- Provided accessible information for clients in all pathways to help promote understanding in accessing primary care and encouraging uptake of national vaccination programmes.
- Provision of accessible letters and information regarding national screening programmes.
- Provided support to harder to reach / engage service users in relation to both Flu and Covid vaccinations – making every contact count.

- Learning Disability teams have provided support to access appointments, vaccine clinics, and physical health clinics for those hard to reach in Health Action Plans through development of robust links with liaison nurses within city hospitals.
- Our Practice Education Team, working in partnership with Higher Education Institutes (HEIs), ensure undergraduate curriculum provides an educational and practice focus on physical health and wellbeing. During this period we have worked with partner HEI's to ensure the curriculum reflects the requirements of safe practice during pandemic.
- Physical Health Skills training was refreshed in April 2021 and has been delivered throughout the pandemic via Teams. During 2020 we promoted a broader range of physical health skills in response to the Covid 19 pandemic.
- Continued to promote health and wellbeing initiatives promoting public health awareness and approach through all areas including cascade of activities, linked to public health campaigns.
- Physical Health Link Nurses continue to facilitate service user physical health and well-being meetings.
- Supported the Recovery colleges to provide a prospectus that includes course in relation to emotional and physical well-being.
- Carers champions identified in all clinical teams.
- Continued to train staff in smoking cessation and brief alcohol awareness.
- Provided information to clients identifying benefits of reduction in medication previously prescribed for behaviours that challenge and replace with more appropriate treatment options and adopting a more holistic approach.
- Continued to promote and disseminate importance of WRAP within teams with a focus on newly recruited staff.

Strategic Aim 2	**Linked to Leading Change, Adding Value – Chief Nursing Officer for England Strategy. Commitments**
Working with people to provide a positive experience of care	We will be centred on individuals experiencing high value care. We will work in partnership with individuals, their families, carers, and others important to them.

As nurses we need to be strong advocates, working in partnership with service users, their families, and carers, developing unique and supportive caring relationships.

We have

- Developed innovative ways to maintain contact with family and carers when visiting was prevented due to covid restrictions.

- Continued to utilise After Action Reviews (AAR), Serious Untoward Incident (SUI) outcomes as a means of promoting reflective practice in particular use of learning forums facilitated by Nurse Consultants to support lessons learnt, influence innovation and change.
- Undertaken thematic reviews of SUIs and complaints at locality level, including sharing of best practice.
- Utilised patient experience questionnaires: Friends and Family Test and Points of You to promote shared learning and positive experiences.
- Embedded Triangle of Care across services.
- Facilitated Service User Involvement and Engagement meetings across services to ensure we listen and learn.
- Continued to promote Positive and Safe Strategy – Talk 1st across all services.
- Implemented new ways of working that improve the way in which individuals experience and receive the care we give through clinical pathways i.e. physical health and wellbeing pathways.
- Supported Trustwide review of care planning and associated training package.
- Utilised Covid 19 outbreak process and learning debriefs to reinforce IPC practice and maintain service user and staff safety.

Strategic Aim 3	**Linked to Leading Change, Adding Value – Chief Nursing Officer for England Strategy. Commitments**
Delivering high quality care and measuring the impact of care	We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

Building our capacity and capability to use quality improvement techniques and tools is essential in promoting a sustainable culture of continuous improvement and in developing and implementing new and positive ideas that promote person centred care.

We have

- Continued to support delivery of Positive & Safe/ Talk 1st priority in reducing restrictive interventions and blanket restrictions.
- Continued to build on initiatives designed to utilise skill mix effectively, including:
  - Development of new roles and ways of working to support our response to the pandemic.
  - Continued development and recruitment to Nursing Associate and Advanced Clinical Practitioner programmes designed to effectively focus on activities that create 'high value'.
  - Daily review of staffing, utilising other disciplines to support activities.

- Made best use of technology to maintain family and peer contact, provide education and most importantly where suitable for clinical appointments maximising impact for service users and staff.
- Encouraged collaborative working across services through audit, action, and evaluation processes.
- Provided opportunities to maintain innovation through coaching, personal development, supervision, and appraisal.

Strategic Aim 4	**Linked to Leading Change, Adding Value – Chief Nursing Officer for England Strategy. Commitments**
Building and strengthening leadership	We will increase the visibility of nursing and midwifery leadership and input in prevention.

Everyone involved in the delivery of care needs to contribute to creating the right environment; strengthening clear compassionate leadership at every level ensures safe, high-quality care and a positive experience for patients and staff.

We have

- Continued to provide access to the Advanced Nurse Practitioner (ACP) programme developing clinical and leadership skills.
- Implemented access to Nurse Consultant clinical and academic supervision and support for students undertaking the ACP programme.
- Increased the number of Consultant Nurses to over 30 across all services providing leadership and development support to clinical staff.
- Developed Clinical Specialist Nurse and Specialist Nurse roles across the organisation.
- Supported Managers / Clinical Managers to undertaking leadership training via the CNTW Academy and MBA Strategic Leadership programme.

Strategic Aim 5	**Linked to Leading Change, Adding Value – Chief Nursing Officer for England Strategy. Commitments**
Ensuring we have the right staff, with the right skills, in the right place	We will lead and drive research to evidence the impact of what we do. We will have the right education, training, and development to enhance our skills, knowledge and understanding We will have the right staff in the right places and at the right time

Ensuring we have the right people with the right values and skills, in the right place at the right time is a key priority in delivering sustainable services.

During 2021, the Trust saw significant pressure on services due to a combination of increased Nursing vacancies and staff absence as a result of Covid 19. Whilst recruitment and retention activity had continued during the pandemic there was an escalation of activity led by the Executive Directors to expedite initiatives to ensure Safe Staffing levels.

We have implemented the Recruitment and Retention Taskforce, which provides strategic direction for recruitment and oversees the work of the Values Based Recruitment steering group.

Specific recruitment initiatives include:

- Engagement in the national Health Care Support Worker Zero Vacancy Project, supported by an innovative online recruitment process.
- Recruitment marketing, including developing short films to support social media campaigns and attendance at recruitment events.
- Reviewing temporary staffing arrangements and deployment of temporary staff to promote continuity of care and infection prevention and control.
- Supporting training and education programmes for Trainee Nursing Associates and developing the Nursing Associate role across the Trust.

International Recruitment

- Continuing to undertake international recruitment of nurses, using an ethical approach and reviewing potential future agency partnerships and markets.
- Invested in professional support for relocation and pastoral support of international recruits and in professional and educational support with respect to undertaking the Objective, Structured, Clinical Examination (OSCE).

Investing in our future workforce - 'Grow Your Own' approach

Our aim is to ensure students (nursing, return to practice, trainee nursing associates and apprentices) are empowered, supported, and inspired to become resilient, caring, and reflective lifelong learners who are capable of working in inter-professional and interagency teams.

We have

- Continued to deliver our grow your own strategy with sustained recruitment to the Registered Nurse Degree Apprenticeship. CNTW Academy offers three pathways providing 2 to 4 year options for existing staff. In addition, in 2021, the Academy launched our first 5 year Registered Nurse Apprenticeship in Mental Health or Learning Disability Nursing designed to attract new NHS recruits.
- The original Business case in 2017 expected circa 20 support staff per year to pursue a nursing apprenticeship. We have substantially exceeded that expectation. At any one time, there are now circa 160 Degree Level Nursing Apprentices on programme across 2, 3, 4, and 5 year programmes.

- Seen our first cohort of Registered Nurse Apprentices qualify in 2022 who will commence the newly revised, Accredited Trust Preceptorship Programme.
- Worked in partnership with local HEI increasing numbers of nursing students across both mental health and learning disability programmes.
- Supported the national clinical placement expansion programme, through the development of innovative placements for mental health and learning disability nursing students across both our services and in partnership with primary and third sector partners.
- Worked in partnership with clinical placements to provide continued access to clinical placements. Considering Covid restrictions this has included significant investment in laptops which enable both Nursing and AHP students to continue clinical education.
- Delivered a pilot placement programme for children's student nurses in mental health children's services. This was very well received, and plans are underway to make this a permanent placement for children's student nurses promoting understanding of mental health services and developing knowledge, skills, and awareness of mental health throughout the physical health pathway.
- Expanded the Practice Education Team providing opportunity to build on their work in developing learning opportunities and working with clinical placements in developing learning environments.
- Practice Education Team have developed a resilience training package which is currently being rolled out. The team have also provided drop-in sessions for students throughout the pandemic and converted Practice Assessor and Supervisor updates to online access to ensure staff could meet the professional bodies requirements.

Developing our nursing workforce to its full potential

A key component of the nursing strategy is to create capacity, capability, and flexibility to work across traditional boundaries and take on new roles. Multi-faceted approaches are needed to develop a workforce which can be both responsive and adaptable to manage complex changes; ensuring our nursing workforce make the greatest possible difference in delivering excellent care.

We have

- CNTW Academy has developed an accredited preceptorship programme for new registrants at Level 6 and 7, the aim being to ensure that all newly qualified registered nurses achieve clinical competence and academic accreditation in their field of practice and support transition into a competent, qualified health professional role.
- CNTW Academy is currently developing an Inpatient Post Graduate Certificate for existing Registrants. The aim is to commence delivery late 2022.
- CNTW Academy has supported development of service specific CPD programmes including the development of a suite of CYPS Accredited modules at academic levels 3 to 6, and stand-alone CPD modules at various levels which can be adapted to individual workplaces.

- CNTW Academy has continued to provide access to essential online training and has developed a range of digitalised approaches to online learning.

Building research capacity and capability

A good evidence base is central to nursing care. Encouraging critical dialogue, research and publicising the work that we do is central to this agenda. Through increasing capacity and capability, we will develop a culture where nurse led research becomes a normative part of clinical practice.

We have

- Appointed a Professor and an Associate Professor of Nursing, in partnership with Northumbria University, to develop the nursing research culture within the Trust.
- Supported the secondment of an existing Northumbria University Professor of Nursing, commencing in 2022. The focus of the secondment is to work jointly with the Associate Professor for Nursing to help shape CNTW research priorities and create nursing pathways into research at all levels to meet the needs of the organisation at clinical, operational, and organisational level.
- Undertaken work to create an informal network of communications / practical experiences between the Trust and University of Sunderland. This includes small, funded internships and aim to join up interested parties with academic mentors (and vice versa) to 'test out' an area of work to see if it feels right for an individual. This will support CNTW staff who may be interested in research but who do not have the necessary qualifications to make a firm career move and / or those who do not wish to leave clinical practice.

Strategic Aim 6	**Linked to Leading Change, Adding Value – Chief Nursing Officer for England Strategy. Commitments**
Supporting positive staff experience	We will actively respond to what matters most to our staff and colleagues.

Evidence shows that the experience of staff, particularly in the form of support received from supervisors and others; as well as staff engagement are associated with the care provided to patients. How staff feel when they are at work is key to the successful delivery of high quality patient care.

Staff health and wellbeing has been a focus during pandemic ensuring support and opportunity to seek time to reflect.

We have

- Provided access to resources dedicated to staff wellbeing, for example the staff well-being service, AWISH, yoga, Schwartz rounds, exercise, and leisure activities.

- Ensured individuals have access to clinical supervision providing opportunity for reflection and professional development aligned to NMC / Professional standards.
- As identified above we have continued to recruit to Nursing Associate, Registered Nurse Apprenticeship and Advanced Clinical Practitioner programmes providing significant career development opportunity and supporting individual aspiration.

Next Steps

After a particularly challenging two years the objectives of the Nursing Strategy have continued to be delivered, although it is fair to say that some of the delivery and pace have been directly affected by the pandemic. However as we move to a phase of Living with Covid there is a plan to review the strategy and its fitness for purpose. In particular actions will include:

- Support reflection on what we have learnt from our response to the pandemic with particular reference to what service users and carers are telling us.
- Review with Group Nurse Directors structure for driving the Nursing Strategy in each locality.
- Reintroduce the Nurse Education Forum and Leadership Forum, both of which had been stood down during the pandemic and in response to staffing.
- Facilitate Nursing Conference in June 2022.
- Support implementation and coordination of the new Preceptorship Programme and Inpatient Post Graduate Certificate.
- Continue to work with operational localities and partner agencies to develop and deliver clinical placement for Nursing and AHP students.
- Continue to build on opportunities for access to career development opportunities to support skill mix and workforce plans.
- Build research capacity in the nursing workforce.

The Board of Directors are asked to note progress to date.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting
Armed Forces and Veterans Update
Wednesday 6th April 2022

Title of report	**Armed Forces and Veterans Update**
Report author(s)	**David Muir, Group Director**
Executive Lead (if different from above)	**James Duncan, Chief Executive**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	N/A
Audit	N/A
Mental Health Legislation	N/A
Remuneration Committee	N/A
Resource and Business Assurance	N/A
Charitable Funds Committee	N/A
CEDAR Programme Board	N/A
Other/external (please specify)	N/A

Management Group meetings where this item has been considered (specify date)	
Executive Team	N/A
Corporate Decisions Team (CDT)	N/A
CDT – Quality	N/A
CDT – Business	N/A
CDT – Workforce	N/A
CDT – Climate	N/A
CDT – Risk	N/A
Business Delivery Group (BDG)	N/A

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Meeting of the Board of Directors
Armed Forces and Veterans Update
Wednesday 6th April 2022

Recent conflicts such as those in Afghanistan and Iraq have seen changes to the way the Armed Forces and Veterans are regarded by society and government. The Armed Forces Bill 2021 gained Royal Assent in Parliament in December enshrining into law the principles of the Armed Forces Covenant (AFC) from April 2022. Here at CNTW we have shown our broad support for the armed forces and veterans through a number of initiatives including the signing of the AFC in 2021.

By signing the AFC we have agreed to a number of principles including that the Armed Forces community should not face disadvantage compared to other citizens in the provision of public and commercial services in the area where they live, the giving of special consideration in some cases, especially for those who have given most such as those injured and the bereaved. More broadly we are recognising the value that serving personnel, reservists, veterans and military families bring to the organisation, and to our country. Through this the Trust (and NTW Solutions) have pledged to promote that they are armed forces-friendly organisations and will support the employment of veterans, recognising military skills and qualifications in the recruitment and selection process and work with the Career Transition Partnership (CTP) to support the employment of service leavers.

As part of this CNTW has achieved both the Bronze and Silver Awards for the Defence Employer Recognition Scheme and we have recently started to work on our Gold Award submission. We have also re-registered for Step into Health which is an NHS Employers initiative that enables NHS organisations to benefit from the transferable skills and values members of the Armed Forces community bring into the workplace and raise awareness of the barriers into employment which members of the community may face. A personal approach to those interested in joining CNTW or the wider NHS has been taken recently where the co-chairs of the Trust's Armed Forces and Veterans network have spent time with individuals, working with those interested in NHS and CNTW for their post-military careers, and this has led to a successful appointment in the South Locality. In addition, a Military Recruitment task and finish workstream has been established under the Trust Recruitment and Retention task force to explore the wider potential of the Trust recruiting staff from current service leavers, established veterans and also their families. As an employer, for those in the Reserve Forces and Cadet Force we support time off for annual camps and other commitments such as compulsory mobilisation through our specific Reserve Forces and Mobilisation Policy and we encourage reservists to register their details with workforce to ensure that it is logged on ESR. Presently we have 5 reservists logged on ESR across CNTW and NTW Solutions.

Our staff armed forces and veteran network continues to grow and we continue to welcome new members including those who have served in the military of other nations in the spirit of inclusivity. Our current membership of 54 includes veterans, active reservists and also family members of both the currently serving and veterans.

CNTW was accredited in March 2021 as one of 103 Veteran Aware NHS Trusts . We have also submitted this year for reaccreditation. This year's submission saw the Armed Forces and Veterans Network and the Trusts Veterans Mental Health, Transition and Liaison Service (TILS) working closely together. Initial verbal feedback from the VCHA Regional Lead for the North of England is positive. The NENC Veterans Mental Health Network are keen to pursue this accreditation and have reached out to CNTW for a wider discussion on this.

We are now turning our sights towards having an Armed Forces and Veterans Trust Strategy to pull together a number of strands and to shape the development of future work and ambitions.

A presentation to the Board will be scheduled later in the year to give more detail of the varied work that is going on in this area.

David Muir, Group Director
April 2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting
Joint Management Executive Group Report on Integrated Care System Development
Wednesday 6th April 2022

Title of report	**Schedule of proposals and actions for implementing the statutory basis of the Integrated Care System (ICS) for the North East and North Cumbria (NENC)**
Report author(s)	**North East and North Cumbria Integrated Care System Joint Management Executive Group**
Executive Lead (if different from above)	**James Duncan, Chief Executive**

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	X
To be a centre of excellence for mental health and disability	X	The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	N/A
Audit	N/A
Mental Health Legislation	N/A
Remuneration Committee	N/A
Resource and Business Assurance	N/A
Charitable Funds Committee	N/A
CEDAR Programme Board	N/A
Other/external (please specify)	N/A

Management Group meetings where this item has been considered (specify date)	
Executive Team	N/A
Corporate Decisions Team (CDT)	N/A
CDT – Quality	N/A
CDT – Business	N/A
CDT – Workforce	N/A
CDT – Climate	N/A
CDT – Risk	N/A
Business Delivery Group (BDG)	N/A

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to

Report from the Joint Management Executive Group

Schedule of proposals and actions for implementing the statutory basis of the Integrated Care System (ICS) for the North East and North Cumbria (NENC).

1. A series of Joint Management Executive Group (JMEG) meetings were convened between October and December 2021, with a membership drawn from senior executives from both the NHS and local authorities and chaired by Sir Liam Donaldson (see appendix 1).

2. These meetings gave us the opportunity to digest the feedback from a year of consultation on ICS development – which included numerous 1-2-1 meetings with senior system leaders and four multi-sectoral engagement events in each of our ICS sub-geographies – alongside a considerable volume of national policy guidance issued to us on the formal creation of statutory Integrated Care Boards and Integrated Care Partnerships.

3. The key themes from those four key engagement events were distilled and discussed at the first meeting of JMEG to help us establish a set of guiding principles for our transition to a new way of working through statutory Integrated Care Systems. These were to:
   - Ensure continuity of effective place-based working sensitive to local needs;
   - Create high quality planning arrangements to address population health needs, reduce health inequalities, and improve care;
   - Secure effective structures and processes to achieve the required level of accountability and oversight for the stewardship of our resources and the delivery of key outcomes
   - Design the right mechanisms to drive developments, innovations and improvements in geographical areas larger than place-level;
   - Maintain high and positive levels of staff engagement and communication at a time of major change and upheaval.
   - Identify those current areas where joint local authority and NHS working is essential to service delivery and those areas where new opportunities could be followed to widen the scope of joint service delivery.
   - Highlight areas of policy, practice and service design where harmonisation of approach by the NHS might benefit local authority services and vice versa;
   - Suggest a model of working inter-relationship between the two boards specified in the Bill (the Integrated Care Board and the Integrated Care Partnership).

4. JMEG then took the lead role in overseeing the necessary preparations for the introduction of a statutory Integrated Care Board (ICB) for the North East and North Cumbria, and make proposals to NHS and local authority decision-makers on the membership and composition of the ICB, and how the ICB will interact with the thirteen 'places' (local authority areas) which the ICS covers, and the functions and responsibilities delegated from the ICB to those places.

5. The insights from JMEG, and our engagement with the ICS HealthWatch Network and the North East and North Cumbria Voluntary Sector Partnership has helped us to build a governance model with representation from all our key professional sectors – including NHS primary and acute care, public health, and adults' and children's social care, as well as the voluntary and community sector, and the voice of patients through HealthWatch.

6. In support of the work of JMEG which set our ICS's strategic direction, our ICS team put in place a robust programme management approach to manage the detailed work of transition from eight CCGs (and their associated governance and staffing arrangements) to a single Integrated Care Board for the North East and North Cumbria by July 2022. The programme priorities for this work were to:
   - Safely transition staff and functions from CCGs into the ICB and implement a new operating model as recommended by JMEG
   - Ensure the necessary operating arrangements are in place to support both the delegation of ICB functions to place, and at-scale working across the integrated care system
   - Secure the necessary regional and national support from NHS England to facilitate accelerated progress in delivery and maturity of our ICS.
   - Manage this transition work while continuing to support the ongoing maturity and transformation of local health and care services across NENC.

7. An ICS Development and Transition Board has also been established to manage the long list of tasks set out in the national 'Readiness to Operate' checklist which we must comply with and submit evidence against to NHS England prior to ICBs becoming statutory organisations in July 2022. These tasks included:
   - Making appointments to the Integrated care board (ICB)
   - Agreeing governance arrangements and drafting an ICB constitution
   - Integrated care partnership (ICP) - initial arrangements and principles agreed
   - Making the transition from CCGs to ICBs
   - Quality, safety and EPRR systems and functions ready for operation
   - Public involvement and engagement strategy / policy
   - Financial Planning 2022/23 developed in line with guidance and functions and systems ready
   - Data, digital and information governance systems ready to operate

8. This checklist helped us to shape the agenda for our series of JMEG meetings, and the following sections of this report cover a schedule of proposals and actions against the following key preparatory tasks:
   - Establishing an Integrated Care Board and agreeing its membership
   - Delegation of functions and accountabilities from the Integrated Care Board
   - Replacing functions of the former Clinical Commissioning Groups
   - Establishing an Integrated Care Partnership and agreeing its membership

9. A key output from these tasks was the **development of a draft ICB Constitution for approval by NHS England**. Much of the mandatory content of that document was set out in a model constitution template issued by NHS England to each ICS. This template also included a number of discretionary elements, which included final board composition and the delegation of ICB functions to place-based partnerships. JMEG's recommendations on these aspects of ICB development were then included in the draft constitution of the North East and North Cumbria Integrated Care Board and submitted to NHS England on 7 December 2021.

ESTABLISHMENT OF AN INTEGRATED CARE BOARD

GUIDANCE:

10. Set out in *Interim Guidance and Governance on the Functions and Governance of the Integrated Care Board, August 2021*

REQUIREMENTS:

11. With the Health and Care Bill going through Parliament, we have worked with the expectation that from 1st July 2022 the NHS North East and North Cumbria Integrated Care Board will take over the responsibilities currently held by eight Clinical Commissioning Groups (CCGs) in the North East and North Cumbria.

12. The Integrated Care Board's role will encompass a wide range of functions including promoting greater synergy and integration of health and care services, improving people's health and wellbeing and reducing health inequalities.

13. The ICB will also allocate and maintain good stewardship of approximately £6 billion of NHS funding for the North East and North Cumbria. It will ensure that high quality, safe health services are accessible to all our communities. It will foster, facilitate, and sustain partnerships of hospitals, community service providers, primary care, local councils, hospices, voluntary community, and social enterprise (VCSE) organisations and Healthwatch partners in all thirteen of our local authority areas: Middlesbrough, Redcar and Cleveland, County Durham, Darlington, Gateshead, Hartlepool, Newcastle upon Tyne, North Cumbria, North Tyneside, Northumberland, South Tyneside, Stockton-on-Tees, and Sunderland.

14. ICB leaders (as they are appointed) were therefore expected to proceed with the design and implementation of ICB governance and leadership arrangements before July 2022 to ensure that it could deliver the proposed key functions of Integrated Care Boards as set out in the Health and Care Bill:
    - Developing a plan to meet the health needs of the population
    - Allocating resources (revenue and capital) to deliver the plan
    - Agree contracts with providers
    - Establishing joint working and governance arrangements between partners
    - Leading major service transformation programmes across the ICS
    - Implement the NHS People Plan
    - Leading system-wide action on digital and data
    - Coordinating joint work on estates and procurement
    - Leading emergency planning and response

15. In addition to these functions, the Integrated Care Board will inherit a comprehensive range of statutory duties which are currently the responsibility of our Clinical Commissioning Groups. These include the duties to:
    - Promote the NHS Constitution
    - Obtain professional advice in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health
    - Improve the quality of services
    - Promote integration
    - Reduce inequalities
    - Promote effectiveness and efficiency
    - Promote patient choice
    - Promote patient involvement
    - Promote education and training
    - Promote research and innovation
    - Have regard to the wider effect of its decisions

KEY ACTIONS

16. A key task for JMEG was to consider how the ICB would be populated. National guidance set out minimum expectations for the membership of the ICB; these were as follows:
    - An Independent Chair plus a minimum of two other independent non-executive directors. (These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.)
    - At least one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
    - At least one member drawn from general practice within the area of the ICS NHS body
    - At least one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.
    - A Chief Executive, a Director of Finance, a Director of Nursing, a Medical Director and other directors as required.

RATIONALE

17. The composition of our ICB Board reflects the size and scale of our ICS footprint. So, in addition to the minimum requirements for three partner members from primary care, foundation trusts, and local authorities we increased the membership in each of those categories to ensure we had the necessary breadth of perspective from all our sectors and ICS sub-geographies. We anticipate that our four local authority partner members will be drawn from our four key sub-geographies, and will also bring professional expertise from the fields of public health, adults' social services and children's services. These four LA members will be matched by four NHS partner members, with the two foundation trust members being drawn from the fields of acute and mental health care.

18. The composition of our ICB Executive Team reflects both the statutory executives required on our Integrated Care Board, as well as key local priorities for the development of our system. So that in addition to the statutory roles of Chief Executive, Director of Finance and the Medical and Nursing Directors (to ensure our system has robust and effective clinical leadership), we will also appoint a Director of Strategy & System Oversight to coordinate the considerable performance management requirements on a system of our size, and likewise a Director of Corporate Governance, Communications and Involvement, to oversee the significant governance and stakeholder engagement tasks across our whole ICS area.

19. We will also appoint directors responsible for Digital and Information, Innovation, and People to deliver our priorities for workforce development, service improvement and transformation. Alongside this we will appoint two Executive Directors of Place-Based Delivery, each with area portfolios to ensure robust links between each of our thirteen places (and their natural sub-regional groupings) and the work of the ICB.

20. Membership of the ICB (referred to in the constitution as "the Board" and members of the ICB (referred to as "Board Members") will consist of:

    13 Non-executive Members
    - Independent Chair
    - Four independent non-executive members
    - Eight Ordinary Members (partner members):
        - 4 Local Authority members
        - 2 Foundation Trust members
        - 2 Primary Medical Services members

11 Executive Members:

- Chief Executive
- Executive Finance Director
- Executive Medical Director
- Executive Chief Nurse
- Executive Chief People Officer
- Executive Chief Digital and Information Officer
- Executive Director of Innovation
- Executive Director of Corporate Governance, Communications & Involvement
- Executive Director of Strategy & System Oversight
- Two Executive Directors of Place Based Delivery

2 Participants (non-voting attendees)

- North East and North Cumbria ICS HealthWatch Network
- North East and North Cumbria Voluntary Sector Partnership

ACTIONS AND TIMESCALES

21. Following the recommendation of JMEG to support the proposed membership and composition of the ICB, a Draft Constitution was then taken through the governing bodies of our eight CCGs who then each took the decision to formally propose the draft for submission into NHS for approval. This was submitted to NHS England on 7 December and they have confirmed that they are content with our Draft Constitution. We then have until 11 March 2021 to make any further amends to the Constitution (in the light of expected further guidance or legislation) after which it must be submitted again to NHS England for ratification. When the ICB assumes statutory status as expected from 1 July 2022, the board will then have to formally adopt the ICB Constitution at its first meeting.

22. We are also required to development a suite of documents which will be attached in a governance handbook to the Constitution. These include a Functions and Decisions Map, a Scheme of Reservation and Delegation and Standing Financial Instructions, and a suite of policies including Conflicts of Interest and Standards of Business Conduct. We must also append the Terms of Reference for all our ICB sub-committees as an annexe to the Constitution. These documents are now in advanced draft pending approval by the ICB's designate Chair and Chief Executive ahead of formal approval by the statutory ICB in July 2022.

DELEGATION OF FUNCTIONS AND ACCOUNTABILITIES FROM THE INTEGRATED CARE BOARD.

23. In addition to the development of the ICB itself, consideration needed to be given by JMEG to the appropriate delegation of functions and accountabilities from the board to its constituent places.

24. Sensitivity to the needs of our places has been a key principle guiding our ICS development work. Indeed, a consistent feedback theme from our meetings with both individual health and care service leaders, frontline staff and service users, and from our multi-sectoral engagement events with colleagues from across our region, was the importance of effective place-based working. In managing this complex transition process we need to be careful not to disrupt the effective local networks of primary care professionals, social care staff, and colleagues in the voluntary sector,

who make service integration work in practice in each of our places – as well as the accountability of local services to elected members and service users.

25. However, our colleagues and partners have also told us that there are exciting opportunities for us to identify those shared challenges where our collective efforts could unlock huge progress in improving health and care. This has been our focus as we prepare for the ICB assuming statutory status in 2022: how to build on and strengthen further how the NHS works at place and neighbourhood level, alongside strengthening our capacity to tackle our strategic challenges with urgency and innovation.

26. Our ICS will therefore build upon existing local place-based arrangements, such as the joint planning and decision-making forums established between the NHS and local authorities, and our NHS foundation trusts and local primary care networks (made up of GPs and other health and care professionals) – working with local authority and voluntary sector partners, in improving health and wellbeing and extending the reach and effectiveness of our services.

27. A key task for JMEG was to consider which of the ICB's functions should be discharged at a strategic system-wide level, and which should delegated to our places. These deliberations were both constructive, and clarifying, and helped us to reach a consensus on a broad division of ICB functions between system and place.

28. Therefore, while recognising that for most people their health and care needs are best met by integrated, place-based services, we are also committed to working together 'at scale' on a number of strategic issues where that makes sense and adds value, harnessing our collective resources and expertise to make faster progress on improving health outcomes. The advantage of working at scale will allow us to:
    - Collectively prioritise based on a shared understanding of need.
    - Target our investment on shared priorities.
    - Mobilise our collective resources, including our 170,000 strong health and care workforce.
    - Set stretching and consistent service standards, especially for vulnerable groups.
    - Manage pressures together as a system.
    - Share and spread best practice.
    - Make better use of technology and digital resources.
    - Develop shared functions and reduce duplication.
    - Act with 'one voice' to represent the region, securing additional resources and influencing the direction of national health and care policy.
    - Manage overall resources, performance and financial risk
    - Plan and commissioning specialised services across larger footprints
    - Deliver improvement programmes for quality and patient safety
    - Harness innovation by building our research capacity
    - Driving digital and advanced analytics as enablers
    - Ensure robust health emergency planning and resilience
    - Improving population health and reducing health inequalities
    - Deliver consistent strategic communications

29. We then considered the relationship between the ICB and the 'place-based partnerships' that will exist in each of our thirteen local authority areas, and which hitherto have been led by our eight Clinical Commissioning Groups. We then agreed the key functions that we will discharge at place level, and the resources that will be delegated to our places in support of integrated working:

- Fostering service development and delivery with a focus on neighbourhoods and communities
- Commissioning local integrated community-based services for children and adults (including care homes and domiciliary care).
- Primary care commissioning – building the capacity of local Primary Care Networks and supporting their clinical leadership role.
- Local Clinical Leadership including clinical pathway redesign and helping shape the commissioning of acute services
- Monitoring the quality of local health and care services – including support to care homes, e.g. infection prevention and control.
- Forging strong working relationships with the wider local system including HealthWatch, the VCSE sector, and other local public services.
- Building strong relationships with communities

30. We must also continue to work alongside each of our local authorities to deliver these key responsibilities:
    - Participation in Health & Wellbeing Boards to develop local Joint Strategic Needs Assessments and Joint Health & Wellbeing Strategies
    - Joint initiatives to promote health, prevent disease and reduce inequalities
    - Joint commissioning and leadership of local services:
        - Continuing Health Care
        - Personal Health Budgets
        - Community mental health, LD and autism
        - Children & young people (transitions/SEND/LAC)
    - Service integration initiatives and jointly funded work through, e.g. the BCF and Section 75.
    - Fulfilling the NHS's statutory health advisory role in adults and children's safeguarding.
    - The provision of updates to local Scrutiny Committees and Lead Members on local health and care services.

GUIDANCE

31. Following the principle of form following function, we then considered the options for place-based governance to oversee these delegated functions, options for which were set out in *Thriving Places: development of place-based partnerships*, September 2021.

REQUIREMENTS

32. Place-based partnerships will remain as the foundations of statutory integrated care systems, building on existing local arrangements and relationships. System partners will need to determine the footprint for each place-based partnership, their leadership arrangements, and what functions they will carry out. ICBs are required to set out which of its statutory duties and functions it delegates and which it reserves, in a **Functions and Decisions Map** which will be included as an annexe to the draft ICB Constitution (see appendix 2).

33. NHS partners will be accountable through NHS England and to central government; local authority partners are *accountable* to their communities through local democracy. Place-based partnerships should therefore agree arrangements to fulfil these relationships appropriately, including how they engage council elected members or NHS non-executive directors in decision-making, as well as their relationships with HWBs and local authority health overview and scrutiny arrangements.

34. Five broad governance options have been set out in the national 'Thriving Places' guidance which the ICB and each of its thirteen-constituent place-based partnerships will need to

consider. These are not an exhaustive list, and each of these options could be adopted wholly or in combination, but it will be up to local decision-makers to decide which models are most appropriate for their system.

- Consultative forum: To inform and align decisions by relevant statutory bodies in an advisory role.
- Individual executives or staff: Delegate functions to individual members of staff to exercise delegated functions with a committee to support them.
- Committee of a statutory body: Delegated authority to make decisions about the use of resources. The terms of references and scope are set by the statutory body and agreed to by the committee members. A delegated budget can be set to describe the level of resources available to cover the remit of the committee.
- Joint committee: The relevant statutory bodies can agree to delegate defined decision-making and budgetary functions to the joint committee in accordance with their respective schemes of delegation.
- Lead provider: Manages resources and delivery at place-level, as part of a provider partnership, under a contract with the ICB and/or local government, to to deliver agreed outcomes for the place (including national standards and priorities) for the defined set of services.

KEY ACTIONS AND NEXT STEPS

35. As part of the development of Integrated Care Systems (ICSs) during 2021/22, NHS England and NHS Improvement asked ICSs to confirm their initial proposals for place-based arrangements for 2022/23 onwards.

36. It was clear from discussion in JMEG that there were differing views on the suitability of these governance models, depending on the maturity and future ambitions of each of our existing local partnerships. Therefore, there was broad support for an approach characterised by the principles of 'Stabilise – Transition – Evolve', with existing place-based arrangements to carry on as now as the key fora where joint planning and decision-making takes place between statutory NHS and local authority partners, with the opportunity for each of our places to consider which (if any) of the models outlined above would be the best fit for their partnership from July onwards. In practice this will mean that (at least in the interim) the officers appointed to the new Executive Director of Place-Based Delivery roles will hold delegated authority from the ICB for decision-making, utilising their place-based partnerships as key consultative fora.

37. Any future governance arrangements would then need to be mutually agreed between the ICB, local government and other system partners, and refined as needed throughout the year and beyond to reflect the development of working relationships. They should set out:
    - The configuration, size and boundaries of the ICS's places.
    - The system responsibilities and functions to be carried out at place level.
    - The planned governance model, including membership, decision-making arrangements, leadership roles as well as agreed representation on, and reporting relationships with, the ICP and ICB.

38. We anticipate that 2022/23 will be a year of transition, as we adapt to new ways of working, whilst ensuring the stability of our teams in each of our places. We look forward to working with our partners to understand their ambitions and consider which of the nationally recommended governance and operating models would work best for their place-based partnerships, and how they relate to the wider Integrated Care System in which they work.

REPLACING FUNCTIONS OF THE FORMER CLINICAL COMMISSIONING GROUPS

GUIDANCE

39. *ICS implementation guidance: Due diligence, transfer of people and property from CCGs to ICBs and CCG close down* NHS England (2021).

REQUIREMENTS IN GUIDANCE

40. To ensure the continuity of system leadership, a total of 168 functions in different categories will be transferred from our eight CCGs to the ICB. These include:
    - Strategic planning
    - Operational commissioning
    - Personalised commissioning, CHC, FNC, personal health budgets
    - Patient rights, NHS constitution, choice, waiting times, individual funding requests
    - Public involvement and overview & scrutiny
    - Emergencies
    - Corporate (non-commissioning) functions
    - Integrated care board: continuity of CCG statutory functions
    - Constitutional arrangements
    - Performance assessment and oversight by NHS England
    - Partnership, joint working and delegation
    - Finance
    - Responding to miscellaneous requests for information
    - General duties to be discharged alongside substantive functions
    - CCG functions in acts of parliament other than the NHS Act 2006 and the Health & Social Care Act 2012

41. Therefore, in addition to the setting up of the new statutory Integrated Care Board, CCGs and designated ICS leads have been working in partnership to develop and implement a due diligence plan to support the transfer of people, property and liabilities to the ICB from our CCGs. Planning so far has involved identifying and managing risks and issues associated with the transition, whilst maintaining a focus on quality (notably patient safety) throughout the transition period.

42. It is recommended in national guidance that the due diligence plan is in place at least six months in advance of the expected date of transfer and legal establishment of ICBs. The plan should identify the SRO (senior responsible officer) at executive level and operational lead(s), the scope of the exercise, how the individual elements of evidence will be collated and confirmed as accurate, the timeline, the sign off process by each CCG, and any internal or external audit input, as deemed appropriate. CCGs should identify the risks of transition as part of their planning.

43. Our detailed ICS Development and Transition work has therefore been arranged around fifteen key transition workstreams, each led by a senior executive officer, and reporting to the ICS Development and Transition Board.
    - ICS development
    - Informatics BI/ICT/GPIT/Population Health Analytics
    - Finance (including property & assets)
    - Clinical leadership – including Clinical Networks, Primary Care Networks, Nursing, Clinical Quality & Safeguarding, and Medicines Optimisation

- Communication & Engagement
- Human Resources & Org Development
- Integrated Governance
- ICS Digital Strategy
- Commissioning, Contracts and Procurement
- Provider Collaborative Development
- Research & Innovation
- System Performance & Improvement
- ICS Workforce Strategy
- Emergency Planning Preparedness and Response
- Transition Programme Management Office (PMO)

44. CCG Accountable Officers are accountable for CCG Closedown due diligence, but they are being supported by a joint coordinated approach to ensure this work is coordinated, information is shared, and duplication is avoided. In support of this a CCG Closedown Due Diligence Sub-Group of the Integrated Governance Workstream has been established, to lead the necessary gap analysis work and joint planning to ensure the safe and effective transfer of these duties from the sending organisations to the ICB.

ACTIONS AND TIMESCALES

45. Our due diligence planning arrangements are now well-advanced. The final stages of this process will include 'stocktake' assessments of each CCG's due diligence and preparations for transition, which will then be followed by approval of these plans by the ICS Development & Transition Programme Board on the 28 January ahead of formal sign off by the CCG AOs and the ICB Chief Executive on the 11 March 2022.

ESTABLISHING AN INTEGRATED CARE PARTNERSHIP AND AGREEING ITS MEMBERSHIP

46. The second key governance feature of ICSs, alongside the Integrated Care Board, is the Integrated Care Partnership (ICP). This is intended to be a broad alliance of organisations and representatives, built upon existing partnerships, and focused on improving population health and wellbeing, reducing health inequalities, and developing an integrated care strategy setting out how the wider needs of the population should be met.

47. An Integrated Care Partnership is a statutory committee of the ICB and the ICS area's constituent local authorities. Integrated Care Systems cannot be fully functional until their ICP arrangements have been established. An interim version must be up and running when Integrated Care Boards assume statutory status in July 2022

GUIDANCE

48. *Guidance on Integrated Care Partnership (ICP) engagement* issued by the Department of Health and Social Care, NHS England and the LGA, setting out expectations for the role of Integrated Care Partnerships (ICPs) within Integrated Care Systems.

REQUIREMENTS

49. The Department for Health and Social Care, NHS England and the Local Government Association have jointly developed five key expectations for Integrated Care Partnerships. They are intended

to help local authorities and Integrated Care Board Chairs Designate maximise the value that Integrated Care Partnerships can bring to their local communities. They complement and build on the principles set out in NHS England's Integrated Care System Design Framework and are as follows. Integrated Care Partnerships:

- Are a core part of the system, driving direction and priorities;
- Will be rooted in the needs of people, communities and places;
- Create space to develop and oversee population health strategies to improve health outcomes and experiences;
- Will support integrated approaches and subsidiarity;
- Should take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights

50. National guidance is clear that Integrated Care Partnerships should complement place-based working, by tackling issues that are better addressed on a bigger area than just a single place, highlighting where system-level coordination is needed on a range of issues, and challenging partners to deliver the action required, including:
    - Addressing inequalities in health and wellbeing outcomes, experiences and access to health services;
    - Developing strategies to address the needs of their population including specific groups
    - Tackling the wider social and economic determinants of health, by strengthening the role of the NHS in increasing local employment opportunities, and its contribution to improving areas like housing and the environment;
    - Improving people's overall wellbeing and preventing ill-health and premature mortality;
    - Creating a holistic view of how the public and patients interact with services across the Integrated Care System, and on the effectiveness and accessibility of care pathways

51. A key requirement of the Integrated Care Partnership is to develop an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all Integrated Care System partners will be accountable for delivering. National guidance sets out a range of recommended areas for potential inclusion in the development of the Integrated Care Strategy, each aiming to consolidate and enhance integration:

    - ***Service provision*** –seamless care across health, social care, housing, education and other public services, and between different NHS and independent providers;
    - ***Strategic planning*** – includes, for example, making a joint plan to improve population health status and health outcomes;
    - ***Integrated commissioning of services*** – strengthening the partnership between local authorities and the Integrated Care Board to enable them, and other partners, to enhance collaboration in areas such as mental health, learning disability, autism, older people, public protection and reducing offending (where there are health considerations);
    - ***Integrated data sets*** – to give all partners access to inform planning and the delivery of services for the benefit of communities;
    - ***Integrated records*** –using shared electronic care records for non-clinical and back-office functions as well as NHS services;
    - ***Integrated budgets*** – a key element of the delegation of functions into places, supporting the principle of subsidiarity and integration, including the use of Section 75 arrangements.

52. In recognition of the importance of place, the draft Health and Care Bill includes an important role for Health and Wellbeing Boards. They will remain legally distinct from Integrated Care Partnerships but the latter's strategic priorities should be informed by local population health

data as expressed through Joint Strategic Needs Assessments, and local Joint Health and Wellbeing Strategies. ICPs should facilitate opportunities to share innovation and expertise in how to deliver integrated approaches in the context of local circumstances – but they should not seek to overrule or replace existing place-based plans.

53. On recommended membership of ICPs, national guidance states that: "to further embed place in the long-term health and care strategies that are developed, as a minimum, we would expect Integrated Care Partnerships to consider representation from the following sectors:
    - Health and Well Being Board chairs;
    - Directors of Public Health;
    - Clinical and professional experts (including primary, community and secondary care);
    - Adult and children's social services
    - Other providers of health, care and related services;
    - The voluntary community and social enterprise sector;
    - Representatives of those with lived experiences of accessing health and social care services
    - Healthwatch – for their insight into user experience from each of our places

RATIONALE

54. Whilst there is a proposed legislative basis for Integrated Care Partnerships set out in the draft bill – and also extensive national guidance – there is, in addition, considerable flexibility for the Integrated Care Partnership's statutory members and wider partners to determine the precise geographical scope, board composition and operating model.

55. There will be a need to comply with the expectation of an Integrated Care Partnership covering organisations within the entire Integrated Care System geographical boundary. It will have a core membership of representatives from the Integrated Care Board and the 13 local authorities. However, this could be established as an annual (or twice-yearly) strategic forum whilst the day-today planning and discharge of functions could be carried out by Integrated Care Partnerships based on smaller geographical groupings. This can be achieved if smaller Integrated Care Partnerships were to be formally designated as sub-committees of the ICS-wide structure. All their members would then attend an annual/biannual meeting of the large Integrated Care Partnership.

56. There are already well-established partnership forums within our Integrated Care System area, based on geographical groupings that have proven their worth in thinking through better coordination of care and creating new opportunities for wider access to services. Indeed, NHS chairs and local authority leaders, as well as their chief executives and senior officers, have already been meeting together informally in this way for several years, building the relationships and trust that are helping to deliver increasing levels of integration and joint planning.

57. These partnerships have been grouped within the Integrated Care System area as follows:
    - In the northern part: Gateshead, Newcastle upon Tyne, North Tyneside, Northumberland;
    - In the central part: County Durham, South Tyneside, Sunderland;
    - In the Tees Valley: Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, Stockton-on-Tees.
    - North Cumbria as a separate partnership given their unique challenges of geographical isolation and service fragility, and their need to collaborate on these challenges with the Integrated Care Partnership for Lancashire and South Cumbria, as well as its neighbours to the east. There is no natural fit with the other north east geographical groupings for Integrated Care Partnership purposes.

KEY ACTIONS AND NEXT STEPS

58. All systems will need to have at least an interim Integrated Care Partnership up and running when statutory Integrated Care Boards assume statutory status in July 2022. An interim ICP needs to comprise a chair and a committee of at least the statutory members (the Integrated Care Board and local authorities), and for there to be agreement on how the committee will be resourced. Local authorities will not be given any additional funding to support the Integrated Care Partnership but should agree with their health counterparts how best to provide the necessary secretariat and other functions vital to the partnership.

59. NHS Integrated Care Board Chairs Designate have been asked by NHS England to ensure the following steps are carried out in their system, in partnership with local government:
    - Ensure that the statutory Integrated Care Partnership partners come together as required to oversee the set-up, including engagement with stakeholders
    - Reach agreement between NHS and local authority leaders as to how the Integrated Care Partnership will be established and a secretariat resourced
    - Appoint an Integrated Care Partnership chair-designate, taking account of national guidance and ensuring there is a transparent and jointly supported decision-making process
    - Determine key questions to be resolved for the system, including, but not limited to, chairing, committee membership, public engagement, and strategy development.

60. The derivation of our approach to ICS development has followed a flow of discussion from the principles of "form following function" and "first doing no harm." These same principles have guided proposals to establish our Integrated Care Partnership arrangements within the North East and North Cumbria Integrated Care System. The members of JMEG were therefore unanimous in their support for the following recommendations:

    a) Establish an overarching single North East and North Cumbria Integrated Care Partnership (to fulfil statutory requirements) that would meet once or twice a year as a strategic forum with core representation from the 13 local authorities and the Integrated Care Board. A wide range of other partners would also become members of this Integrated Care Partnership. The functions of this ICP will follow draft legislation and national guidance for Integrated Care Systems but broadly encompassing, for example: tackling the wider determinants of poor health and health inequalities, NHS action to contribute to economic regeneration and sustainable environments and ensuring that all communities in places have wider and equitable access to diagnosis and treatment in specialist centres.

    b) Appoint a chair of the overarching Integrated Care Partnerships after consultation with local authorities and the NHS.

    c) Establish four Integrated Care Partnerships as subcommittees of the North East and North Cumbria-wide statutory Integrated Care Partnership. The functions of each to follow draft legislation and national guidance for Integrated Care Systems but broadly encompassing, for example: tackling the wider determinants of poor health and health inequalities, NHS action to contribute to economic regeneration and sustainable environments, and ensuring that all communities in places have wider and equitable access to diagnosis and treatment in specialist centres. These four Integrated Care Partnerships to cover:

    - **The north**: comprising Gateshead, Newcastle-upon-Tyne, North Tyneside, Northumberland;

- **The central part**: comprising County Durham, South Tyneside, Sunderland;
- **The Tees Valley**: comprising Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, Stockton-on-Tees.
- **North Cumbria:** acknowledging its relative remoteness, its relationship to forthcoming local authority structural changes, and the need to interact with other Integrated Care Systems.

d) The chair of each of the four Integrated Care Systems to be appointed in consultation with local stakeholders.

e) The Integrated Care Board together with local authorities to convene a first exploratory meeting of the system-wide Integrated Care Partnership in early 2022 – initially with statutory members only (representatives of the ICB and the 13 local authorities). This meeting will consider chairing and membership arrangements, the relationship between the system-wide and sub-regional ICPs, and how we can jointly develop our integrated care strategy building up a picture of health and care needs from each of our places.

CONCLUSION

61. The meetings of JMEG have been an extremely important milestone for our integrated care system in the North East and North Cumbria. The consideration of both local feedback and national guidance on ICS development has helped to build a broad-based understanding across our statutory partners in the NHS and local authorities of the tasks ahead of us, and the opportunities that moving to this new way of working presents for the public and patients of the North East and North Cumbria.

62. JMEG's deliberations have helped us to shape a strong Constitution for our ICB and a membership that is both appropriately inclusive and representative. We have considered the needs of our places, and how the work of the ICB can continue to support our existing place-based working arrangements through the appropriate delegation of ICB functions. We have also set out some guiding principles for the development of our Integrated Care Partnership, which will include a model of sub-regional working that is sensitive to existing partnerships and ways of working.

63. The experience, insight and constructive engagement that colleagues have brough to this process have been exemplary and have helped us to build a governance and operating model for our ICS that we hope will command the confidence of all our staff, our stakeholders, and the communities that we serve.

APPENDIX 1

JOINT MANAGEMENT EXECUTIVE GROUP (JMEG) OF NHS BODIES AND LOCAL AUTHORITIES TO DISCUSS IMPLEMENTATION OF STATUTORY ARRANGEMENTS FOR THE INTEGRATED CARE SYSTEM (ICS) NORTH EAST AND NORTH CUMBRIA (NENC)

LIST OF PARTICIPANTS

NHS MANAGEMENT

Sir Liam Donaldson, Chair Designate, NHS North East and North Cumbria Integrated Care Board. liam.donaldson1@nhs.net

Clinical Commissioning Groups

Mark Adams, Accountable Officer, NHS Newcastle Gateshead CCG, NHS North Cumbria CCG, NHS North Tyneside CCG, NHS Northumberland CCG mark.adams11@nhs.net

Dave Gallagher, Accountable Officer, NHS Tees Valley CCG dgallagher@nhs.net

Dr Neil O'Brien, Accountable Officer, NHS County Durham CCG, NHS South Tyneside CCG, NHS Sunderland CCG neilobrien@nhs.net

NHS Foundation Trusts

Ken Bremner, Chief Executive, South Tyneside and Sunderland NHS Foundation Trust ken.bremner@nhs.net

Dame Jackie Daniel, Chief Executive, The Newcastle upon Tyne Hospitals, NHS Foundation Trust jackie.daniel@nhs.net

Julie Gillon, Chief Executive, North Tees and Hartlepool NHS Foundation Trust julie.gillon1@nhs.net

Sir Jim Mackey, Chief Executive, Northumbria Healthcare NHS Foundation Trust Jim.Mackey@northumbria-healthcare.nhs.uk

Lyn Simpson, Chief Executive, North Cumbria Integrated Care NHS Foundation Trust Lyn.Simpson@ncic.nhs.uk

Apologies:

Alan Foster, Executive Lead, NHS North East and Cumbria Integrated Care Board alan.foster7@nhs.net

John Lawlor, Chief Executive, Cumbria, Northumberland, and Tyne and Wear, NHS Foundation Trust John.Lawlor@cntw.nhs.uk

LOCAL AUTHORITY MANAGEMENT

Gill Steward, Chief Executive, Cumbria County Council gill.steward@cumbria.gov.uk

LA7 group of Local Authorities:

Paul Hanson, Chief Executive, North Tyneside Council paul.hanson@northtyneside.gov.uk

John Hewitt, Chief Executive, Durham County Council john.hewitt@durham.gov.uk

Daljit Lally, Chief Executive, Northumberland County Council daljit.lally@northumberland.gov.uk

Al McDowell, Director of Adult Social Care and Integrated Services, Newcastle City Council alison.mcdowell@newcastle.gov.uk

Jon Ritchie, Executive Director of Corporate Services, Sunderland City Council (and representing Local Authority Finance Directors) jon.ritchie@sunderland.gov.uk

Nicola Robason, Head of Corporate and External Affairs, South Tyneside Council (and representing Local Authority Monitoring Officers) nicola.robason@southtyneside.gov.uk

Alice Wiseman, Director of Public Health, Gateshead Council alicewiseman@gateshead.gov.uk

Tees Valley group of Local Authorities:

John Sampson, Managing Director, Redcar & Cleveland Council john.sampson@redcar-cleveland.gov.uk

Mark Adams, Director of Public Health, Redcar & Cleveland and Middlesbrough Councils mark_adams@middlesbrough.gov.uk

Craig Blundred, Director of Public Health, Hartlepool Council craig.blundred@hartlepool.gov.uk

Erik Scollay, Director of Adult Social Services, Middlesbrough Council erik_scollay@middlesbrough.gov.uk

James Stroyan, Director of People, Darlington Council james.stroyan@darlington.gov.uk

Ann Workman, Director of Adults & Health, Stockton-on-Tees Council ann.workman@stockton.gov.uk

TRANSITION TEAM AND SECRETARIAT

Nic Bailey, Chief Officer, NHS County Durham CCG nicola.bailey5@nhs.net

Jo Dobson, Director of Improvement and Sustainability, NHS North East and North Cumbria Integrated Care Board joannedobson@nhs.net

Vicky Evans, Senior Project Manager, North of England Commissioning Support Victoria.evans5@nhs.net

Dan Jackson, Director of Governance and Partnership, NHS North East and North Cumbria Integrated Care Board danjackson@nhs.net

Michelle McGuigan, Organisational Development & Corporate Services Director, North of England Commissioning Support m.mcguigan@nhs.net

Audrey Pickstock, Director of Operational Finance (North East and North Cumbria) NHS England and NHS Improvement audrey.pickstock@nhs.net

Alison Slater, Director of Strategy and Transformation (North East and North Cumbria) NHS England and NHS Improvement alison.slater3@nhs.net

Ali Wilson, Director of Strategic Development, NHS Tees Valley CCG ali.wilson@nhs.net

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting
6 April 2022

Title of report	Modern Slavery Statement 2021/22
Report author(s)	Debbie Henderson, Director of Communication and Corporate Affairs/ Board Secretary
Executive Lead	James Duncan, Chief Executive

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing		Work together to promote prevention, early intervention and resilience	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	
To be a centre of excellence for mental health and disability		The Trust to be regarded as a great place to work	X

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	N/A
Audit	N/A
Mental Health Legislation	N/A
Remuneration Committee	N/A
Resource and Business Assurance	N/A
Charitable Funds Committee	N/A
CEDAR Programme Board	N/A
Other/external (please specify)	N/A

Management Group meetings where this item has been considered (specify date)	
Executive Team	N/A
Corporate Decisions Team (CDT)	N/A
CDT – Quality	N/A
CDT – Business	N/A
CDT – Workforce	N/A
CDT – Climate	N/A
CDT – Risk	N/A
Business Delivery Group (BDG)	N/A

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or disability		Reputational	x
Workforce	x	Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness		Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
N/A

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Modern Slavery Statement

1. Executive Summary

Every organisation with a turnover of £36m+ has to produce a Modern Slavery Statement and prominently display it on its website. This is a legal requirement from the Modern Slavery Act 2015.

The Trust statement has been updated for the end of the financial year 2021/22 in-line with the statutory requirements and has been approved by the Board of NTW Solutions Limited at its meeting on 15 March 2022. It is also displayed on the NTW Solutions Limited Website.

The statement provides assurance to the public that all aspects of our business is transparent, particularly in relation to our supply chain and recruitment processes and reiterates the Trust's commitment to tackling modern slavery.

2. Recommendation

The Board of Directors are asked to approve the organisations Modern Slavery Statement provided in Appendix A for the financial year 2021/22 for uploading to the Trust website.

Debbie Henderson
Director of Communications and Corporate Affairs/Company Secretary
April 2022

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Modern Slavery Statement 2021/22

Modern Slavery Statement

Due to the scope of our business Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) recognises that we may be at risk of Modern Slavery (slavery, servitude, forced labour and human trafficking). The following statement has been published in accordance with the Modern Slavery Act 2015 and sets out the steps that will be taken by CNTW during the financial year to the end of March 2023 to prevent modern slavery and human trafficking in its business and supply chains.

Our Organisation

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust is a specialist provider of mental health and disability services within the UK.

Our Commitment

CNTW condemns slavery of all forms and is fully committed to working with suppliers within our supply chain to support the human rights and welfare of the employees working alongside CNTW. We expect organisations with whom we do business to adopt and enforce policies that comply with this legislation; and would immediately seek to terminate our relationship with a supplier where evidence of a failure to comply with our policies was discovered.

CNTW is committed to ensuring that those involved within the supply chain of our business operations are working of their own free volition, in the delivery of high-quality services to all customers through a skilled and experienced workforce. CNTW will endeavour to make a conscious effort to monitor operations to ensure no individual is taken advantage of. It is the intention of CNTW to train relevant staff to recognise and report instances where the freedom of an individual is questioned.

Policies and Procedures.

Our policies and procedures demonstrate our commitment to acting ethically and with integrity in all our business relationships and to implementing and enforcing effective systems and controls to ensure slavery and human trafficking is not taking place anywhere in our supply chains.

CNTW complies with external policies and processes for safe recruitment and where necessary relevant employment checks will be conducted.

The approach for internal recruitment follows robust processes which are in line with UK Employment Laws including ‘right to work’ document checks and contracts of employment. Our Pay structure is from national collective agreements and is based on equal pay principles.

All policies and procedures are developed alongside the relevant subject matter expert and signed off at an appropriate level within the Organisation.

Due Diligence
As part of our efforts to monitor and reduce the risk of slavery and human trafficking occurring within our supply chain, we have taken steps to enable us to: -

- Establish and assess areas of potential risk in our business and supply chain
- Monitor potential risk area in our business and supply chains
- Reduce the risk of slavery and human trafficking occurring in our business and supply chains through the expectation that each entity in the supply chain, at least adopt 'one-up' due diligence on the next link in the chain as it is not practical for us to have a direct relationship with all links in the supply chain and
- Provide adequate protection for whistle-blowers.

Most of our purchases are against existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of contract which have the requirement for Suppliers to have suitable anti-slavery and human trafficking policies and processes to be in place.

We understand that our biggest exposure to Modern Slavery is within the recruitment process and undertake to raise awareness within the business in order to identify any potential situations from the first instance.

Due diligence is expected throughout the whole recruitment process and throughout the workers employment within the business. Procedures are reviewed to eliminate risk and gain compliance across all business locations.

Training and Awareness
All new internal employees must attend a local inductions session which will provide information on the organisation, our values, policies and procedures and include information on Modern Slavery.

Existing staff will be made aware of Modern Slavery through local briefings planned through the year.

Our Procurement and Logistics service employ Chartered Procurement & Supply Professionals who are qualified as Fellows and Members of the Chartered Institute of Procurement and Supply who have passed the Ethical Procurement and Supply Final Test which is attached to this Professional Registration.

Overview
CNTW are committed to ensuring we operate towards the best practices at all times. By implementing and continually reviewing checks which minimise the risk of any form of modern slavery taking place within our operations, we are able to support the relevant government authorities in reporting any identified situations, and as such protect our business, our clients businesses and first and foremost, our workers.

James Duncan
Chief Executive on behalf of the Board of Directors
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
April 2022