Board of Directors Meeting (PUBLIC)

Wed 03 February 2021, 13:30 - 15:30

Microsoft Teams

Agenda

1. Service user story

Service User

2. Welcome and apologies for absence

Ken Jarrold, Chairman

3. Declarations of Interest

Ken Jarrold, Chairman

4. Minutes of meeting held 2 December 2020

Ken Jarrold, Chairman

4. mins Board PUBLIC meeting 2.12.20 DRAFT final.pdf (9 pages)

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

Ken Jarrold, Chairman

5. BoD Action Log PUBLIC as at 03.02.21.pdf (2 pages)

6. Chairman's Update

Ken Jarrold, Chairman

7. Chief Executive's Update

John Lawlor, Chief Executive

7. CE_Report_February_2021.pdf (4 pages)

Quality, Clinical and Patient Issues

8. Covid-19 Response Update

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

8. Covid 19 Update (Jan 2021).pdf (5 pages)
8. Covid 19 Update (Jan 2021) - Appendix 1.pdf (2 pages)

8.1. Covid-19 Infection Prevention and Control Assurance Report

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

8.1 IPC - Board Assurance Framework -Q3 end Dec for Feb Board 2021 FINAL.pdf (22 pages)

9. Safer Staffing Levels (Q3) including 6 monthly skill mix review

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

9. Safer Staffing Report Including Six Month Skill Mix - November 2020 data.pdf (13 pages)

10. Service User and Carer Experience Report (Q3)

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

10. Service User and Carer Experience Report Q3 2020-21 FINAL.pdf (7 pages)

11. Commissioning and Quality Assurance Report (Month 9)

Lisa Quinn, Executive Director Commissioning and Quality Assurance

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

Strategy and Partnerships

12. ICS Collective Promise

Lynne Shaw, Executive Director Workforce and Organisational Development

12. ICS Collective Promise.pdf (5 pages)

13. Update on CAMHS services, Tees Valley

Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

13. West Lane Board Update Jan 2021 Final.pdf (4 pages)

Workforce

14. Medical Recruitment update

Rajesh Nadkarni, Executive Medical Director

14. Medical Recruitment Update - NCumbria. January 2021...pdf (5 pages)

Regulation and Compliance

15. Board Assurance Framework and Corporate Risk Register (Q3)

Lisa Quinn, Executive Director Commissioning and Quality Assurance

- 15. Trust-wide Risk Management Report - Appendix 1.pdf (1 pages)
- 15. Trustwide Risk Management Report Jan 21.pdf (9 pages)
- 15. Trust-Wide Risk Management Report - Appendix 3 Jan 21.pdf (28 pages)

16. CQC Report - Children and Young People's Service

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 16. CAMHS Inspection Report - FACAC (Appendix 1).pdf (7 pages)
- 16. CAMHS Inspection Report - Final 15.01.21 (Appendix 2).pdf (7 pages)
- 16. CQC CAMHS Focused inspection - Final report.pdf (3 pages)

17. CQC Must Do Action Plan update

Lisa Quinn, Executive Director Commissioning and Quality Assurance

- 17. CQC Must Do Action Plans Q3 Update FINAL.pdf (32 pages)

18. CQC Strategy for 2021 and beyond

Lisa Quinn, Executive Director Commissioning and Quality Assurance

- 18. CQC New Strategy Consultation.pdf (5 pages)
- 18. CQC New Strategy Consultation (Appendix 2).pdf (26 pages)

19. NHSE/I Single Oversight Framework Compliance Report

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 19. NHS Improvement Single Oversight Framwework - Quarter 3 2020-21.pdf (4 pages)

20. Standing Financial Instructions and Scheme of Delegation

James Duncan, Executive Director Finance and Deputy Chief Executive

- 20. Board Report SFIs and SORAD.pdf (3 pages)
- 20. Scheme of Reservation and Delegation - latest draft SJ.pdf (29 pages)
- 20. Standing Financial Instructions Policy (005) (clean) - C.pdf (62 pages)

21. Resource Planning for 2021/22

James Duncan, Executive Director of Finance and Deputy Chief Executive

- 21. CNTW Finance for a purpose.pdf (8 pages)
- 21. Resource Planning 2021-22 (Feb Board).pdf (7 pages)

22. Quality Account

Lisa Quinn, Executive Director Commissioning and Quality Assurance

- 22. Quality Account 2021 (Feb Board).pdf (7 pages)

23. HENE Self-Assessment Report

Rajesh Nadkarni, Executive Medical Director

- 23. 2019-20 CNTW GRID.pdf (1 pages)
- 23. 2020 Education Self Assessment Report Board summary.pdf (2 pages)
- 23. Summary cover sheet 2020 board.pdf (1 pages)

Minutes and papers for information

24. Committee updates

Committee Chairs

25. Council of Governor issues

Ken Jarrold, Chairman

26. Any Other Business

Ken Jarrold, Chairman

27. Questions from the public

Ken Jarrold, Chairman

For Information

28. Item 23. CNTW Self-Assessment Report (SAR) 2020

- 23. CNTW Self-Assessment Report (SAR) 2020.pdf (57 pages)

29. Date and time of next meeting

Wednesday 3rd March 2021, Via Microsoft Teams

Wednesday 3rd March, 1:30pm - 3:30pm Microsoft Teams

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

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

Present:

Ken Jarrold, Chairman
David Arthur, Non-Executive Director
Darren Best, Non-Executive Director
Les Boobis, Non-Executive Director
Paula Breen, Non-Executive Director
Alexis Cleveland, Non-Executive Director
Michael Robinson, Non-Executive Director
Peter Studd, Non-Executive Director

John Lawlor, Chief Executive
James Duncan, Deputy Chief Executive/Executive Finance Director
Rajesh Nadkarni, Executive Medical Director
Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
Lisa Quinn, Executive Director of Commissioning and Quality Assurance
Lynne Shaw, Executive Director of Workforce and Organisational Development

In attendance:

Debbie Henderson, Director of Communications and Corporate Affairs
Kirsty Allan, Acting Corporate Affairs Manager (Minute Taker)
Fiona Grant, Lead Governor, Adult Services
Anne Carlile, Carer Governor for Adult Services
Fiona Regan, Carer Governor for Learning Disabilities
Claire Keys, Staff Governor - Clinical
Margaret Adams, Public Governor for South Tyneside
Tom Bentley, Public Governor for Gateshead
Bob Waddell, Staff Governor – Non-clinical
Felicity Mendelson, Local Authority Governor
Russell Bowman, Service User Governor – Neuro Disability Services
Wilf Flynn, Local Authority Governor – South Tyneside Council
Kelly Chequer, Local Authority Governor - Sunderland
Evelyn Bitcon, Shadow Public Governor - Cumbria
Frances Saint, Peer Support Worker
Anna Foster, Deputy Director of Commissioning and Quality Assurance *(Item 15)*
Sarah Neil, Sustainability Officer *(Item 15)*
Allan Fairlamb, Head of Commissioning and Quality Assurance *(Item 11)*
John Bolland, IPS Team Lead, North of Tyne *(Item 12)*
Junior Atalassi, Newcastle City Council IT Technician *(item 12)*

1. **Service User story**

Ken Jarrold extended a warm welcome and thanks to Fran Saint, Peer Support Worker who attended the Board to share her story including her experiences, achievements and challenges on her journey to recovery.

Lisa Quinn shared with Board that Fran was a member of the interview panel undertaken at national level, for the Provider Collaborative process. Lisa referred to Fran's request to champion Peer Support Workers and people with lived experience as part of the new ways of working around provider collaboratives, particularly in the young person's pathway.

2. Welcome and apologies for absence

There were no apologies for absence.

3. Declarations of interest

There were no conflicts of interest declared for the meeting.

4. Minutes of the meeting held 4 November 2020

The minutes of the meeting held 4 November were considered.

Approved:

- **The minutes of the meeting held 4 November 2020 were approved as an accurate record**

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

With regards to action 06.11.2019 (12) and 02.09.20 (5) Gary O'Hare mentioned the Staff Friends and Family Test will be aligned with the Reset and Redesign work and an update will be provided at February Board.

With regards to action 02.09.20 (13) Rajesh Nadkarni confirmed an update will be provided at February Board.

With regards to action 05.08.20 (07) James Duncan confirmed the Trust Green Paper will be launched in January. The Board agreed for the action to be closed.

6. Chairman's remarks

Ken Jarrold referred to this meeting as the first Board meeting since being re-appointed as Chairman and expressed his gratitude to the Governors for his re-appointment as Chairman of Council of Governors but also as Chairman of Board of Directors.

Ken referred to the national Consultation on Integrated Care Systems and advised that, alongside submitting his own views, consideration was being given to the value of submitting a Trust level response given the complexities of the Trust's geography and membership of several ICPs. Ken also invited Governors to submit their own individual responses. Ken referred to the proposals and noted his concerns regarding the role of Primary Care, and ensuring involvement and influence at every level of the NHS.

Resolved:

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

7. Chief Executive's Report

John Lawlor referred to the national staff survey and noted the Trust response rate as lower than the previous year at 51%. John also noted the Trust's decision to move away from distribution of printed copies of the survey to completion of the survey electronically due to Covid-19 restrictions. There has been a lower response rate in inpatient areas. The full report is expected to be published by NHS England in February 2021.

John briefed the Board on the launch of the Trust Organisational Improvement Collaborative on 26th November 2020. The collaborative will be open to staff working at all levels who would like to be involved in improvement projects across the Trust, with the ambition of improving service delivery and experience for our service users, carers and staff. John discussed the benefits in engaging staff in transformational and incremental change. The collaborative supports delivery of the Trusts strategic ambitions, workforce priorities and supporting talent management by supporting people to learn new skills and gain experience outside of their current role.

John referred to the Community Mental Health Transformation programme which sets out a vision for transforming community mental health for the North East and North Cumbria region. A region-wide proposal was submitted to NHS England in November with feedback on plans expected in December 2020.

John acknowledged the first anniversary of the National Institute for Health Research Applied Research Collaboration (ARC), hosted by the Trust. It represented one of 15 ARCs nationally, each tasked to lead on a specific area of research. The CNTW ARC had been asked to lead on two themes: prevention and inequalities.

Resolved:

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

Quality, Clinical and Patient Issues

8. Quality Accounts 2019/20

Lisa Quinn briefed the Board on the alternative arrangements, due to Covid-19, for consultation with stakeholders on the 2019/20 Quality Account, including Overview and Scrutiny Committee (OSC) feedback. Lisa noted that final stakeholder statements had now been included in the final version submitted to the Board for approval.

Lisa provided responses to the comments received from the Newcastle OSC. Lisa noted that the statement received was a fair reflection of the Trusts current areas of focus for improvements. This had also been demonstrated in other stakeholder feedback although an opportunity to provide assurance to Newcastle Clinical Commissioning colleagues as part of the consultation process had not been

forthcoming. Assurance would be provided via monthly meetings with Commissioning colleagues going forward.

Michael Robinson referred to the OSC statement and queried how the ongoing dialogue would be achieved. Lisa advised that an invitation had been extended to the Trust to provide ongoing assurance and noted that the Trust has always had close links with the OSC, including development and delivery of the 'Deciding Together' Programme with Newcastle/Gateshead CCG.

Resolved:

- **The Board received and approved the Quality Account.**

9. Response to COVID-19 Pandemic

Gary O'Hare provided an update on the Trusts response to the Covid-19 pandemic and advised the Board there is a levelling off across the region of the number of Covid-19 patients as well as admissions into acute hospitals.

There have been 261 staff tested positive for Covid-19 since the beginning of September and currently 273 staff are absent from work with Covid-19 related symptoms being either positive, shielding or self-isolating with an overall staff absence equivalent to 9% of the workforce.

Gary noted there had been 16 outbreaks across the Trust since 1st September and the Trust was currently managing seven outbreaks all within inpatient wards. Gary confirmed there are four patients currently positive with Covid-19, none of which are hospital acquired. Gary mentioned that since the instruction that face masks be worn across the whole Trust at all times there have been no outbreaks which is a positive reflection of staff behaviours.

Gary confirmed 500 Lateral Flow Device test kits had been deployed to community staff within older people and learning disability services, who also work within care homes, as a priority. Gary estimated it would take approximately four weeks to deploy 6500 LFD test kits to staff across the Trust and a clear plan was in place.

Gary confirmed the Pfizer vaccine had received approval from Medicines and Healthcare products Regulatory Agency (MHRA) and work was underway to be in a position to deploy the vaccine as soon as it arrives into the Trust.

Gary drew the Boards attention to the ongoing learning opportunities resulting from the Trusts actions in response to the pandemic and noted after every outbreak the Trust reviews the learning to minimise any future outbreaks.

Resolved:

- **The Board received and noted the Response to COVID-19 Pandemic.**

10. Commissioning and Quality Assurance Report (Month 7)

Lisa Quinn noted three remote Mental Health Act reviewer visits. Lisa mentioned there were a number of areas of concern raised for each of the inspections resulting in the development of an action plan, monitored by the weekly Business Delivery Group meetings.

Lisa reported a further reduction in people waiting more than 18 weeks to access non-specialised adult services and children and young people's services..

James Duncan highlighted at Month 7 the Trust had delivered a £96k surplus. Bank and overtime costs had decreased but remained higher than levels in 2019-2020 with the decrease being an offset by an increase in agency costs. The Trust had incurred £0.3m additional costs due to Covid-19 and these had been included in the forecast in the financial plan. The Trust had identified £4.7m operational Covid-19 costs up to Month 7. The Trust was also incurring the costs of additional services developed to support the pandemic.

Peter Studd queried the Mental Health Act visits and referred to two comments about a patient going missing at Tweed and patients waiting for transfer or admission into PICU that did not need to be there. Lisa confirmed both comments were correct. Gary O'Hare noted a full action review regarding the absconded patient had been carried out, which would be circulated with Board members.

With regard to the admission to PICU, Lisa advised that a patient was admitted due to the lack of beds available in the male pathway. It was acknowledged that there was a significant number of learning disability service users within the adult pathway currently resulting in potential pressure to utilise PICU beds.

Ken Jarrold advised the Mental Health Act Reviewer reports provided a valuable reminder of the importance of ensuring no complacency. Ken also referred to the issues discussed relating to the acute patient pathway, the shortage of beds and the impact on community care, and the importance of the Community Transformation programme.

Resolved:

- **The Board received and noted the Commissioning and Quality Assurance Report (Month 7).**

Action

- **After Action Review associated with the Mental Health Act visits to be circulated to Board members for information**

11. Community Mental Health Survey

Allan Fairlamb provided an analysis of the CQC Community Mental Health Survey published on 24 November 2020. The report reflected the outcome of the national survey, gathering information from over 17,000 adults who were in receipt of community mental health services between September and November 2019.

The response rate for CNTW was 28%, higher than the national response rate of 26%. Allan noted the value of the survey in providing a national benchmarking analysis, while complementing the findings of the Trust internal service user and carer experience tool (Points of You).

Allan referred to the CQC key areas for improvement, which include: crisis care, support and wellbeing; accessing care; involvement; and communication. CNTW scores were higher than the national score for all sections and were rated better than expected for all sections with the exception of crisis care, medicines, NHS therapies and support and wellbeing. Allan confirmed CNTW was the second highest performing Trust nationally for the number of questions scoring better than expected.

Ken Jarrold thanked Allan for providing an encouraging report which is a tribute to the tremendous work Done throughout the Trust.

Resolved:

- **The Board received and noted Community Mental Health Survey.**

12. Individual Placement Support

John Bolland, IPS Service Lead and Junior Atalassi, Newcastle City Council IT Technician attended to provide the Board with an update on Individual Placement Support throughout the Trust and presented slides which can be accessed here .

Ken thanked John Bolland and Junior Atalassi for their excellent presentation and said that anyone who has had experience themselves of mental illness or of supporting people with mental illness will understand the powerful connection between employment and wellbeing.

Resolved:

- **The Board received and noted Individual Placement Support presentation.**

Strategy and Partnerships

13. Update on CAMHS services, Tees Valley

Gary O'Hare spoke to the enclosed report highlighting operational management changes from 1st December 2020 with specialist children and young people services transferring to the North Cumbria Locality. This would enable improvements in the joining up of services across the West Lane site in Tees Valley, Ferndene and Alnwood, together forming a North of England Centre for Children and Young People's inpatient care.

Gary confirmed initial agreement had been reached with TEWV that the hospital site and ward should be renamed as part of the CAMHS Mobilisation Programme.

Gary noted that the Trust's had received approval for £200k capital investment from NHS England to provide further work to be undertaken in preparation to ensure safe opening of services in 2021.

Gary confirmed recruitment continued for unqualified and qualified staff. Gary highlighted the Trust was recruiting posts for West Lane, Ferndene and Alnwood as some current members of CNTW staff would be rotated into West Lane to provide continuity in terms of CNTW culture.

Resolved:

- **The Board received and noted update on CAMHS services, Tees Valley.**

14. Collaborative Newcastle Agreement

James Duncan presented the report which reflected a commitment from partner organisations across the Newcastle region to develop place-based arrangements to improve outcomes for local communities.

James highlighted the partners had developed Collaborative Newcastle arrangements in order to establish an improved financial, governance and contractual framework for delivering integrated health, support and community care to develop and ultimately improve health and care outcomes for Newcastle's residents. James mentioned Collaborative Newcastle partners have identified five initial priority areas where parties will develop and implement work plans for each of the initial priority areas in order to monitor progress against key milestones. James informed the agreement will be formally launched at the City Future Board in December and requested for Board support to approve the collaboration agreement.

Ken Jarrold referred to the significant challenges facing the NHS, society and the Trust and said that increasing collaboration was one of the most important priorities. Ken complimented the organisations involved in the creation of the Collaborative.

Resolved:

- **The Board received and approved the Collaborative Newcastle Agreement.**

15. Delivering a 'Net Zero' National Health Service

Anna Foster and Sarah Neil spoke to the enclosed report and mentioned NHS England and NHS Improvement (NHSE/I) recently published the Delivering a Net Zero report which reflect on the implications for CNTW in the context of the CNTW Board declaration of Climate and Ecological Emergency in March 2020 and commitment to becoming "net zero" by 2040.

Anne highlighted NHSE/I were shifting its priorities and expectations around sustainability becoming the world's first health system to commit to become 'net zero' to mitigate the impact of climate change and its profound threat to the health of the nation. Anna mentioned in line with CNTW's aspiration to influence the national

sustainability agenda CNTW represents the mental health and disability sector as a member of the national 'net zero system leadership group' to evaluate provider support needs and share good practice.

Resolved:

- **The Board received and noted the Delivering a 'Net Zero' National Health Service report.**

16. North Cumbria ICP Board

John Lawlor referred to the report which provided detail of the North Cumbria Partnership Group. John noted that whilst there are challenges the report reflected an inclusive approach in terms of partnership working.

Resolved:

- **The Board received and noted the North Cumbria ICP Board report.**

Workforce

17. Workforce Directorate Quarterly update

Lynne Shaw suggested in the interest of time that the report should be taken as read and no comments were made.

Resolved:

- **The Board received and noted Workforce Directorate Quarterly update**

18. Strategic Workforce Planning update

Lynne Shaw provided an update on the Trusts approach to workforce planning and the inclusion of the Integrated Care System and NHS England Improvement Plan.

Resolved:

- **The Board received and noted the Strategic Workforce Planning report.**

Regulatory / Compliance

19. Provider Collaborative Sub-Committee Terms of Reference

Lisa Quinn referred to the draft terms of reference following the Board decision to establish an additional sub-committee of the Board with a focus on Provider Collaboratives. Lisa advised that the terms of reference would be reviewed on a regular basis.

Ken Jarrold referred to the Governments proposals and mentioned Provider Collaboratives in various forms would be a very important part of the future for health and care organisations.

Resolved:

20. The Board received and noted Provider Collaborative Sub-Committee Terms of Reference.

Minutes/papers for information

21. Committee updates

There were no further updates to report.

22. Council of Governors update

Ken Jarrold referred to the Governor elections which are ongoing.

23. Any Other Business

No further business for discussion.

24. Questions from the public

None to note.

Date and time of next meeting
Wednesday, 3 February 2021, 1.30pm via Microsoft Teams

Board of Directors Meeting held in public

Action Log as at 3 February 2021

Item No.	Subject	Action	By Whom	By When	Update/Comments
Actions outstanding					
02.09.20 (13)	Quarterly Workforce Report	Details of the allocation and placement of overseas staff to be circulated to the Board	Rajesh Nadkarni	~~October~~ ~~November~~ ~~December~~ ~~2020~~ February 2021	Verbal update to be provided at the November meeting A paper to be circulated detailing medical staffing positionsin NC locality
06.11.19 (12) 02.09.20 (5)	Staff Friends and Family Test	Agreed that actions to address potential impact of automated messages on people who contact services by telephone to be included in the Reset and Redesign of services work.	Gary O'Hare	~~May 2020~~ ~~August 2020~~ ~~December 2020~~ February 2021	Update to be provided in line with the Reset and Redesign work and staff friends and family test
02.12.20 (10)	Commissioning and Quality Assurance Report	After Action Review associated with the Mental Health Act visits to be circulated to Board members for information	Lisa Quinn	February 2021	Update to be provided to the February meeting
05.08.20 (07)	Chief Executive's Report	Update on Trieste to be provided to a future Board development session	James Duncan	March 2021	Included on annual cycle for Board development topics
Completed Actions					
05.08.20 (07)	Chief Executive's Report	Trust Green Paper to be presented to the December meeting	James Duncan	December 2020	Complete – presented to December meeting
05.08.20 (18)	BAF/CRR	A future Board Development Session to be arranged to further review the BAF / CRR	Lisa Qiunn	February 2021	Complete – February Board Development meeting

Item No.	Subject	Action	By Whom	By When	Update/Comments
07.08.19 (19)	Safer Staffing Levels incl 6 monthly skill mix review	A revised paper to include an MDT approach to safer staffing including agency medical locums to be presented to a future Board meeting	Gary O'Hare/Rajesh Nadkarni	February 2021	Complete – MDT reporting included in Feb 2021 report

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 3 February 2021	
Title and Author of Paper:	Chief Executive's Report John Lawlor, Chief Executive
Paper for Debate, Decision or Information:	Information

Key Points to Note:

Trust updates

- COVID-19: Our continued response.
- Professor of Mental Health Nursing – Joint Appointment, Northumbria University & CNTW NHS Foundation Trust.
- Staff Survey 2020.

Regional updates

- Community Mental Health Services Transformation.

National updates

- National Planning Update.
- Reforming the Mental Health Act White Paper January 2021.

Outcome required: For information

Chief Executive's Report
3 February 2021

1. Trust updates

1.1 Covid-19: Our continued response

Staff across the trust have continued to rise magnificently to the challenges presented by the pandemic. Levels of the COVID virus amongst our patients has remained at low levels, will very few cases of nosocomial infections.

Services have recently been under strain since the end of the year in the face of the third wave of the pandemic. A particular challenge has been the levels of staff absences related to COVID 19 – as a result of staff shielding, self-isolating and due to illness. The pressure has been particularly significant in North Cumbria, given the very high levels of COVID-19 circulating in the local community.

A major achievement has been the rapid progress we have made in vaccinating staff. In just two and a half weeks we have completed first dose vaccinations for over 5,000 staff. This is an outstanding result and has involved staff from right across the trust volunteering to become part of our three Vaccination Teams.

I would like to put on record my admiration and appreciation for everything that our staff have done since the pandemic first struck last March. Through their professionalism, dedication and resilience we have maintained our existing services; introduced new service offerings; and responded to COVID-related policies such as the wearing of PPE. All of this has been at the same time that many staff have had make arrangements for childcare and organize support to vulnerable family members.

1.2 Professor of Mental Health Nursing – Joint Appointment, Northumbria University & CNTW NHS Foundation Trust

As part of the ongoing developments associated with our Nursing Strategy, the Trust has been working closely with several universities to establish Chairs of Mental Health and Learning Disability nursing. I am delighted to announce that the advert for the first of these posts is now out, seeking to recruit a Chair of Mental Health Nursing. Interviews are scheduled to take place towards the end of March 2021.

The Trust is also working with other universities to establish and recruit to a Chair in Learning Disability Nursing which will hopefully be appointed to in the middle of 2021.

1.3 Staff Survey 2020

The staff survey 2020 closed on 27 November 2020 and the initial results have now been received. More detailed results, including the breakdown of responses to locality/team level are due to be published shortly.

The results, which at this stage only include a comparison to the Trust's 2019 responses and those of our comparator organisations, are currently embargoed and cannot be shared outside of the organisation. Once the embargo is lifted details will be presented at the Trust Board of Directors' and other relevant meetings and priority actions agreed.

Early indications are that the results compare favourably with results from 2019.

2. Regional updates

2.1 Community Mental Health Services Transformation

As previously discussed with the Board, submissions were required to be made by each ICS on 20th January, setting out plans for the development of new models of care and utilisation of funding in 2021/22, to develop our approach to the Integrated Community Framework for Mental Health. The North East and North Cumbria ICS submitted on time and this is now subject to national review. Given the size and geographical spread of the ICS, the submission was necessarily at a high level.

Given the current differential state of developments at the seven 'places' we operate across, plus the restrictions arising from current management of the pandemic, it has not been possible to agree detailed financial plans at this stage. Indicative figures have been submitted to broadly support the development of new care models and a set of principles agreed to underpin the development of more detailed plans as the national position becomes clearer.

A high level core model has been agreed, but this is subject to local agreement and variation. Co-production is a key part of the model going forward, and we need to ensure that this is embedded from the start. The national timelines for submission have somewhat precluded this to date, but this is something that each locality is looking to develop at pace as plans for 2021/22 are worked through in detail

At a local level, partnership arrangements are in place across all localities, and continue to be further refined. Governance and leadership is being put in place and significant effort is required to ensure that co-production and co-design is fully embedded at all levels. A further Board development session is planned to explore the developing models.

3. National updates

3.1 National Planning Update

A National Directors of Finance meeting took place on 21st January, led by Julian Kelly, Chief Finance Officer for NHSEI, to update on planning for next year. This confirmed the position outlined earlier in a letter from Amanda Pritchard (COO NHSEI) that the national planning round for 2021/22 would not be taking place in the current quarter. Instead, the existing arrangements, whereby block contracts are nationally determined, will be continued for at least the first quarter of 2021/22 - that is until 30th June.

It is expected that the level of funding received will be commensurate with that received in the second half of 2020/21, although there are a number of issues that will need further clarity. These will include such items as: the level of COVID specific funding; the level of system top up support; expected inflation funding (including pay awards); the efficiency requirement; the additional investment funding; and the treatment of Non-NHS Income. Negotiations between DHSC and Treasury are ongoing and are not expected to be concluded before March. Therefore it is likely that we will only have full understanding of the financial picture very close to the commencement of the new financial year.

Mental Health Services will be allocated all expected funding for the year in advance. While the mechanism for this is unclear this will include the Mental Health Investment Standard, Community Transformation Funding, other Service Development Funding and the £500m in non-recurring funding announced for 2021-22 that has been allocated for mental health

services to support COVID recovery. Work is now starting to understand the picture more fully with commissioners and to prepare for guidance when it materialises.

The current timeline is as follows:

Early February:	Further guidance on Q1 'rollover' and associated requirements.
March:	Final Q1 financial envelope to be confirmed.
Early April:	Q2-Q4 operational planning guidance issued.
End of June:	Q2-Q4 final operational plans submitted.

3.2 Reforming the Mental Health Act White Paper January 2021

The Government has now opened a consultation to invite views on changes to the Mental Health Act to help put patients at the centre of decisions about their own care. This follows the Government Commission and Independent Review of the Mental Health Act published in December 2018 which concluded that the current Mental Health Act did not always work as well as it should for patients their families and their carers.

Wide ranging changes are being proposed along four principles: choice and autonomy; least restriction; therapeutic benefit; and viewing the person as an individual. The consultation will close on 21st April 2021.

John Lawlor
Chief Executive

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	COVID-19 update
Report author(s)	Jose Robe, Group Nurse Director.
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer/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)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	N/A	Executive Team	N/A
Audit	N/A	Corporate Decisions Team (CDT)	N/A
Mental Health Legislation	N/A	CDT – Quality	N/A
Remuneration Committee	N/A	CDT – Business	N/A
Resource and Business Assurance	N/A	CDT – Workforce	N/A
Charitable Funds Committee	N/A	CDT – Climate	N/A
CEDAR Programme Board	N/A	CDT – Risk	N/A
Other/external (please specify)	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
3rd February 2021

1. Executive Summary

This report provides an exception report in response to the COVID-19 pandemic since the last Trust Board. For the purpose of this month the report includes four areas:

- Outbreak management and Learning lessons
- Asymptomatic Staff Testing
- COVID-19 Vaccination Programme
- Enhanced physical care: COVID-19 Remote Inpatient Support Team (CRIST)

For the sections previously reported i.e. Personal Protective Equipment (PPE), new Guidance and Service Change Assurance is provided through Gold Command and the Incident Management Group (IMG).

2. Trust COVID-19 Outbreak management:

When a COVID-19 outbreak is declared it cannot be closed unless there has been 28 days without any new patients or staff testing positive that are deemed to be linked to the initial outbreak. We have declared 31 outbreaks through the pandemic, of which 14 have been declared from the 1st December 2020. This rise in outbreak activity is reflective of the high levels of community prevalence of COVID-19 at a regional and national level, which has led to the Tier system and now national lockdown. The Trust has observed higher levels of both patients and staff testing positive as part of these recent outbreaks.

There are currently 11 live outbreaks open across all clinical localities and 1 additional outbreak in corporate services.

NORTH	NORTH CUMBRIA	CENTRAL	SOUTH	CORPORATE
2	3	3	2	1

2.2 All outbreaks are managed and have a robust action plan in place overseen by the Director of Infection Prevention Control (DIPC) Gold Command and Locality leadership team. Board members will be kept informed of any further escalations related to outbreaks out-with the Board meeting.

2.3 Learning from Outbreaks

The learning has been embedded through the following routes:

- Sharing feedback within outbreak meetings to ensure real time learning
- One to one documented supervision
- Team meetings

- Group level sitrep meetings
- Weekly IPC assurance meetings
- Ward to Board IPC assurance framework.

The impact of the learning has been

- Clinical leaders increased on site visits, observing practice and addressing concerns directly with staff.
- Themes through the outbreak are changing – less issues with using PPE and application to clinical settings.
- Teams where IPC practice has been highly focussed on PPE usage have smaller contained outbreaks where less staff to patient transmission are noted.
- Reduced anxiety of staff which has enabled staff to remain at work and supported through the process.
- Increased Lateral Flow Testing (LFT) uptake as staff understand the impact of asymptomatic testing. This has been noticeable within the outbreak areas and the connected Clinical Business Unit (CBU).
- Patient collaboration and working together – care plans to support complex clinical management.
- Increased cleaning schedules in wards and departments above the baseline.
- Creative solutions from teams such as inpatient patient activity packs- individualised to patient needs.

3. Patient and Staff Testing

CNTW continues to provide testing in-line with the Government's testing strategy, including the introduction of patient swabbing on days 1,3, 5 & 7 for new admissions, and every 7 days thereafter.

3.1 Staff Testing and new developments

PCR testing continues for staff or household members who are symptomatic via the drive through and mobile teams.

In addition, we have rolled out the distribution of the Asymptomatic Lateral Flow testing kits to those staff that have signed up to the twice weekly testing arrangements. Since commencement 125 individuals have reported positive LFT results so far, 13 of these were subsequently negative via PCR test.

Any staff testing positive will be required to self-isolate and a PCR swab test will be arranged through the absence line to confirm the result. Any staff testing negative through PCR swab test will be asked to return to work.

We have developed an online solution to support staff to return results as we are reporting daily to Public Health England and weekly to NHS England / Improvement.

3.2 COVID-19 Vaccination

We have moved forward with the Government's plans to vaccinate staff and patients with the COVID-19 Vaccination. This has been via two programmes, the first commencing mid-December in conjunction with North Cumbria Integrated Care (NCIC) who have supported the administration of the Pfizer vaccination for CNTW's North Cumbria staff, alongside their own staff.

On the North East side, CNTW have rolled out their own vaccination programme from the 8th January 2021, using the Oxford Vaccine. This commenced with a one site administration clinic at St Nicholas Hospital which has moved to a three-site model at St George's Hospital and Hopewood Park.

In line with the Joint Committee on Vaccination and Immunisation (JCVI) interim guidance prioritises health and social care workers as one of the initial cohorts eligible for the vaccine. To date 6,970 staff and some partners expressed an interest in having the vaccine with 3152 staff having received their first dose of the vaccine.

- 3,143 through CNTW
- 394 recorded for NCIC

In addition, the Trust has also commenced its vaccination of those patients in hospital who fall within the priority groups with around 100 patients being vaccinated to date.

3.3 Enhanced physical care: COVID-19 Remote Inpatient Support Team (CRIST)

In the context of the COVID-19 pandemic, all providers of health care are reviewing the care they provide and considering how they can best prepare for the changing demands to produce guidance for supporting patients who are unwell with COVID-19 in a mental health and learning disability inpatient facility.

CNTW already had a solid base on which to build. The CNTW Standards for the Assessment and Management of Physical Health, was developed as People with a Learning Disability or Mental Health problems are more likely than other citizens to have significant health risks and develop major physical health problems. Once they have developed a physical illness both groups are likely to die younger.

From discussions with inpatient teams its apparent that managing patients within inpatient services who are COVID-19 positive can create significant challenge as well as be resource intensive. This is a particular issue out of hours where there is reduced access to support, and many of the services providing this out of hours support are under significant pressure. With this is in mind, the Trust is taking forward its plans around the development of an Enhanced Physical Care – Unit and mobile Team.

Enhanced physical care – Unit

- Marsden ward – Monkwearmouth Hospital.

- Working group looked at this in the first and second wave.
- Currently plan is for it to be used by South Tyneside and Sunderland NHS Foundation Trust (STSFT) in line with their escalation plans but at the time of reporting, this has not been mobilised.

Enhanced physical care mobile team

- Access to the recovery at home team.
- Monkwearmouth Hospital and Hopewood Park.
- Discussion with STSFT regarding a SLA.

In addition, in the last two weeks, the Trust has introduced the COVID-19 Remote Inpatient Support Team (CRIST) which has been established for Inpatients with COVID-19 within CNTW. CRIST aims to provide support to ward / teams dealing with patient who are COVID-19 positive and ensure physical health needs are discussed and a plan is in place. The CRIST is a multi-disciplinary team and has number of senior clinicians - both medical and nursing from a number of specialties, working age adult, old adults and patient with a learning disability - already involved.

The main roles of the CRIST will be to provide support on daily basis during the weekend to clinical Inpatients with COVID-19. This should allow the ward team to review the presentation and management of patients with positive COVID-19 infections with a team of clinicians at weekends without routinely needing to link with first on call medical staff, although in cases where face to face review is needed this will still be able to be accessed through the normal routes. There will also be the option of an enhanced Multidisciplinary Team (MDT) on a Wednesday. The intention would for the CRIST to support wards to review current physical health needs, provide guidance on restraint and segregation for non-cooperation with physical health care checks and provide guidance on IPC issues.

In addition to the development of the CRIST team there has also been a physical health workbook produced which is available as a reference point for staff on the Trust intranet.

4. How Communications Have Supported CNTW though the COVID-19 Pandemic

The Communications Team has played an integral part in Gold Command in ensuring the timely distribution of guidance and important updates to support staff understanding of the Trusts emergency planning and pandemic response. This has been achieved through a range of mediums (Appendix 1)

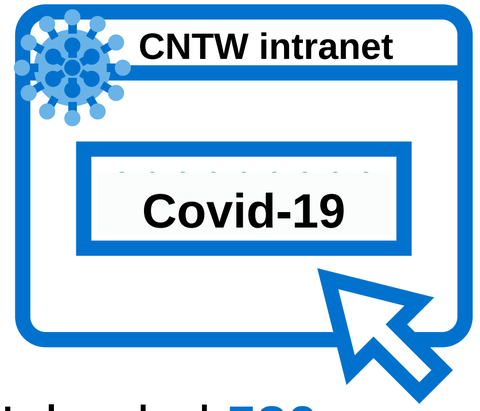
5. Recommendation

The Board are asked to receive this report for assurance on the measures taken to date.

Jose Robe
Group Nurse Director

How Communications have supported CNTW through Covid-19 since 23rd March 2020

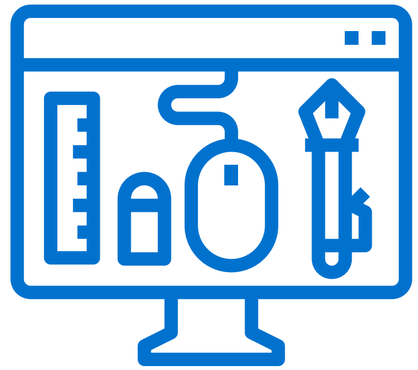
Reach **30,000** per day on social media



Uploaded **530** resources the Covid-19 intranet page

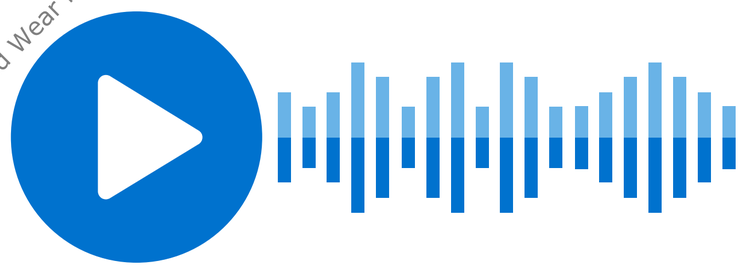
25 AWISH editions

300 daily covid updates

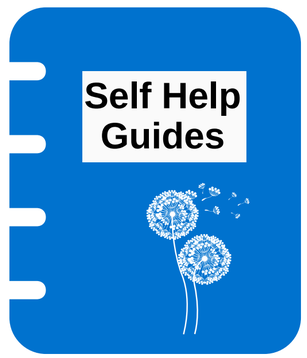


Designed over **230** posters, leaflets, screensavers and social media assets

New visitors to the website **81.2%**



58,864 views of our relaxation techniques



149,183 downloads of the self help guides

Respond to **541** Facebook messages

11 radio interviews

894 new Twitter followers

29 staff Q&A sessions

51 Press enquiries

2,225 new Facebook followers

Shared **2,034** social media posts

79 positive new stories

148 news stories on the Trust website

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	IPC Board Assurance Framework
Report author(s)	Anne Moore, Group Nurse Director Safer Care, Director of Infection Prevention and Control
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer/Emergency Planning Executive Lead

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)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance		Executive Team	
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)	31,7,20

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

Infection Prevention and Control (IPC) Board Assurance Framework
Trust Board Meeting

1. Executive Summary

The IPC Board Assurance Framework issued by the Chief Nursing Officer, Ruth May, in May 2021 is designed to help providers assess themselves against the Infection Prevention and Control guidance for Covid19 as a source of internal assurance that quality standards are being maintained. It is also intended to identify any areas of risk and show the corrective actions taken in response. The tool also provides assurance to trust boards that organisational compliance has been systematically reviewed for other potential Nosocomial or Hospital Acquired Infections (HAI's.)

Board Members received papers in May and August 2020. At that time, the self-assessment also coincided with the first national lockdown and restrictions on movement for the general population. During that period community Covid 19 prevalence was seen to be reducing nationally and locally over the summer and CNTW only had one C19 outbreak in that period. However, since the last report there has been an exponential increase nationally in cases along with the new variant, resulting in a movement to regional Tier 4 restrictions and national lockdown to reduce transmission.

2 Compliance

During this period performance against the self-assessment for Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust has been tested via the routine review of standards in all settings, but also via the 31 Covid-19 outbreaks which have been managed since the last report. The checklist has been used as a framework to manage outbreak Control Meetings, identifying the root cause and actions to prevent further transmission

Trust level compliance was demonstrated across all standards, except for the items summarised below which has emerged following outbreaks:

This related to:

- limited isolation facilities at Hadrian clinic for presumptive positive patients awaiting admission screening test results- mitigation includes the decision to admit directly to Bede ward pending COVID-19 Screening results. However, during the height of wave 2 both Fellside and Bede experienced outbreaks and the model was suspended due to the high number of positive cases in both units and admissions were direct to other wards in the trust

- Some gaps in staff compliance regarding cleaning, touchpoints, PPE, Car sharing and exceeding Covid secure environments has been identified in some outbreaks. Actions to resolve these have been taken at each area and lessons learnt have been shared across the organisation

- since the last report CNTW Test and Trace model has fully implemented CNTW Absence line and Senior Nurse/ IPC Team have developed local protocols to respond in a timely way to ensure all staff and household members where they are

index cases are tested and Close Contact Risk Assessments are undertaken to ensure staff are isolated in a timely manner to prevent risks to patient and staff safety

- wearing of Face masks for the potential use by patients in Covid19 positive areas continue to be risk assessed on a case by case basis considering communication challenges, ability to comply with social distancing and ligature risk from mask types. Staff are now wearing face masks in all clinical and non-clinical settings irrespective of the 2-metre distance

All clinical areas in patient and community have completed the Infection prevention and control COVID-19 management checklist, version 1.3 (Dec 2020). Locality Group Nurse Directors and review on a monthly basis through Locality Quality & Standards meetings

It was agreed to provide the Trust Board with an updated paper reminding the board of the specifics of the IPC Board Assurance Checklist in addition to the monthly Covid Update paper to the Board.

This paper specifically highlights the Trust wide position and any associated actions.

2 Assurance mechanisms for the initial and new standards

In addition, actions to support assurance of the self-assessment during the COVID19 Pandemic also include:

- Covid19-Gold Command, led by the Executive Director of Nursing and Chief Operating Officer has continued to operate as a hub for rapid decision making in response to guidance impacting on safe clinical practices, Covid19 secure workplaces and relaxation of lockdown. The Command team are managing the escalation of daily sitreps, distribution and demands on PPE as well as emergency response.
- The Test and Trace processes, staff absence management, is a new vital part of assuring staff are being assessed for close contacts and isolated accordingly
- Reports to Covid19 IMG by Group Nurse Director Safer Care/DIPC on national and emerging IPC guidance and implications, PPE position, staff and index case testing. These meetings have moved from daily to twice weekly over the period
- IPC Assurance meetings weekly. Membership includes Director for Infection Prevention and Control (DIPC)/Group Nurse Director for Safer Care, Group Medical Director Safer Care, IPC Team, Locality Group Nurse Directors and Deputy Director of Communications;
- Daily IPC Assurance Agenda has continued to be action focused with the purpose to ensure rapid assessment required to implement national clinical guidance e.g. Patient cohorting, implementing staff testing, process for daily stocktake of and guidance on the use of PPE, Aerosol Generating Procedures, admission and discharge screening, cleaning regimes and waste management;
- IPC/PPE Communications brief has been distributed – separate to the Daily COVID-19 communications aimed at exclusive route and reference for IPC/PEE messages-backed up with guidance on the intranet;
- IPC team have continued throughout the Pandemic to undertake scheduled and adhoc ‘Teams’ Meetings with Clinical Nurse Managers, Ward Managers and clinical

care groups to discuss complex cases, practical application of 10- and 14-day isolation, restraint and management of violence and aggression;

- IPC Team have continued where possible and to minimise transmission, to make 'visit/walkabouts' to hospital and some community service sites enabling switch over of recalled eyewear, spot check hand washing, social distancing, advise on inappropriate use of PPE then reinforced in daily communications brief;
- IPC Team have repeated sessions with NTW Solutions Domestic Supervisors and domestic/facilities staff at ward and service level in addition to ward-based sessions; led by ward managers; regarding cleaning regimes for covid and non covid areas
- The comprehensive roll out of Fit Testing of FFP3 masks continues to be led by IPC Team and Academy Physical Health Leads to staff and has also enabled clarification of understanding on safe IPC practices and updated IPC guidance 98% of risk assessments have been completed
- Staff Testing Training continues to be delivered by a combination of DIPC/CNTW Academy Physical Health Trainers, and this has also been developed into a package for Domiciliary Providers and care homes across the ICS;
- The Public Health Team members including DIPC/ IPC/Tissue Viability have led the daily co-ordination of the Staff and Index Case Testing Teams with responsibility to observe IPC practice and induct new trainees during testing sessions; and

3. Conclusion

The IPC standards for preventing the spread of Nosocomial have been met. Self-assessment and triangulation will continue. There have been no instances of Hospital acquired infection or outbreaks of COVID19 or other infections in the period since the last report.

Anne Moore
Group Nurse Director Safer Care, Director of Infection Prevention and Control.
December 2021

Infection Prevention and Control board assurance framework – completed December 2020

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission • compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	All admissions into the Trust are screened on day 1, 3 and day 5 following admission and managed appropriately. Appropriate care plan re isolation until result known. Documented in Rio progress notes and alerts. Community teams contact patients prior to visit to establish any COVID-19 infection risks. Transfer of COVID-19 positive patients is limited as much as clinically possible Discharge and transfer guidance has been developed with Bed Management team notifying referrers and on discharge to are	None Clinically dependent	If the patient's mental health or disability diagnosis is a priority then this is risk assessed and measures

• patients and staff are protected with PPE, as per the PHE national guidance • national IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate	homes or other settings of covid status Trust PPE guidance reflects the guidance issued nationally by PHE. Daily communications are released to update staff around any changes to national IPC guidance. Weekly meeting with clinical teams via 'Teams' to provide an update in guidance and application at clinical level. Spot check visits by IPC team members in addition to individual case discussions Daily contact with DIPC/Gold Command to discuss any changes in guidance. Discussed with Executive Team at daily Incident Management Team. Board members receive daily communications updates Risks added to Trust risk register as appropriate.		

• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Staff continue to report infections via the web-based incident reporting system. IPC policies and advice provided.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line	All ward staff appropriately trained and upskilled to manage COVID-19 patients Where clinically/IPC required, cohort areas/wards introduced across the Trust All domestic staff have thorough Trust IPC induction and targeted training sessions in relation to the management of COVID-19. Domestic supervisors and support staff link in and meet with IPC team on a regular basis. Decontamination and terminal decontamination included in Trust guidance in line with PHE advice. Specific poster produced for		

with PHE and other national guidance	domestic staff and Q&A via NTW solutions	North Cumbria locality using Tristel-Fuse as per NCIC products	
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	All areas throughout the Trust utilising Chlor-Clean as a precautionary measure. All isolation areas decontaminated at least once daily.		
• Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Domestic staff are instructed in the required standards and pay particular attention to cleaning of toilets/ bathrooms		
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	All areas throughout the Trust utilise neutral purpose detergent and chlor-clean (a chlorine based disinfectant) Staff have training and guidance on using this		

• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, egg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE	Domestic staff have been made aware of the importance of following manufacturers guidance in use of all cleaning / disinfect products Cleaning and decontamination will increase to the twice daily standard Staff working with keyboards, desk tops etc are aware of increased frequency of cleaning for these areas. Ward managers advise domestic teams when top enter rooms for cleaning following patient movement or clinical interventions	Several outbreaks in on clinical areas have specifically highlighted the risk of transmission from shared equipment, keypads on entry to sites, and office spaces Actions include Covid checklist at handover, and start of day, covid champions and personal responsibility reiterated i.e. 'if you touch it, clean it,'	

removal by groups of staff (at least twice daily)			
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	All linen from possible/confirmed COVID-19 patients managed as infectious linen and disposed of/laundered appropriately.		
• single use items are used where possible and according to Single Use Policy	Single use items used throughout the Trust in accordance with Single Use Policy		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Reusable equipment is decontaminated appropriately and effectively after use in line with Trust policy		
• review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Rooms in CNTW are not typically mechanically ventilated and openable windows is the only method.	All staff have been advised to maintain open windows and where possible doors to maintain air flow and reduce build-up of aerosols in both patient and non-clinical settings	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			

Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Arrangements are in place and prescribing is monitored. In addition, Incident reports submitted where antibiotics are prescribed Antibiotic surveillance is reported into the IPCC on a quarterly basis		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are where possible	In line with national guidance, visiting was suspended across the Trust except for patients requiring End of Life Care and Children. Access is restricted to core team members where COVID-19 positive patients is suspected/ confirmed		All visitors are via booked sessions, with welfare checks prior to visit, and PPE provided. Where we have large patient outbreak areas then plans for visiting will be reviewed via the DIPC

being treated in areas marked with appropriate signage and where appropriate with restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	COVID-19 resource pages available on the intranet including easy read and specifically designed resources for patients with a Learning disability Documented on Patient Electronic Record i.e. RiO - evidenced that this is communicated on patient transfer		and Executive Director for Nursing and Operations
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate	Patients with possible or confirmed COVID-19 are isolated from non-COVID-19 patients	There are occasions when patients do not wish to comply with social isolation pending results	Triage via Bed Management Clinical Team.

them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance			Asymptomatic Patients are also routinely tested on admission
• mask usage is emphasized for suspected individuals	Some patients do not wish to comply with social isolation or alternative mask use	This can be due to communication difficulties of sensory impairment or risks of ligature use of masks	Staff wear full PPE at all times.
• ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	Perspex screens are being placed insitu in reception areas		
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Contact tracing now in place PHE guidance for local implementation is in early days. Outbreak control Boards are being formed		
• patients with suspected COVID-19 are tested promptly	All patients who develop symptoms are tested and isolated promptly with continued monitoring of the patient's physical health		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	Patients who are symptomatic are isolated, if continue to display symptoms following negative result they will be retested		

• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Reduced face-to-face appointments and increased use of technology. Staff check with the patient that they are well and symptom-free before appointment where possible to reduce risk of spread		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	All staff receive in-depth IPC training on induction into the Trust. Targeted training sessions across all sites in the Trust in relation to PPE (appropriate use/donning and doffing). As above		

• a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be	Training records are maintained by training facilitators Trust not currently advocating re-use of PPE however fully aware of the CAS Alert describing potential options if supply interrupted Incident reporting system is in place to report any PPE related concerns Adherence to PHE National Guidance is undertaken via Routine checks by Clinical Nurse Managers, and IPC Team All inpatient staff across the Trust undertake hand hygiene competency assessments/IPC on an annual basis. Hand washing is promoted as a core message via Daily communications and posters in every ward/department across the Trust Hand towel dispensers are available in all areas and are regularly maintained.		

dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance			
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand hygiene posters are readily available and clearly displayed in all prominent areas.		
• staff understand the requirements for uniform laundering where this is not provided for on site	Communications on personal Uniform laundering has been issued via Daily Communications briefings		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms	All staff displaying symptoms of COVID-19 are contacting the Central Absence Reporting Centre within the Trust for advice and to access Trust based Testing Team for themselves and family members.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	As above, all areas compliant facilities to support isolation/cohorting with the exception of Hadrian Clinic Compliance in line with PHE guidance No change in usual management of these infections	Hadrian Clinic difficult to isolate due to layout (no en-suite facilities).	Designation of Bede Ward for admission screening and if negative transfer. If positive the patient will remain and be cared for via isolation on Bede Ward
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure:			

• testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance • screening for other potential infections takes place	All Trust staff undertaking testing are appropriately trained Testing of both staff and patients is undertaken promptly (usually same day that symptoms are first noticed). Screening takes place to rule out other infections/symptoms being displayed		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and	IPC Team are in daily contact with clinical areas regarding IPC processes and advising wards/teams where other infections are reported Any changes to PHE guidance communicated to staff as soon as possible via the daily		

effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it	communications and Team meetings All waste related to suspected or confirmed COVID-19 cases is disposed of appropriately as infectious clinical waste into orange bags Central management of PPE has been introduced to ensure adequate stock for all areas based on usage		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff in 'at risk' groups identified and supported appropriately, including the completion of individual risk assessments		

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	All staff that are required to wear FFP masks undergo fit-testing by an appropriately trained individual. Training is recorded		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Staff teams remain on their allocated areas with minimal movement. This includes Domestic Teams.		
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Staff are aware of the need for social distancing. Work is underway to ensure there are 2m floor spacers to prompt and remind staff re need for 2m distancing. Posters are on display in all wards/departments across the Trust.		
• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	The Trust Covid19 Environmental working group has undertaken environmental risk assessments and recommended modifications required trust wide		

• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work	Staff absence and well-being monitored via individual team managers and centrally through the Central Absence Line. Well-being checks undertaken Information is provided to staff at point of test explaining outcome of results i.e. negative and positive including ongoing support should symptoms worsen or re-occur. Welfare calls support staff to either return or onward referral to Occupational Health		

Trust Board
3rd February 2021

Title of report	Safer Staffing Report including Six Month Skill Mix – November 2020
Report author(s)	Anne Moore, Group Nurse Director, Safer Care Directorate
Executive Lead (if different from above)	Gary O'Hare, Executive Director of Nursing and Chief Operating 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	
To achieve "no health without mental health" and "joined up" services		Sustainable mental health and disability services delivering real value	X
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	
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	Covid19 Gold Command and IMG

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	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	

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

Safer Staffing Report – Including Six Month Skill Mix
Trust Board
3rd February 2021

Executive Summary

The purpose of the report is to provide assurance on the current position across all inpatient wards within CNTW in accordance with the National Quality Board (NQB) Safer Staffing requirements. In addition the NHSI publication of 2018 builds on the NQB guidance and recommended that the Workforce Standards are continually reviewed in the context of the Safer Staffing returns.

The following report includes the exception data of all wards against Trust agreed Safer Staffing levels for the period November 2020. The period covered includes the response to the Covid19 Pandemic which coincided with the North East being in Tier 3 and the 2nd national lockdown.

Despite the challenges of Covid19 it was agreed that the plan for recruitment to the Trust should continue where safe to do so using alternative assessment methods underpinned by values-based recruitment. This has been led in parallel by the Central Recruitment Team.

The report also includes information on Allied Health Professionals and Medical staffing as separate sections.

Risks and mitigations associated with the report

The group should note that the daily scrutiny at Clinical Business Unit (CBU), Group and Executive level has ensured the safe provision of services to patients.

Recommendation/summary

The group is asked to receive the executive summary and locality data attached for information and assurance.

Purpose of this report

This report is an exception report that highlights wards that are either 10% + under or 20% + over planned staffing levels. The exception reporting is via a RAG rating that identifies the following categories:

- **Red** for any ward under 90%
- White for within range
- **Green** for wards over 120%
- Blue maximum safe staffing levels

North Cumbria Locality

North Cumbria CBU has 11 wards

Ward Name	Day Registered %age	Day Unregistered %age	Night Registered %age	Night Unregistered %age	Narrative
Ashby	72.78%	229.55%	77.57%	216.29%	High level of acuity
Fraser	64.87%	169.51%	104.50%	248.73%	High levels of acuity. Staff being redeployed to cover wards with deficits.
Lennox	109.20%	255.57%	113.66%	399.00%	High acuity, Band 5 vacancies Staff sickness

Redburn	101.17%	190.78%	130.70%	194.30%	Redburn – Band 5 vacancies and acuity PICU - Band 5 vacancies
Stephenson	127.34%	162.28%	155.37%	141.45%	8 x Band 3 vacancies
Edenwood	117.28%	231.48%	84.70%	225.88%	High Acuity and increased skills mix
Hadrian	92.12%	122.07%	99.39%	181.03%	Covid19 outbreak. Site safer staffing support
Oakwood	118.52%	159.11%	106.49%	157.95%	Increase acuity and frailty of patients.
Rowanwood	81.09%	133.33%	104.07%	183.85%	8 RMN vacancies, safer staffing site support.
Ruskin	76.10%	132.89%	180.70%	114.02%	Increased acuity.
Yewdale	82.34%	117.33%	88.09%	218.14%	Acuity of patients, vacancies under recruitment.

North Cumbria

All wards have required an increase in staff to support therapeutic activity and safer staffing during Covid19 and the outbreak on Hadrian. Clinical acuity has been high on all of the wards and this is reflected in the increased number of staff required for to support patients. Short term contracts for agency staff were offered to support with the qualified staff deficiency and extensions to those Healthcare Assistants (HCAs) on fixed term contracts to March 2021.

With high levels of vacancies, sickness and maternity leave on the Cumbria wards, several temporary posts remain in place to backfill the shortfall by fixed term contracts being offered to provide consistency to the wards. Several Preceptorship nurses have been working within the wards. Skill mix/ leadership within all the wards has continued during this period resulting some of the substantive registered staff being redeployed to other wards to be able to supervise the Preceptors. There continues to be ongoing discussions with Staffing Solutions in regards to Nurse bank support in order to reduce agency requests.

North Cumbria Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	Vacancies
Physiotherapists	1	1
Occupational Therapists	14	4

North Locality

The North CBU has 8 inpatient wards

Ward Name	Day Registered %age	Day Unregistered %age	Night Registered %age	Night Unregistered %age	Narrative
Alnmouth	83.66%	258.84%	28.80%	162.78%	Agency qualified nurse covering nights, not on TAER so would not pull through on report.

					Staffing levels increased to 5/5/4
Embleton	74.46%	292.44%	53.10%	199.40%	Carter Pool - Site deployment.
Hauxley	95.02%	90.33%	104.86%	124.45%	Reduced bed occupancy – 12 beds. Registered nurse vacancies. Safer staffing levels supported by wider site deployment via daily staffing huddle.
Kinnersley	168.55%	283.56%	300.71%	269.08%	Kinnersley bed increase from 21 to 28, with increased skill mix. Extra care packages for patients and site deployment.
Newton	98.91%	161.34%	101.18%	180.45%	High acuity. Vacancies.
Warkworth	89.03%	246.95%	99.44%	230.05%	Qualified nurse vacancies, Site deployment and high acuity.
Woodhorn	68.17%	239.01%	95.71%	150.02%	High acuity supported by wider site.
Mitford	119.06%	158.60%	97.39%	141.40%	Covid outbreak resulted in increased staffing, vacancies and acuity.

North Locality

All admission wards with the exception of the HDU ward have qualified vacancies and the effect of Covid related sickness has contributed to areas that are showing numbers below safer staffing numbers. All wards have seen high levels of acuity and this is reflected in the number of service users on enhanced levels of engagement and observation. The increased levels of acuity and the increase of admissions continue to show increased pressures on the acute female and male pathways. This is being mitigated by daily staffing safety huddles and the deployment of Carter Pool staff according to risk level and acuity. This is overseen by the senior clinical leadership team.

North Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	Vacancies
Physiotherapists	0	0
Occupational Therapists	13	0
Dietitians	4.81	1
Speech and Language Therapists	6.18	1.25

Recruitment & Retention

The use of social media and less conventional ways of advertising have seen a modest increase in the unqualified applications (which have always seen a significant number of applications) and an improved number of applications for our registered nurse vacancies – as per below. Recent recruitment drives carried out in December 2020 X2 filling nurse specialist posts, X30 Band 3 but unfortunately not all positions were filled.

Developments

The approaches taken to attract and retain staff within the North Inpatient Services are being completed with support from colleagues within our communications and include: A 'day in the life' advert, a video production of what staff nurses / Band 6's do on a shift to publicise on social media – Instagram, YouTube, Facebook and Twitter – and an Open 'Teams' recruitment evening that follows the same format of the recent Royal College of Nursing (RCN) conference where staff virtually visit a ward and when clicking on there, there will be a member of staff to talk to them about the role. In line with social media campaigns, the team are formulating posters with photographs and quotes / captions of nurses describing why they enjoy and believe in what they do.

Central Locality

Central Locality has 17 wards

Ward Name	Day Registered %age	Day Unregistered %age	Night Registered %age	Night Unregistered %age	Narrative
Aidan	80.95%	165.81%	103.80%	197.36%	Clinical acuity and seclusion.
Akenside	81.49%	107.75%	94.13%	110.39%	Qualified absence and 1 vacancy - Ward manager supported deficits
Bede	65.50%	598.21%	163.73%	472.70%	High turnover of patients, sickness of both qualified and non-qualified staff and high levels of observations.
Castleside	83.97%	132.40%	100.57%	160.42%	Qualified absence and Increased acuity
Cuthbert	60.75%	132.74%	89.56%	148.25%	3 x qualified nurse vacancies supported by unqualified.
Elm House	74.59%	104.02%	88.21%	94.97%	Short term sickness
Fellside	71.96%	276.59%	113.20%	211.40%	Increased acuity and use of seclusion Staff covid related absence due to outbreak, 5 x vacancies
Lamesley	95.64%	187.71%	96.30%	199.05%	1 Band 7 short due to managing Elm house. Sickness. High levels of clinical activity

Lowry	81.81%	232.06%	95.66%	141.62%	High levels of clinical activity. Short term sickness / absence related to Covid19
Oswin	78.48%	101.49%	119.00%	74.29%	2 x maternity leave. 1 Vacancy. Reduction of non-registered staff at night as preceptorship staff nurse on nights to support development
Willow View	100.20%	164.16%	106.88%	174.73%	Increase in engagement and observations.
KDU Cheviot	84.53%	204.06%	110.58%	229.87%	1 Registered nurse vacancy. Due to clinical acuity and supporting Patient on Tweed
KDU Lindisfarne	86.47%	171.81%	111.61%	227.69%	Vacancy and increased acuity
KDU Wansbeck	71.60%	180.26%	103.05%	186.51%	Vacancy and acuity
Tweed Unit	85.15%	228.90%	107.59%	278.81%	Vacancies. 1 Patient in long-term segregation. Therapeutic activity support.
Tyne Unit – LD	61.75%	306.31%	105.10%	427.55%	1 Registered nurse vacancy. 1 Patient in long-term segregation.
Tyne Unit – MH	84.26%	61.79%	100.60%	52.39%	2 Registered nurse vacancies. Unqualified should be white as there are no vacancies and the ward has additional unregistered staff from Hadrian on Tyne MH gaining experience. Safer staffing levels maintained at all times.

Central Locality

Ongoing bespoke recruitment. Covid related absences impacting on staffing levels. There is pressure on registered staffing figures on Beadnell due to 1 vacancy, sickness absence and 1 nurse on maternity leave. Gibside have 1 nurse vacancy.

Central Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	Vacancies

Physiotherapists	2	0
Occupational Therapists	4	0
Psychologists	2	0
Dietitians	5.16	0.25
Speech and Language Therapists	26.84	5.10

South Locality

The South Locality has 20 wards

Ward Name	Day Registered %age	Day Unregistered %age	Night Registered %age	Night Unregistered %age	Narrative
Aldervale	102.61%	236.17%	140.88%	193.28%	Patient in long-term segregation
Beadnell	82.97%	121.98%	105.56%	226.60%	Sickness absence, x1 vacancy.
Beckfield	75.42%	221.88%	80.83%	189.64%	4 Band 5 vacancies, 3 Band 5 absent. Long-term seclusion and increased acuity.
Bridgewell	105.77%	218.36%	115.97%	263.57%	Acuity of patients
Brooke House	63.98%	99.05%	102.42%	123.29%	1 Band 5 vacancy, mat leave and phased return
Cleadon	124.97%	139.31%	103.06%	191.43%	Increased skill mix following Covid outbreak. Acuity of need. escorting patient at acute Trust.
Clearbrook	86.76%	276.12%	107.30%	180.66%	Increase in clinical activity. 1 Band 3 redeployed, 2 Band 3 & 1 Band 4 maternity leave. staff isolating due to Covid.
Longview	86.73%	262.96%	118.84%	216.02%	2 Band 5 nurses deployed to Beckfield. High levels of clinical activity.
Marsden	0.00%	0.00%	0.00%	0.00%	N/A
Mowbray	75.31%	198.17%	117.69%	255.84%	1.8 Band 5 vacancies. Increased acuity
Gibside	80.13%	273.29%	116.06%	226.22%	1 Nurse on non-clinical duties and 1 nurse on maternity leave. 1 Vacancy. Increased acuity.

Roker	131.43%	161.95%	97.15%	210.44%	Covid admission isolations.
Rose Lodge	95.28%	230.84%	226.81%	307.38%	2 Band 6 absent, 2 Band 5 absent. Increased observations. Night duty skill mix- 2 registered staff.
Shoredrift	69.69%	434.44%	95.19%	327.00%	2 Band 5 nurses deployed to Beckfield High levels of acuity and Covid isolation support.
Springrise	61.13%	367.42%	98.40%	258.48%	2 Band 5 vacancies & 1 Band 5 working on Beckfield, 1 Band 4 deployed to physical health team. High acuity of need/ support/ observation levels, Covid isolation.
Walkergate Ward 1	92.51%	68.98%	104.82%	84.97%	4 Band 2 vacancies, 3 Band 3 LTS.
Walkergate Ward 2	88.38%	91.62%	111.29%	139.78%	8 Qualified staff sickness (LTS, CEV, staff impact with Covid and outbreak. High clinical acuity.
Walkergate Ward 3	78.89%	80.15%	100.60%	150.27%	3 Band 5 vacancies, 3 Band 2 vacancies. High acuity.
Walkergate Ward 4	62.18%	96.50%	105.06%	154.81%	2 Qualified CEV. High clinical acuity.
Ward 31A	104.70%	80.13%	104.96%	104.01%	Staff sickness absence and 1 Band 5 vacancy.

South Locality

The adult acute wards in November continue to operate at maximum capacity in relation to patient numbers. Longview admission / transfer rate continues to be high due to supporting Covid plans in central locality. Patient acuity remains high and as a result, additional unqualified staff are rostered to support, this is reflected in the majority of ward data. Some areas / wards are supporting with complex co morbid presentations that require bespoke care packages, this often results in increasing the staffing resource.

Vacancies across the wards for Band 5 continue to be monitored in November, with 13 Band 5 vacancies. There was particular pressure on Beckfield, to support the qualified deficit a review of all Band 5 establishments took place to assist the level load across the wards.

An additional pressure in November that affected Cleadon, Shoredrift and Beckfield was Covid related absences, this was managed locally and did not require escalation. Ward 31a have 2 vacancies which were unsuccessfully recruited as part of a bespoke campaign. All vacancies are now back out to advert. Gaps in staffing numbers have been covered by Band 3 staff or agency nurses where possible.

Walkergate Park

There is pressure on staffing across the inpatient wards, to support this level loading across the centre is utilised and ongoing recruitment campaigns. Outbreaks on 2 of the wards and supporting Clinically Extremely Vulnerable staff to work from home. Acuity across the centre has been high.

South Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	**Vacancies**
Physiotherapists	5.46	
Occupational Therapists	13.80	
Psychologists	3.8 +0.2 bank +0.8 (planned sick leave until 01/03/2021)	4.0
Dietitians	6.06	0.50
Speech and Language Therapists	15.50	2.80

Neuro & Specialist Services	**Staff in post**	**Vacancies**
Physiotherapists	WGP wards 11.2 qualified, 3.2 Unqualified.	No vacancies.
Occupational Therapists	WGP 9.8 qualified, 3.3 unqualified, Ward 31a 0.9 qualified, Gibside 1 qualified.	No vacancies.
Psychologists	WGP 3.8 qualified, 1.0 Band 4. Beadnell 0.2 Band 7.	0.5 Band 7/8a development post vacancy. 0.5 Band 6.
	RADS = 0	0
	REDS/ Ward 31a, X1 WTE Band 8D, X1 Band 8A (non-substantive), X1 WTE Band 7, X1 WTE Band 4.	0.4 WTE appointed in October. Start date February 2021. No vacancies. RWDS posts are under discussion because the current arrangements are not permanent.

Recruitment & Retention:

The Band 8a psychology post for Rose Lodge was advertised with no candidates applying, alternative banding to support recruitment is being considered.

New qualified Band 5 preceptees x2 from Teesside have been allocated to Beckfield and Springrise.

Paper is due to be submitted proposing development of Band 7 psychologist therapy post at Walkergate Park into a B7/8a development post due to difficulties retaining staff into this post.

Developments:
2 Nurse Consultants have been successfully recruited for Adult Acute and Adult Recovery & Rehabilitation pathways, both are due to commence this post on 4th January.

A six month secondment assistant psychologist has been appointed to work on the acute care pathway with patients with learning disabilities/ autism and associated with complex needs.

An exciting opportunity has arisen to trial, the clinical lead nurse Band 7 on one of the rehabilitation wards. It is a role many of the ward areas would like to see develop so that all ward areas can use this model.

Psychology staffing is being reviewed into the eating disorder service, the current arrangements are not permanent, psychology staffing into the mother and baby unit is also under review.

Physiotherapy input into the specialist mental health wards is currently covered by Walkergate Park on a referrals basis, proposal to carry out a pilot for 1 session per week for the 3 wards to be allocated has been accepted and is being progressed.

Medical Workforce Summary
On a monthly basis the Trustwide Medical Managers Meeting receives a comprehensive report on the Medical Staffing position where this is discussed and debated. A summary of these reports as below provides the Trust position by CBU for October 2020. It is anticipated that the future arrival of a number of international Doctors will help improvements through reducing the vacancy factor Trust-wide.

Locality	CBU	2020/21 Budget	Monthly Payroll	Add PA's	Agency	Vacancies
SOUTH	Access	8.14	7.86	0.70	0.00	0.42
SOUTH	Community	28.02	31.47	0.93	0.40	4.78
SOUTH	Inpatient	18.91	17.93	1.30	1.30	1.62
SOUTH	Specialist	26.87	23.85	0.31	0.05	-2.66
SOUTH	**Total**	**81.94**	**81.11**	**3.24**	**1.75**	**4.16**
CENTRAL	Access	12.15	8.90	0.40	0.28	-2.57
CENTRAL	Community	33.08	33.75	1.13	1.90	3.70
CENTRAL	Inpatient	12.32	12.49	0.10	1.06	1.33
CENTRAL	Secure	13.96	12.14	0.10	0.00	-1.72
CENTRAL	**Total**	**71.51**	**67.28**	**1.73**	**3.24**	**0.74**
N.CUMBRIA	Community & Access	19.54	15.69	0.56	1.00	-2.29
N.CUMBRIA	Inpatient	17.81	16.30	0.00	4.60	3.09
N.CUMBRIA	**Total**	**37.35**	**31.99**	**0.56**	**5.60**	**0.80**
NORTH	Access	8.36	5.83	0.40	0.00	2.13
NORTH	Community	34.44	30.56	1.28	4.50	3.90
NORTH	Inpatient	15.30	15.36	0.48	4.00	4.54
NORTH	CYPS	13.96	9.95	0.67	0.00	-3.34
NORTH	**Total**	**72.06**	**61.70**	**2.83**	**8.50**	**0.97**
TRUST	**Total**	**262.86**	**242.08**	**8.36**	**19.09**	**6.67**

Trust wide value based recruitment and retention

Recruitment update
Despite the challenges of Covid-19 the agreed plan for recruitment to the Trust through substantive and bank and agency staff has continued to be prioritised, where safe to do so using

alternative assessment methods underpinned by values-based recruitment. Bespoke recruitment campaigns have been successful. The recruitment activity has been led in parallel to managing the major incident by the Central Recruitment Team and we can report significant progress on qualified, unqualified and bank vacancies. From an assurance perspective even though much recruitment has been done through virtual means, fidelity to the values-based recruitment process has been maintained.

PMVA training has continued with increased pace to support new starters which has increased training compliance month on month. This is supported by Covid19 testing prior to commencement and models for increasing capacity to deliver PMVA to support recruitment have been developed. International recruitment work has enabled new starters to be confirmed for Doctors and Nurses during November/ December. Recruitment activity is also underway to support newly registered nurses commencing in the new year. All new starters are being offered bank contracts. Preceptee nurses who recently commenced in post are currently being supported through the preceptorship programme.

Retention Strategy

During November we experienced an increase in Covid related activity for both staff and patients and it has been more important than ever that we continue to recognise the significant achievements since March in relation to working differently during the Covid pandemic. Although staff are experiencing weariness as a result of the pandemic there is much evidence of team comradery and active support via the CBU leadership teams.

The self-help resources have been disseminated through the 'A Wish' initiatives which has continued. The staff absence line has had a positive impact on supporting staff with access to testing and wellbeing advice and support. Senior nurses continue to provide individual support and advice to staff with positive feedback being received particularly relating to practical advice and support at a time when staff are anxious. Risk assessments for staff to measure health risk have been completed as an online system. This supports safe working practice which has seen monthly increases of staff undertaking the risk assessment.

As the Trust continues to manage Outbreaks, we have developed a learning and debrief meeting which is being welcomed by staff and positively evaluated as a means of consolidating learning associated with the deeper understanding of the root cause of the outbreak and learning associated with a sustained change of Infection, Prevention Control (IPC) practice. Supervision remains an important method of supporting staff particularly given the duration of the pandemic. Staff appraisals continue to be completed at pace. The importance of staff health and wellbeing, and safe working practices will continue to be a priority as we maintain to engage staff as we move into the second surge of Covid19, where we anticipate the increase in Mental Health referrals and prepare our plans for winter and the Flu season.

Six monthly skill mix review & analysis of current staffing matters

This current six monthly update focusses specifically on how the workforce numbers have been maintained during a period of National unprecedented emergency as follows:

Covid19 Pandemic & Enhancing the Workforce

During the Pandemic many of the courses within the higher education establishments were suspended. This created an exciting opportunity to reinforce our Nursing workforce through the employment of 1st, 2nd and 3rd year students whilst training was suspended. This is currently being considered again for 3rd year nurses and the Trust awaits confirmation from the Chief Nursing Officer.

The Senior Student Nursing Assistants, Band 4, are the students in their final six months, due to qualify in September 2020. These students were interviewed and allocated posts; many of the

students selected the areas they had been working in as a Band 4 for their Band 5 posts upon qualifying and we have seen the students move into preceptorship posts, many of whom have significantly benefited from the increased experience at band 4. They are also automatically given an opportunity to continue on the Nurse Bank.

The first-year students were employed on fixed term contracts, 7.5 hours, for three months and were allocated to the flexi pools. These students are also being offered the opportunity to stay on the nurse bank given their recent experience as Support Workers and many have remained as regular bank staff members.

The second-year students worked as Student Nursing Assistants with fixed term contracts. These were offered the opportunity of continuing on the nurse bank whilst completing their training which they took up offers and remain on the bank.

Utilising the student nurses during the height of the pandemic allowed us to compliment the nursing workforce through an additional circa 160 staff. Although the higher education institutions reinstated courses from September 2020, we have seen a second Covid lockdown which impacted on learners study. Through the staff absence line we made arrangements for learners to receive Covid related testing which was agreed with all Higher Education Partners. This enabled the learners to be fully supported whilst the Trust being aware of their Covid status. This initiative has been welcomed by learners and their mentors. Learners are receiving Lateral Flow Kits and arrangements are currently underway to support access to vaccination, these clinical skills and experience would be retained via the nurse bank as above.

Covid19 Staff Shielding

Although many nurses came into the protected groups who were required to shield in accordance with government guidance, a large percentage of these staff, although shielding, have continued to work from home. This has enabled service continuity as they have been able to provide patient contact via virtual means.

Covid19 Staff Support Health & Wellbeing

Throughout the pandemic it has been critical to ensure staff have been well supported through:

- Continued access to clinical supervision and support, often through virtual means
- Clear communication and interpretation of emerging National Guidance to provide safe frameworks to underpin their practice
- Availability of Personal Protective Equipment (PPE) and changes to the environment to allow social distancing
- Wherever possible staff have continued to work from home, with an ongoing review and staff risk assessments continuing to take place
- Dissemination of information to support health and wellbeing
- Psychological wellbeing support and helpline
- Central staff absence line which has given staff immediate support and guidance
- Timely and responsive staff testing and Lateral Flow testing to allow staff to return to work as soon as possible
- During December the Covid vaccinations under development were approved for use. Guidance was received in relation to the development of Covid vaccination clinics which commenced on the 11th January 2021. This has been delivered and significant proportion of the staff group have been vaccinated with their first dose.

There has been no significant Skill Mix change undertaken in the last 6 months during the Covid-19 pandemic however we have seen a continuance of positive safety culture which can be seen through the daily review of safer staffing levels against acuity. The skill mix requirements to

maximise safety and quality of care have been supported by the deployment of staff with roles being adjusted to meet the needs of patient groups. Locality Care Groups will be reviewing all structures as vacancies and potential retirements emerge to ensure these are filled to ensure safe staffing levels. During the pandemic a number of acting up positions have been come available as a result of wider deployment which has enabled career progression with exposure into new areas of responsibility.

Conclusion

Daily risk assessment takes place according to changing clinical need and levels of acuity supported by ward team safety huddles and sitrep meetings. Adjustments have been made as necessary to ensure that patient safety is not compromised and any risks escalated. The report highlights the significant collaborative work undertaken during the Covid19 pandemic to ensure staffing levels remain safe and that staff continue to feel well supported in the face of this adversity.

Anne Moore, Group Nurse Director
January 2021

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	**Service User and Carer Experience Report (Q3 2020/21)**
Report author(s)	**Paul Sams, Experience & Effectiveness Officer Commissioning & Quality Assurance**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of 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	

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	27.01.21
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	25.01.21
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		Environmental	
Financial/value for money		Estates and facilities	
Commercial		Compliance/Regulatory	
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 Service User and Carer Experience Summary Report
Quarter 3 2020-21

Executive Summary

This is the first quarter that summarises the new version of Points of You, as such there is no comparative analysis to any previous data. In future reports this will return.

The Friends and Family Test remains stood down nationally due to the current and ongoing Covid situation, therefore the usual national benchmarking data is not available.
Points of You mailshot will recommence in February 2021.

Online and hard copies of the new Points of You survey are available.

76% of feedback through Points of You was positive in theme.

Points of You (PoY) Uptake

216 PoY responses were received during this quarter. They are made up of 160 from service users/patients, 31 on behalf of service users/patients, 14 from a carer/relative/friend and 11 were returned without specifying either of the previous three groups.

Locality	Total PoY responses
South	104
Central	42
North Cumbria	30
North	29
Not Stated*	11

*feedback for a team that isn't assigned to a locality by a CQC Core Service code or a hard copy without its team visible on the form.

It is worth noting that national reporting of Friends and Family Test (FFT) is currently stood down in response to Covid-19 and the pressures on 'business as usual' that all Trusts are facing. As a result the usual ways of supporting wards and teams to receive feedback through PoY has been on hold, although feedback has still been accepted when offered during this period.

As a result of the new version of PoY being introduced in September and the unprecedented circumstances in the last year, the data for this quarter will stand alone, rather than being compared with previous data as would usually be expected.

Key Points Relating to Feedback

- 48% of PoY feedback came from the South locality
- Feedback from inpatient settings remains low. Community meetings and mutual help meetings are likely to be preferred methods of receiving feedback in these areas
- 14% of PoY feedback relating to exercise therapy – 84% of this was positive and none was negative
- North Cumbria received the most positively themed feedback with 84%

Locality Themes of Feedback

	Positive %	Negative %	Neutral %	Compliment %
North Cumbria	83.87	5.65	4.84	5.65
South	78.70	9.17	11.24	0.89
North	70.19	16.35	8.65	4.81
Central	67.52	16.56	12.74	3.18

Friends and Family Test Summary

Question 1 of Points of You is the national Friend and Family Test question 'Overall, how was your experience of our service?' and responses give us an overall FFT score. This score is calculated by assigning a score to each option, (V.Good = 10, Good 7.5 etc, this is then divided by the number of responses (excluding not answered) to give a score).

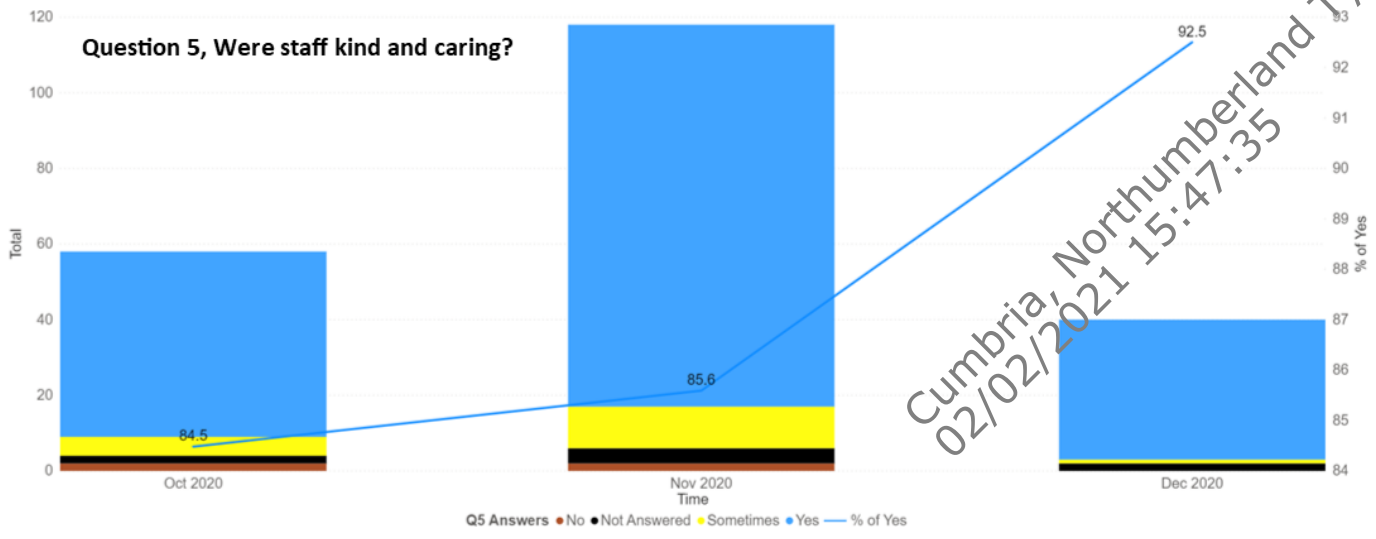
	Average FFT Score for Quarter (out of 10)	Total number of responses
Trustwide	8.59	216
North Cumbria	9.22	30
South	8.62	104
North	8.36	29
Central	7.99	42

South locality received the most feedback with almost half of the Trust total, averaging slightly higher than the Trust average for FFT. North Cumbria received less feedback but averaged the highest FFT score over the period. North locality received the least feedback and averaged slightly below the Trust average. Central received the lowest average FFT score this quarter.

Points of You Experience Analysis

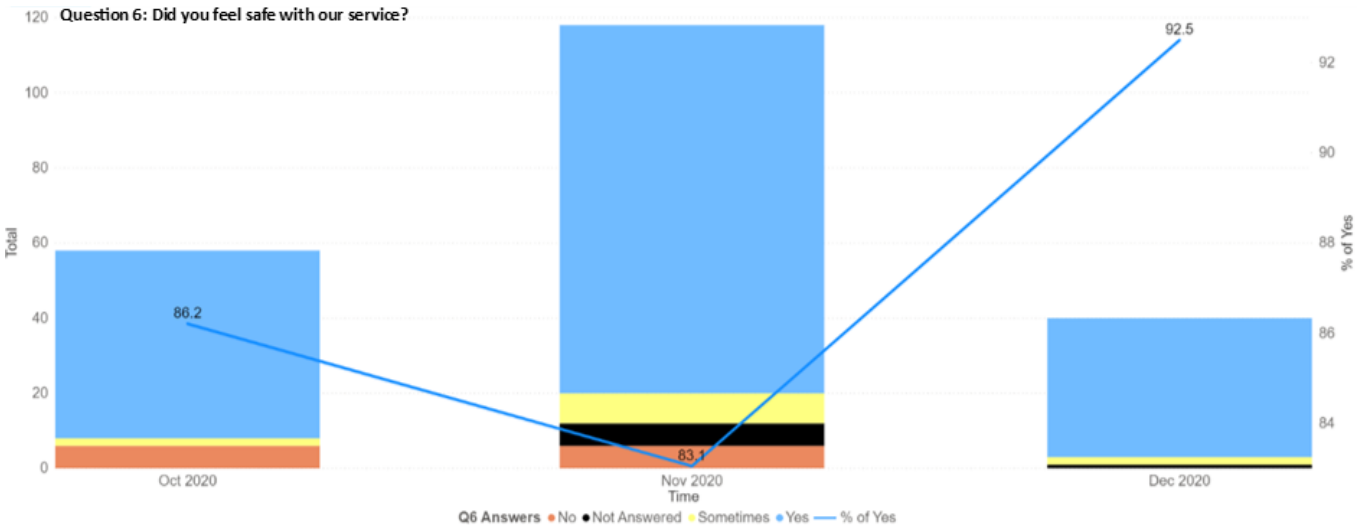
Top 3 Questions by Score

1. Where staff kind and caring?



The Trust average score for this question was 87% of people agreeing with this statement. Two people answered ‘no’ to this statement across the quarter.

2. Did you feel safe with our service?

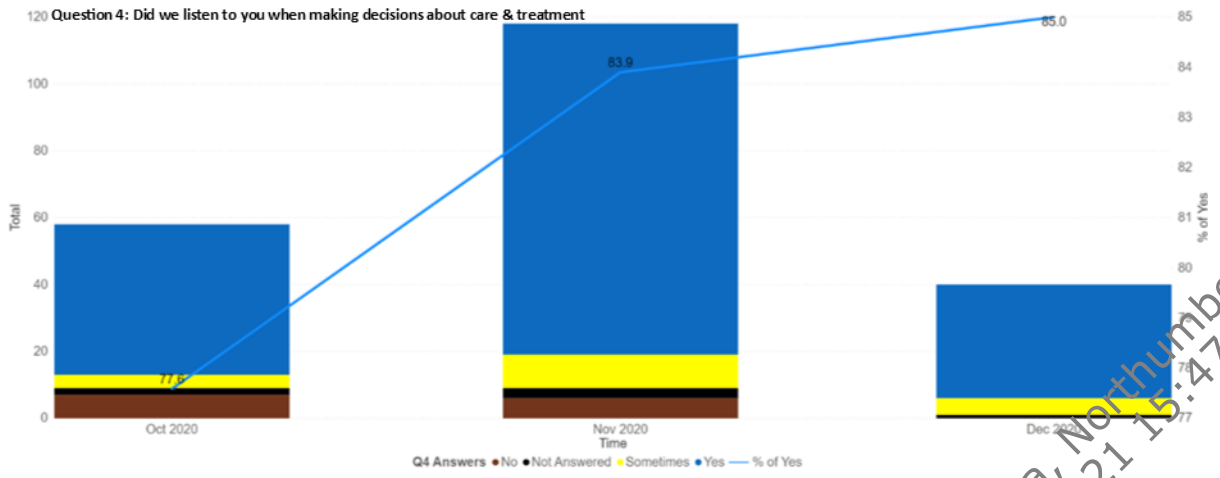


The Trust average score for this question was 86% of people agreeing with this statement. 12 people answered ‘no’ to the statement during the quarter, in comparison with 184 who responded ‘yes’.

The main themes for people saying ‘no’ are in relation to acute settings and these being ‘noisy’ or ‘chaotic’ with some people feeling intimidated by the presentation of other patients.

Themes for people saying ‘yes’ appear to centre around staff offering reassurance.

3. Did we listen to you when making decisions about care and treatment?



During this quarter 82.41% of people completing a PoY questionnaire chose yes as the answer to this question. Percentage of ‘Yes’ responses rose month on month across the quarter.

Feedback Demographics

Of 216 PoY responses were received during this quarter, 160 were from service users/patients, 31 on behalf of service users/patients, 14 from a carer/relative/friend and 11 were returned without specifying either of the previous three groups. The following tables show the satisfaction of these respondees by age, ethnicity, faith and sexual orientation, including how many PoY responses each demographic offered.

Age	FFT Score (out of 10)	Number of Surveys
0-18	10	2
75-84	9.5	21
25-34	9.4	29
85+	9.2	3
35-44	9.0	34
55-64	8.9	22
45-54	8.5	31
19-24	8.5	13
65-74	8.3	25
Not Stated	6.8	17
Preferred not to say	5.3	8

Ethnicity	FFT Score (out of 10)	Number of Surveys
Black/African/Caribbean/Black British	10	3
Other ethnic group	10	3
White	8.86	168
Asian/Asian British	8.75	4
Prefer not to say	8.33	6
Not stated	6.56	16
Mixed/Multiple ethnic groups	5	4

Faith	FFT Score (out of 10)	Number of Surveys
Buddhism	10	1
Hinduism	10	2
Paganism	10	2
Atheism	9.25	10
Islam	9.17	3
Spiritualism	9	5
Not Stated	8.80	66
Christianity	8.63	67
Other	8.08	40
Blank	7.86	7
Judaism	3.75	2

Orientation	FFT Score (out of 10)	Number of Surveys
Questioning	10	1
Intersex	10	1
Heterosexual	8.89	95
Gay/Gay Man	8.75	2
Not Stated	8.70	78
Blank	7.92	6
Other	7.50	16
Bisexual	5.42	6

Themed Comments

A total of 765 comments were themed from the 216 PoY responses. Of these 584 (76%) were themed as positive, with 81 (11%) themed as negative.

The top 3 categories for themes were;

Positive	Negative	Neutral
Values & Behaviours (250)	Communications (24)	Patient Care (27)
Patient Care (160)	Patient Care (21)	Facilities (20)
Communications (149)	Facilities (9)	Communication (13)

Themes by Locality

North Cumbria

Although North Cumbria received very few PoY returns, they scored above the Trust average over this quarter, even with a month on month reduction in their average. 3 main themes are evident when looking at how the FFT score was so high, these are; Values and behaviours, communications and patient care. There was no themes evident for negative feedback, only appointments and communication had any multiple responses recorded, there were no sub-themes evident. One individual commented that there was nobody on reception when they arrived for an appointment.

South

During quarter 3, the South locality revied almost half of all PoY responses for the Trust with 97 of 205 received relating to services in the south. During this period the average FFT score for the South locality was 8.62, slightly above the Trust average fo the same period. October (31 surveys) and November (58 surveys) were almost identical averages, 8.47 and 8.44 respecively, December (15 surveys) was significantly higher with an average of 9.53.

North

It is notable that the FFT score for October (8.75) and November (8.96) was above the Trust average score of 8.59, however the average score was much lower for December, achieving only 6.79 (see table 20). When looking for the reasons for such a low score in December there is no clear theme evident, however there is an increase in neutral and negative feedback during the month.

Central

During quarter 3, Central locality averaged an FFT score of 7.99 from the 41 PoY responses they received. Responses predominantly came from service users/patients or on their behalf, with 34 and the remaining 7 were offered by carers/friends/relatives of those receiving care.

Recent, local and national developments

FFT remains stood down as effort continue to deal with the effects of Covid and the restrictions it imposes. While this situation remains, efforts are being made in the Trust and with stakeholders to develop a strategy to engage more people in the PoY process.

Lisa Quinn
Executive Director of Commissioning and Quality Assurance

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

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

2020-21 Month 9 (December 2020)

Executive Summary

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

2 There have been two remote Mental Health Act reviewer visit report received this month.

Oakwood, Carleton Clinic (Ward for older people with mental health problems) – 15 December 2020

One issue was identified from this visit which is to be addressed and relates to how referrals are made to the IMHA service. There were a number of positive remarks noted from family interviews:

- Families were positive about the ward and said that staff were caring and compassionate. One relative commented: "It's absolutely marvellous. Staff are brilliant, caring and compassionate."
- Families said the care was very good. They felt their relative was safe. One commented "they can read him like a book."
- Staff had invited families to meetings, and they said that they felt informed and got any information they requested.
- Families said they could visit, and this was well organised. Visits took place in private. One family member said; "I've been treated as an individual." Both relatives said that they felt staff recognised the importance of their contact with their spouses and that staff had been very supportive and creative to enable visits to take place. One relative said they had joined the ward bubble and totally quarantined when at home in order to maintain contact and keep everyone safe.
- One family knew who their relative's named nurse was and had a copy of the care plan. The other relative wasn't sure regarding the named nurse but felt well informed and had opportunity to speak with nursing staff.

Ward 31a, Royal Victoria Infirmary (Specialist Eating Disorder Service) – 21 December 2020

Two issues were identified from this visit which are to be addressed. They relate to patients not being provided with a bedroom door key or having the facility to lock away any valuables. Also, the Wi-Fi available to patients was poor and led to patients losing connection or needing to use their own data. However, there were a number of positive remarks of note:

- Patients said staff treated them with respect. Comments included; "They are fantastic, done everything they can" and "All staff are supportive. Staff go out of their way to give you time".
- Patients described their one-to-one therapy and activity sessions. They discussed craft sessions, baking, working on finding out what interests them and "movement with meaning" sessions.
- Patients felt they were involved in decisions about their care. Both patients said they had copies of their care plan and they got a written record of their multi-disciplinary

meeting. They said; “I feel I’m part of the decision-making process. It’s a tailored personalised approach.”

- Both patients had experienced self-isolating after periods of leave or at admission. They felt it was as comfortable as it could be and described that staff popped in to chat with them. One commented, “they made it as comfortable as possible.”
- The two patients understood their rights as either an informal or detained patient. The patient detained under the MHA knew of their right to an independent mental health advocate and had chosen not to have one.

3 The Trust met all local CCG’s contract requirements for month 9 with the exception of:

- CPA metrics within Newcastle Gateshead, Durham, Darlington and Tees and North Cumbria CCG’s.
- Numbers entering treatment within Sunderland IAPT service (448 patients entered treatment against a target of 801) and North Cumbria (316 patients entered treatment against a target of 605)
- Delayed Transfers of Care within Durham, Darlington and Tees

5 The Trust met all the requirements for month 9 within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (98.2%).

6 All CQUIN schemes for 2020/21 have been suspended due to the COVID-19 pandemic.

7 There are 38 people waiting more than 18 weeks to access services this month in non-specialised adult services (37 reported last month). Within children’s community services there are currently 390 children and young people waiting more than 18 weeks to treatment (287 reported last month).

8 Training topics below the required trust standard as at month 9 are listed below:

Fire (83.2%)	Medicines Management (84.9%)
Information Governance (85.5%)	PMVA basic training (21.8%)
PMVA breakaway training (65.2%)	Mental Health Act combined (65.8%)
MHCT Clustering (61.9%)	Clinical Risk (79.6%)
Clinical Supervision (78.1%)	Seclusion training (68.2%)
Rapid Tranquilisation (77.8%)	

9 Appraisal rates currently stand at 77.9% Trust wide against an 85% standard which is an increase from last month (77.0%).

10 Clinical supervision training is reported at 78.1% for December (was 77.4% last month) against an 85% standard.

11 The confirmed November 2020 sickness figure is 6.10%. This was provisionally reported as 6.20% in last month's report. The provisional December 2020 sickness figure is 6.19% which is above the 5% standard. The 12 month rolling average sickness rate has increased to 5.63% in the month.

12 At Month 9, the Trust has a deficit of £0.2m which is in line with the Trust's revised plan for the year. The revised plan and forecast deficit is £2.2m. In line with the financial arrangements put in place in response to COVID-19 the Trust was breakeven at the end of September. Additional costs due to COVID-19 from April – December were £5.7m. Agency spend at Month 9 is £11.5m of which £5.2m (45%) relates to nursing support staff and forecast agency spend is £15.1m.

Other issues to note:

- There are currently 21 notifications showing within the NHS Model Hospital site for the Trust.

- The number of follow up contacts conducted within 72 hours of discharge has increased in the month and is reported trust wide at 95.1% which is above the 80% standard. (was 93.5% last month).

- There were no inappropriate out of area bed days reported in December. All out of area placements were appropriate and admitted whilst away from home. This compares with 26 inappropriate bed days in November.

- During December 2020 the Trust received 39 Points of You survey returns, of which 79% were from service users and 21% from carers. Of the 39 responses, 38 answered the FFT question with 84% of service users and carers stating their overall experience with CNTW services was either good or very good.

Future reporting of Training & Appraisals during pandemic

The Trust is experience continuing pressure maintaining services through the extended wave 3 Covid 19 period. The Executive Team and Operational Directors have stood down non-essential meetings and the centre have ceased several reporting requirements. We have explored the continuation of the training and appraisal standards. In wave 1 we paused the standard and gradually reintroduced them during the summer. Following management discussions, the following is proposed to the board:

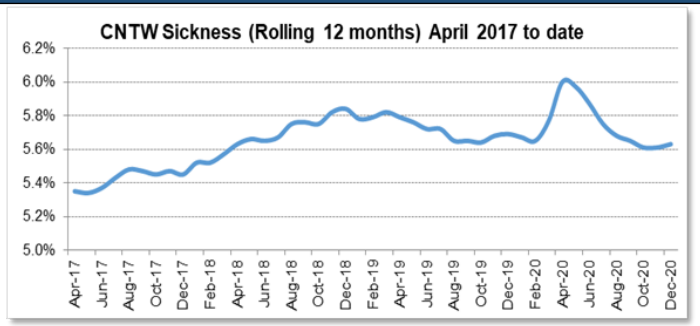
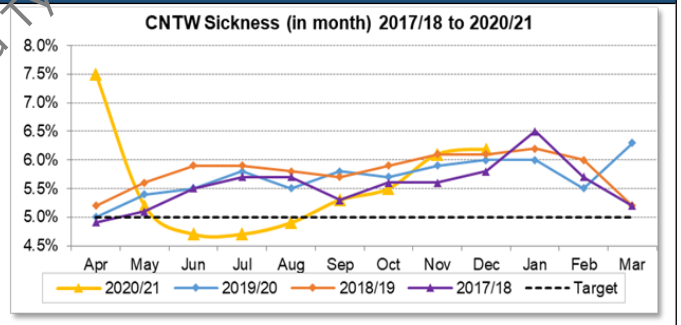
The Operational Groups would like to continue to make best endeavours to achieve the standards for training and appraisals however recognise this is not always possible in managing safe care with fluctuating staffing levels, managing patient co-horting to ensure we continue to remain open to admissions and managing varying restrictions. We will continue to monitor training and appraisals through the Board and the Accountability Framework meetings but not performance manage the expected standards. This will be reviewed each quarter with the Board.

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 two Mental Health Act reviewer visit reports received since the last report. The visits continue virtually with the process including interviews with Ward Managers/Clinical Leads, service users and carers and IMHA representatives	
	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%	100%	100%	90%	100%	93%	62%	90%
	Contract Summary: Percentage of Quality Standards achieved in the quarter:							
	94%	100%	100%	90%	100%	93%	62%	90%

CQUIN - Suspended										
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 2020/21										

Internal	**Accountability Framework**							
	North Locality Care Group Score: December 2020		Central Locality Care Group Score: December 2020		South Locality Care Group Score: December 2020		North Cumbria Locality Care Group Score: December 2020	
	4	The group is below standard in relation to CPP metrics and training 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: Quarter 1 internal assessment RAG rating				
	Improving the inpatient experience	Improve Waiting times for referrals to multidisciplinary teams	Equality, Diversity & Inclusion and Human Rights		
	Waiting Times				
	The number of people waiting more than 18 weeks to access services has decreased in the month for non-specialised adult services. The number of young people waiting to access children's community services has increased in month 9. 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:**				**Appraisals:**
	Number of courses Standard Achieved Trustwide:	Number of courses <5% below standard Trustwide:	Number of courses Standard not achieved (>5% below standard):	Fire training (83.2%) and Medicines Management training (84.9%), are within 5% of the required standard. Rapid Tranquilisation training (77.8%), Information Governance (85.5%), PMVA basic training (21.8%), PMVA Breakaway training (65.2%), MHA combined training (65.8%), MHCT Clustering Training (61.9%), Clinical Risk training (79.6%), Seclusion training (68.2%) and Clinical Supervision training (78.1%) are reported at more than 5% below the standard.	Appraisal rates have increased to 77.9% in December 20 (was 77.0% last month).
	6	2	9		
	Sickness Absence:				
		The provisional "in month" sickness absence rate is above the 5% target at 6.19% for December 2020 The rolling 12 month sickness average has increased to 5.63% in the month			
Finance	At Month 9, the Trust has a deficit of £0.2m which is in line with the Trust's revised plan for the year. The revised plan and forecast deficit is £2.2m. In line with the financial arrangements put in place in response to COVID-19 the Trust was breakeven at the end of September. Additional costs due to COVID-19 from April - December were £5.7m. Agency spend at Month 9 is £11.5m of which £5.2m (45%) relates to nursing support staff and forecast agency spend is £15.1m				

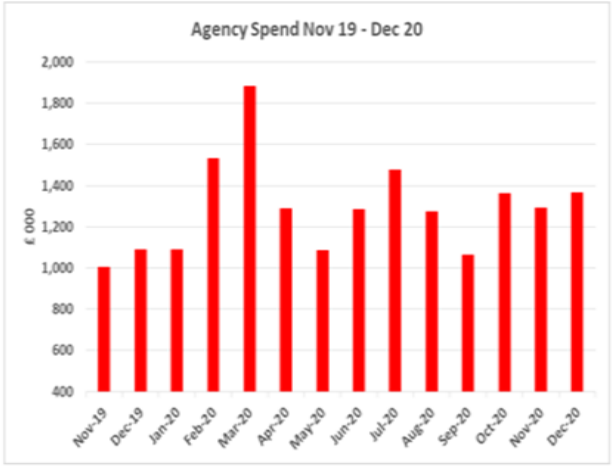
Financial Performance Dashboard

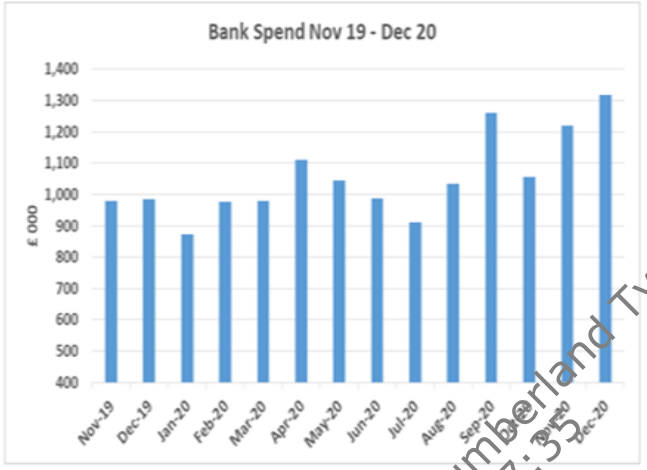
Income & Expenditure

	Year to Date				Forecast		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Income	310.6	312.6	(2.0)		414.6	418.2	(3.6)
Pay	(248.2)	(249.8)	1.6		(332.8)	(335.8)	3.0
Non Pay	(62.6)	(63.0)	0.4		(84.0)	(84.6)	0.6
Surplus/(Deficit)	**(0.2)**	**(0.2)**	**0.0**		**(2.2)**	**(2.2)**	**0.0**

Key Indicators

Key Indicators	Year to Date	Forecast
Surplus/ (Deficit)	(£0.2m)	(£2.2m)
Agency Spend	£11.5m	£15.1m
Cash	£70.0m	£39.3m
Capital Spend	£9.4m	£23.2m





Key Issues/Risks

- Following agreement with the North Integrated Care Partnership (ICP) the Trust has an agreed financial profile of income and expenditure for month 7 – 12.
- At month 9 the Trust has delivered a £0.2m deficit which is in line with M7-12 plan.
- Bank & Overtime costs have remained high in month 9 to support the response to wave 3 of the pandemic.
- Month 9 pay costs have increased due to enhancements paid over Christmas and an increase in overtime costs as well as a provision for additional ad hoc pension charges. The Trust has incurred £0.7m additional costs due to COVID-19 in month 9. These were included in the forecast in the M7-12 financial plan. The Trust has identified £5.7m of Operational COVID costs up to month 9. The Trust is also incurring the costs of additional services developed to support the pandemic.
- Cash – £70.0m at month 9 which is higher than normal due to early payment of income.
- Capital Spend - £9.4m at month 9 which is £4.7m less than plan.

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

	30/11/2020		07/12/2020		14/12/2020		21/12/2020		28/12/2020	
Medical	118	54	118	54	107	43	107	43	102	43
Qual Nursing	149	121	153	122	203	107	169	97	148	91
Unq Nursing	990	126	1,079	67	1,160	46	1,044	44	456	43
A&C	74		69		72		72		48	
	1,331	**301**	**1,419**	**243**	**1,542**	**196**	**1,392**	**184**	**754**	**177**

In December the Trust reported an average of 220 price cap breaches (47 medical, 108 qualified nursing and 65 nursing support). At the end of December 9 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 9.
- 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.

Agree the approach to training and appraisals monitoring.

Allan Fairlamb	Lisa Quinn
Head of Commissioning & Quality Assurance	Executive Director of Commissioning & Quality Assurance

19th January 2021

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
3 February 2021

Title of report	Our collective promise to our Black, Asian and minority ethnic colleagues and communities
Report author(s)	Christopher Rowlands, Equality and Diversity Lead
Executive Lead (if different from above)	Lynne Shaw, Executive Director of Workforce and Organisational Development

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	27/01/21
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	16/12/20
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	
Workforce	X	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			

Our collective promise to our Black, Asian and minority ethnic colleagues and communities
Trust Board of Directors
Wednesday 3 February 2021

1. Executive Summary

Healthcare leaders at NHS Trusts across the North-East and Cumbria Integrated Care System (ICS) have signed a collective promise to Black, Asian and Minority Ethnic (BAME) colleagues. The promise aims to ensure fairness for all and embedding a culture where people can thrive no matter what their race, background or personal experience. The leaders are committed to ensuring that no one person's experience is influenced by prejudice - either as a staff member or patient accessing health and care services. The collective promise includes projects to increase diversity in the workforce, introducing new training for all staff to raise awareness of BAME issues, dedicated BAME leadership programmes, a zero tolerance for bullying and harassment as well as other BAME community and staff engagement initiatives.

2. Risks and mitigations associated with the report

At Trust Level renewal of our equality, diversity and inclusion plans, our Workforce Race Equality Standard actions and current work of our BAME staff network are aligned to the new collective promise. Actions are also aligned to the NHS People Plan and work is currently taking place to meet the requirements set out in that.

At the NENC ICS level there have been initial meetings held for staff network chairs from around the region. For operational reasons much of the work is planned to commence from April 2021. Lisa Crichton-Jones has been appointed as the Senior Responsible Officer and a request has been made of the NHS Deputy Directors of Workforce for one of them to lead this work operationally. The key deliverables for this work at ICS level are:

- Increase diversity across all levels of workforce, boards and governing bodies (including leadership), underpinned by transparent and fair recruitment processes. (work already taking place at CNTW)
- Work alongside colleagues on the System Development and Leadership priority to develop or identify and implement high impact annual learning and development activities for all staff on unconscious bias and/or cultural intelligence.
- Develop systems to ensure that there are robust means in which leadership boards have a programme of reporting, training and development which focuses on workforce equality standards.
- Develop and implement effective feedback mechanisms for all protected groups which can demonstrate specific feedback from colleagues and communities, ensuring that they are created to ensure that there is psychological safety.
- Work alongside colleagues on the System Development and Leadership priority to develop or identify and implement high impact talent and leadership programmes specific to our BAME colleagues.

3. Recommendation/summary

The Board of Directors is asked to receive this paper for information. Updates will be provided as this work develops both at Trust and ICS levels.

Chris Rowlands
Equality, Diversity & Inclusion Lead

Lynne Shaw
Executive Director Workforce OD

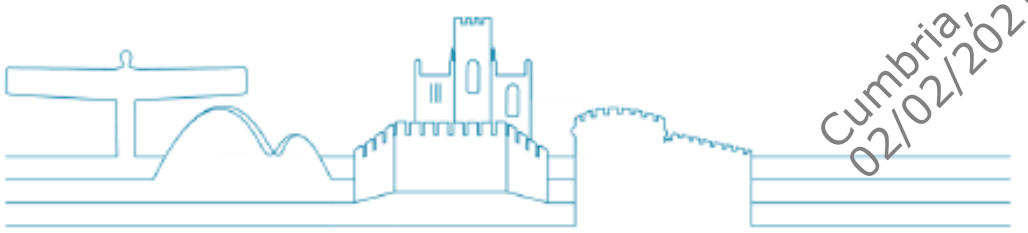
January 2021

Our collective promise to our
Black, Asian and minority ethnic colleagues and communities

Healthcare leaders across the North East and Yorkshire are committed to better supporting people from Black, Asian and minority ethnic (BAME) communities. This includes ensuring fairness for all and embedding a culture where, no matter your race and/or background, your personal experience, either as a staff member or as someone who accesses health and care services, is one that is not influenced by racism or any bias, be it unconscious or not.

Our collective promise includes:

- Devising an agreed framework to increase diversity across all levels of workforce, boards and governing bodies (including leadership), underpinned by transparent and fair recruitment processes
- Introducing yearly learning and development activities for all staff on the subject of unconscious bias and/or cultural intelligence
- Develop systems to ensure through commissioning and encouragement that all leadership boards have a programme of reporting, training and development which focuses on workforce race equality standards, such as WRES metrics or other locally determined measures.
- Develop feedback mechanisms are firmly in place for all protected groups and can demonstrate specific feedback from BAME colleagues and communities creating psychological safety
- Develop a system to support zero tolerance for bullying and abuse as a result of racism
- Identify a programme which recognises the talent and leadership potential of our BAME colleagues
- Ensuring our work place environments support people from all backgrounds



- Ensuring all organisations have established staff networks to support listening into real, tangible action, where not already in place
- Develop a framework that shows a commitment to continue to understand and develop strong allyship to our BAME communities and colleagues
- Ensure promotional or communications activity actively reflects the communities we service and our workforce
- Engaging BAME service users and carers in patient and carer involvement activities

Signed:	Signed:	Signed:
Date:	Date:	Date:

Report to the Board of Directors
3rd February 2021

Title of report	Children and Young Peoples Inpatient Services, West Lane Hospital: Board Briefing Paper
Report author(s)	David Muir – Group Director. North Cumbria Locality
Executive Lead (if different from above)	Gary O'Hare - Executive Director of Nursing & Chief Operating 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	✓	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	
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
BAF - Risk Number 1680 - Compliance and Regulatory

Children and Young Peoples Inpatient Services, West Lane Hospital:
Board Briefing paper
3rd February 2021

1. Introduction

This brief paper follows on from last month's Board update paper and outlines continued progress in relation to establishing services at West Lane Hospital.

Children's inpatient services in West Lane closed following regulatory action in 2019 and NHS England issued a formal request to CNTW take over the running of inpatient services at West Lane. This will be to set up a 10 bed General Adolescent Unit comprising 10 beds in the first instance. This will be operated on the West Lane site, with an anticipated 'opening' of April 2021 with incremental patient occupation thereafter determined by both staffing numbers and demand.

2. Operational Management

Following the transfer of the Specialist Children and Young Peoples Services in December to the North Cumbria Locality as their 3rd Clinical Business Unit work continues to be undertaken to embed the services that will operate on the West Lane site with existing CNTW children and young people's inpatient services at Ferndene and Alnwood forming a North of England Centre for Children and Young Peoples Inpatient Care[1].

This will give clear operational and quality focused advantages that centre around having a unified clinical, governance and management structure. This is particularly significant given the Trust's receipt, earlier this month, of the CQC Children and Adolescent Mental Health Wards inspection report which details a single Must Do action that focuses on the use of restraint and mechanical restraint. Work has already begun to review this action with the intention of withdrawing the use of mechanical restraint at an agreed future point. The use of mechanical restraint at West Lane has never been planned, having been agreed at the outset of the programme that it would not be used.

3. Progress to Date

3.1 Communications and Service User / Care Involvement

Stakeholder meetings have continued and have gone well. John Lawlor and Gary O'Hare have continued engaging with families. The visit to Ferndene services for impacted families because of continued Covid-19 restrictions has not taken place.

'Lotus Ward' has been chosen as the preferred name of the ward[2]. It was selected after the Communications Team researched extensively options across a number of areas including nature and geographical references, pulled together an initial long-list of names including rationale. Following discussions with Group and CBU managers, a shortlist was created.

[1] CBU also includes specialist children's outpatient's services and secure in-reach
[2] Symbol of regeneration

Young People at Ferndene and Alnwood then reviewed and selected by vote from the final two options.

An expected consultation has begun led by Tees, Esk and Wear Valley NHS FT (TEWV) with regards the renaming of West Lane Hospital. It is expected that this will be completed by the end of February. Subject to Covid-19 restrictions, there is a possibility of holding an open day for the families to attend the site, if not this will be done virtually before opening.

The Communications Team have created a virtual walkthrough video of the facility which has been shared with the Young People for their input on the design of the facilities on the ward and any feedback received will be forwarded to relevant workstreams. The final walkthrough video will be uploaded to the website once it has been upgraded as a 360-degree tour.

3.2 Operational Management and Safety

This workstream, as per previous updates, continues to influence to the direction of all the other workstreams and is currently engaged in several areas of work including those linked to these areas, particularly, estates and workforce. Progress continues to be made across several areas related to operational management and safety.

Processes are very much aligning, Clinical Environmental Risk Assessments (CERA) assessments have been done, policy and procedures groups are meeting regularly pulling together updated versions incorporating national and local changes. The chaplaincy service has been arranged to work into the service once a week. Education links have been made with the local authority and contracts are being finalised. Initial scoping the installation of Oxehealth[3] patient safety system onto the ward is also underway.

3.3 Workforce

Following a high number of withdrawals and DNAs not all posts were appointed in previous recruitment campaigns. A further round of shortlisting has been undertaken for both registered and non-registered nursing staff with interviews beginning again week commencing 25th January. These will be undertaken via Teams because of the current Covid restrictions.

Medical recruitment remains a challenge with advertisements not receiving applicants. Re-advertisements have been placed and a direct targeting campaign employed via the Royal College of Psychiatry.

Agreements have been reached with regards the whole time equivalency and skill mix needed to build the wider multi-disciplinary team and these have been advertised. Economies of scale continue to be sought across the service especially in leadership and managerial posts. Specific weekly meetings have commenced to focus in on recruitment, induction and training e.g. PMVA.

[3] www.oxehealth.com – allows the remote monitoring of vital signs to enable less intrusive monitoring of patients on observation. Currently installed in Hopewood Park.

The ability to recruit enough staff numbers has been flagged from the outset on the programme risk register. In order to mitigate this alongside continued recruitment contingencies are being explored e.g. expressions of interest, secondments.

3.4 Estates (Facilities) / Informatics

Estates and Informatics groups continue to have links with colleagues in TEWV. Further site visits have been undertaken. As pointed out previously Westwood rather than Newberry has been chosen because of its layout, suitability and a requirement for less capital investment.

IT requirements have also been scoped and associated costs established. Across both, £200k capital is now available having been confirmed by NHSE as part of winter funds 20/21. Informatics are working with TEWV colleagues and Virgin to secure stronger Wi-Fi connections that will be accessible to CNTW across the site. Access to TEWV Wi-Fi has also been secured as an interim measure to allow staff working on this programme to be able to connect to CNTW systems whilst on site.

TEWV and CNTW have agreed to work together to ensure estates work is completed. As there is not the need for the extensive building work that would have been required in Newberry, a range of minor works has already begun. Capital recharge costs for use of the site have yet to be confirmed by TEWV at time of writing. Cross-checks are also being carried out on what equipment and furniture is already in situ and what remains to be ordered. Going forward attention to other elements of commissioning the ward will come to bear e.g. curtains and crockery amongst other elements.

3.5 Commissioning and Regulation

The application to register the site with the CQC has been submitted and this takes approximately 11 weeks to achieve. Preparation to dovetail the new ward into CNTW reporting and assurance frameworks also continues. Work also continues across several areas to reach agreement with regard the budgetary elements of the programme and ultimately an acceptable Occupied Bed Day price.

3.6 Programme Approach, Governance and Risk

The frequency of Multi Agency Joint Steering Group continues a monthly basis alternating. Based on the crossover between the workstreams, IT, Estates, workforce and operational work meetings have merged to facilitate a more programme-based approach. Work streams continue to have joint CNTW / TEWV membership going forward.

4. Recommendation

1. Note the contents of this paper.
2. Advise on further detail or supplementary information required at this stage.

David Muir
Group Director – North Cumbria Locality Care Group

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NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	Medical vacancies and Recruitment Update
Report author(s)	Mrs Becky Dioh Dr Stuart Beatson Dr Bruce Owen Dr Neeraj Berry
Executive Lead (if different from above)	Dr Rajesh Nadkarni, Executive Medical Director

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	
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	X
Workforce	X	Environmental	
Financial/value for money	X	Estates and facilities	
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness	X	Service user, carer and stakeholder involvement	

Board Assurance Framework/Corporate Risk Register risks this paper relates to
None

Medical vacancies and Recruitment update
Trust Board
January 2021

1. Executive Summary

In October 2019 Mental Health and Learning Disability services from Cumbria Partnership NHS Foundation Trust joined the Trust to form Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

This report is to provide a brief update on Medical vacancies and Recruitment Update in Cumbria.

2. Risks and mitigations associated with the report

- Ongoing lack of medical staff and potential risk to services
- Impact of limited resources on the health and wellbeing of existing medical staff
- Impact of limited resources on recruitment and retention
- Gaps in training schemes limiting future local supply of medical staff

3. Recommendation/summary

The Board are asked to receive the paper for information only

Name of author: **Becky Dioh**

Job title of Author: **Head of Medical Recruitment and Education**

Name of Executive Lead **Dr Rajesh Nadkarni**

Job title **Executive Medical Director**

14/01/2021

Medical Vacancies and International Recruitment Update

1. Medical Staffing Issues in CPFT

Mental Health services in Cumbria have historically had significant problems recruiting and retaining senior Psychiatric medical staff. This led to significant clinical pressures on services.

The main issues leading to the difficulties in medical recruitment are as follows:

1. Cumbria's geography is unattractive for a lot of doctors who have trained within the inner city areas. To practice as a Consultant in Cumbria requires significant amounts of driving in covering large clinical areas.
2. Cumbria mental health services have historically been focused on core services and have suffered from a lack of in-house access to significant sub specialisms such as forensics. This has resulted in Consultants having to cover a wide variety of complex cases.
3. The junior doctor training rotations which were historically under the North West Deanery and recently transferred to the North East Deanery have had significant recruitment problems, and it is not unfair to say that Cumbria has been at the end of the queue when other parts of the deanery have been prioritised in receiving junior doctors. This has 2 effects as it makes the Consultant jobs unattractive due to lack of junior support and also means that doctors do not have training experiences within Cumbria and therefore are less likely to settle here when they are looking for senior posts.
4. CPFT for a number of years had significant problems improving its CQC rating from requires improvement. In line with a number of Trusts in similar positions it made the Trust less attractive to potential applicants.
5. In 2015 the Trust went through a major reorganisation, and as part of this the specialist medical staffing resource was dissolved. This had a significant impact on medical recruitment as the majority of the processes for recruitment fell on the Clinical Directors and the expertise and knowledge held by medical staffing was lost.
6. In addition to the above historical issues, in more recent years with the mental health services merging with at first community services, and then with the Acute Trust in Cumbria it was a challenge to maintain the profile and risks of the psychiatric staffing when the Trust was dealing with other significant issues such as A&E processes and bed pressures in 2 large DGH sites.
7. Medical staffing in North Cumbria historically has been dependent on locum doctors, although fortunately risk and negligence issues were infrequent with this medical cohort. It is to be noted that their lack of dependability and lack of long-term appointment meant that due to the small size of services the loss of one or two doctors could have a catastrophic effect on clinical pathways.
8. A related non-medical factor was the lack of development in CPFT of other professional groups to offer alternatives to the traditional Medical Consultant model within clinical teams and it would best to say that the development of nurse consultants and non-medical AC's and RC's although having some spectacular successes was at a strategic level, was lacking senior leadership support.

2. Staffing establishments and vacancies

In October 2019 N Cumbria mental health services (CPFT) joined NTW to form CNTW. Throughout the year, there has been an increase in funded posts. We have also had some leavers and have been working towards backfilling these posts. It is worth noting 2 wte agency doctors have now left the establishment thus reducing our agency wte from 5.6 wte to 3.6 wte and we have 3 consultants who will soon be joining us in the next couple of months.

N Cumbria WTE	Funded	Substantive	Agency
October 2019	34.35	24.28	5
December 2020	37.35	31.99	3.60

2.1 N Cumbria Medical (Consultant, SAS and Fellowship) Recruitment – CNTW (post October 2019)

Since North Cumbria services merged with NTW forming CNTW, there has been a more structured approach to recruitment and has benefited from the increased support from a bespoke Medical Staffing Department.

The international recruitment scheme will be a major benefit to North Cumbria services but this needs to be seen as a developmental process as most of the current vacancies and locum's within North Cumbria are at Consultant grade, and as such it will takes a period of time for international recruits to build up the skills and achieve relevant qualifications to function at Consultant level.

In discussions with recent applicants for posts to North Cumbria the feedback is that potential candidates are looking much more optimistically at adverts from CNTW compared to adverts from CPFT. The outstanding CQC rating is a major factor for these applicants.

In addition to these new applicants, we have been successful in retaining some of our junior doctors who have been with us for a number of years in North Cumbria (but unfortunately have not managed to progress with their training) into career grade specialty doctor posts.

2.2 International Recruitment

Out of 27 International doctors (overseas qualified psychiatrists) who accepted the job offer from the last trip, Cumbria was allocated 8 doctors (6 fellows, one SAS and one Consultant). Covid had an impact with delays, and the required isolation for 14 days on arrival. Cumbria under the Fellowship scheme has now has its own Associate director (Dr Roger Cable) to monitor these developments within the wider Trust governance structures of the scheme. The program guide covers clinical, corporate, pastoral and health and wellbeing induction to escalate the settlement into the region. (Details can be provided if requested).

Status	Name	Grade	Locality	Service
Arrived	Arun Kuruppath	Fellowship Dr	CUMBRIA	Cumbria - Adult - Carlisle CMHART - Carleton Clinic
Arrived	Sharath Vishwaraj	Fellowship Dr	CUMBRIA	Cumbria - Adult - Rowanwood
Arrived	Radhika Mukherjee	Fellowship Dr	CUMBRIA	Cumbria - Child (Community on Carleton site)
Arrived	Sneh Babhulkar	SAS Dr	CUMBRIA	Eden CMHART (Penrith)
Arrived	Vamsi Sreenivas Ramanujam	Fellowship Dr	CUMBRIA	Cumbria - Child (Community on Carleton site)
Arriving Jan 21 (Visa Issued)	Neha Singla	Fellowship Dr	CUMBRIA	Liaison post in new service development
Start date February 21	Satya Krishna Kumar Rayapureddy	Consultant	CUMBRIA	Cumbria - Adult Inpatient (CARLETON) - Hadrian

Start date February 21	Jayanth Purayil	Fellowship Dr	CUMBRIA	Liaison post in new service development

2.3 Live Recruitment

There are currently 4 adverts live on NHS Jobs (3x Consultants and 1x Specialty Doctor). The next rolling interview panel is on 21st January 2021.No posts currently in the shortlisting stage. 1 candidate going through recruitment process and is currently awaiting a start date to be confirmed.

2.4 Junior Medical Staff

Junior doctor medical posts processes for North Cumbria were subsumed within the CNTW medical education team in accordance with the arrangements for the rest of the trust after the transfer of services from North Cumbria in October 2019.

Using wider trust training resources and initiatives to support the locality, and in collaboration with local consultants and local education leaders to expand the available supervisors, (and working with HEE NE) five core training posts were recruited to in 2020.

We appointed a trust employed teaching fellow to support the clinical service and undergraduate education. In addition we appointed a clinical and a research fellow, both of whom have novel posts working into Newcastle for part of their work but doing our of hours work in North Cumbria. Finally the GP training posts were filled meaning that from August 2020, we had 13 doctors working into the out of hours rota ensuring this has been able to move from a limited service to a full shift covering the Carleton Clinic 24 hours a day.

Plans ongoing to further improve recruitment, include introducing F2 doctors onto the out of hours rota, Expand supervision capacity and Higher Trainee posts, and Out of hours Specialist Registrar cover.

3. Conclusions

Medical provision in North Cumbria has been significantly improved and enhanced over the past 15 months. Along with the developments described above significant efforts have been made in engaging and valuing the current medical workforce through clinical leadership training programmes, Trustwide management, educational and training opportunities and access to a wide range of Continuous Professional development opportunities.

The future sustainability of the medical workforce needs to focus not only on local recruitment within North Cumbria, and junior medical cover consolidation, but also on the wider possibilities provided by the use of digital platforms such that doctors do not need to be based in North Cumbria to provide clinical services.

Furthermore, significant developments are being made in the development of the non-medical workforce solutions to support recruitment and enhance quality of services.

Mrs Becky Dioh
Head of Medial Recruitment and Education
January 2021

Appendix 1

Select a risk appetite category based on the impact of your identified risk

Risk Appetite Statement

Cumbria, Northumberland, Tyne & 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 & Wear NHS Foundation Trust will not accept risks that materially provide a negative impact on quality.

However, CNTW has a greater appetite to take considered risks in terms of their impact on organisational issues. CNTW has a greatest appetite to pursue Commercial gain, partnerships, clinical innovation, Financial/ Value for Money and Reputational risks in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

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**
Workforce	CNTW has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce.	**12-16**
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**

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting on Wednesday 3 February 2021

Title of report	Board Assurance Framework (BAF) Corporate Risk Register (CRR) Exception Report
Report author(s)	Lindsay Hamberg, Risk Management Lead.
Executive Lead (if different from above)	Lisa Quinn, Executive Director of Commissioning and 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	27 Jan 21
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	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

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Board Assurance Framework and Corporate Risk Register

Purpose

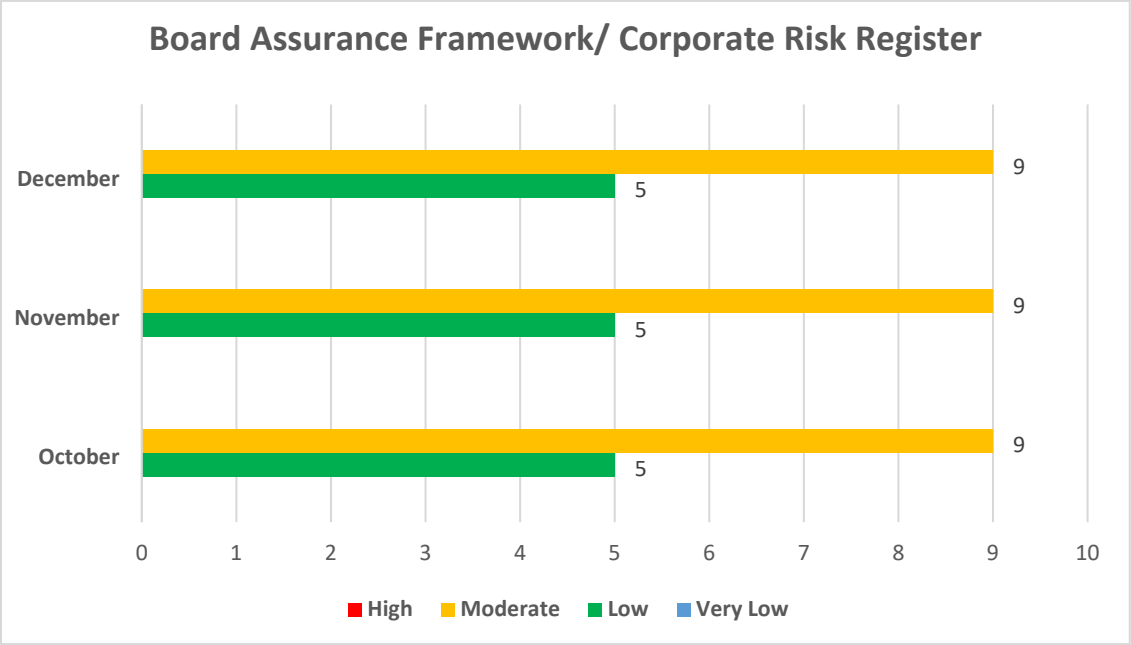
The Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust Board Assurance Framework/Corporate Risk Register identifies the strategic ambitions and key risks facing the organisation in achieving the strategic ambitions.

This paper provides:

- A summary of both the overall number and grade of risks contained in the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).
- A detailed description of the risks which have exceeded a Risk Appetite included on the BAF/CRR.
- A detailed description of any changes made to the BAF and CRR.
- A detailed description of any BAF/CRR reviewed and agreed risks to close.
- A copy of the Trusts Risk Appetite table is attached as **appendix 1.**
- A copy of the BAF/CRR is included as **appendix 2**.
- **Appendix 3** gives a summary of both the overall number and grade of risks held by each Locality Group, Corporate Directorate Risk Registers, Clinical Groups, Corporate Business Units and Executive Corporate Risk Registers on the Safeguard system as at October 2019 there have been no risks escalated within the quarter, action plans are in place to ensure these risks are managed effectively and all risk are held at the appropriate level..

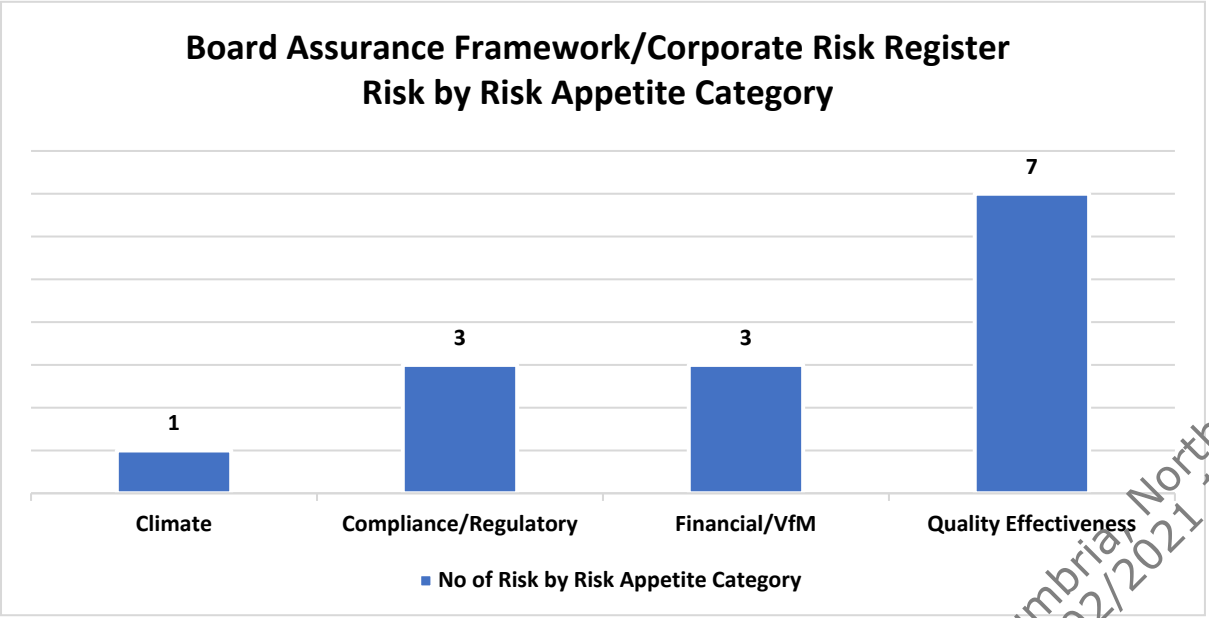
1.0 Board Assurance Framework and Corporate Risk Register

The below graph shows a summary of both the overall number and grade of risks held on the Board Assurance Framework/Corporate Risk Registers as at end of December 2020. In quarter 3 there are 14 risks on the BAF/CRR.



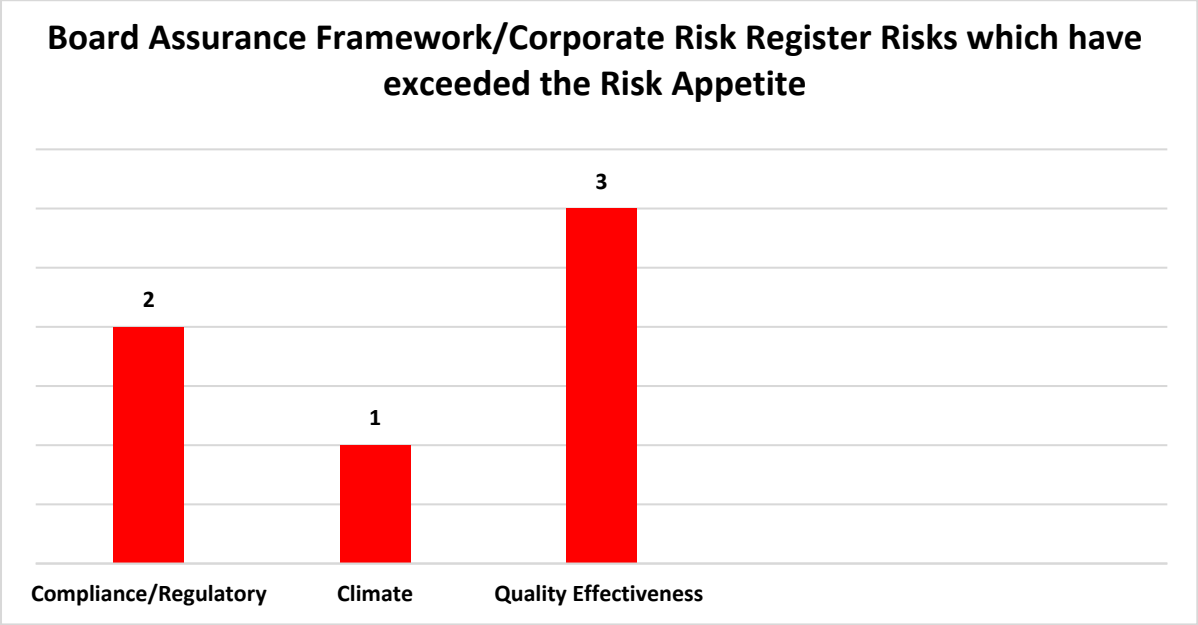
1.1. Risk Appetite

Risk appetite was implemented throughout the Board Assurance Framework/Corporate Risk Register in April 2017. The below table shows risks by risk appetite category. The highest risk appetite category is Quality Effectiveness (7) which is defined as risks that may compromise the delivery of outcomes.



Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 14 risks on the BAF/CRR and 6 risks which have exceeded a risk appetite tolerance.

The table below shows all BAF/CRR risks which have exceeded a risk appetite tolerance.



A detailed description of each BAF/CRR risk which has **exceeded a risk appetite** can be found below. Action plans are in place to ensure these risks are managed effectively:

Risk Reference	Risk Description	Risk Appetite	Risk Score	Executive Lead
1680v.27 **SA1**	If the Trust were to acquire additional geographical areas this could have a detrimental impact on CNTW as an organisation.	Compliance/ Regulatory (6-10)	3x4 = 12	Lisa Quinn
1683v.14 **SA1**	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands.	Quality Effectiveness (6-10)	4x4 = 16	Gary O'Hare
1691v.23 **SA5**	As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory	Compliance/ Regulator (6-10)	3x4 = 12	Rajesh Nadkarni

	duties and regulatory requirements.			
1694v.13 **SA5**	Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services	Quality Effectiveness (6-10)	3x4 = 12	Gary O'Hare
1836v.4 **SA4**	A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm.	Quality Effectiveness	3x4 = 12	Gary O'Hare
1853v.2 **SA4**	Due to the effects of global warming there is a risk to human health and the environment caused by carbon omissions impacting on current and future generations. The delivery of the Green Plan is paramount to reduce the impact of climate change.	Climate & Ecological Sustainability	3x4 = 12	James Duncan

1.2. Amendments to BAF

Following review of the BAF/CRR with each lead Executive Director/Directors, the following amendments have been made:

Risk Ref	Risk description	Amendment	Executive Lead
1680 SA1	If the Trust were to acquire additional geographical areas this could have a detrimental impact on CNTW as an organisation.	2 actions updated; 2 new actions added one action complete	Lisa Quinn
1682 SA1	That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services.	1 new action and 2 actions complete	Lisa Quinn
1683 SA1	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands.	Action progress re: access and waiting times has been updated. Bi-monthly review	Gary O'Hare
1685 SA3	Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services.	Risk Owner transferred from John Lawlor to Lisa Quinn	Lisa Quinn
1687 SA4	Failure to deliver strategic financial and ongoing productivity improvements at a group and corporate trust level, leading to long term financial instability, reporting of losses and potential external intervention.	Detail of actions have been updated	James Duncan
1688 SA5	Due to the compliance standards set from NHSI, CQC and for Legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements.	Target date updated re quarterly review	Lisa Quinn
1691 SA5	As a result of not meeting statutory and legal requirements regarding	Risk review has been moved to quarterly. Action target dates have been updated. Training	Rajesh Nadkarni

	Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.	action updated.	
1694 SA5	Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services.	Risk remains the same	Gary O'Hare
1762 SA1	Due to restrictions in capital funding there is increasing reliance on Trust cash to deliver capital programmes, which over the medium term could lead to a risk of significant reduction in cash reserves, and reliance on short term borrowing	Action detail updated	James Duncan
1819 SA1	Due to restrictions of capital funding nationally and lack of flexibility on PFI, failure to meet our aim to achieve first class environments in all areas of the Trust. Particular risk in North Cumbria and at Rose Lodge, which could result in risk of harm to patients	Action detail updated	James Duncan
1831 SA4	Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users	4 actions complete. One new action added	Lisa Quinn
1836 SA4	A failure to develop flexible robust Community Mental Health Services may well lead to quality and service failures which could impact on the people we serve and cause reputational harm.	Progress within the action. Discreet work has been undertaken in the past month on the Community Mental Health Transformation Fund and the Urgent & Emergency Alternatives Transformation fund to promote more flexible and responsive models of provision that will support the emerging models linked to the Community Mental Health Framework	Gary O'Hare
1852	There is a risk that the Trust	Action progress update:	Gary O'Hare

SA4	may have to invoke its Emergency Response Arrangements due to a viral pandemic causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver Trust business. This will impact on the quality and safety of care for patients.	The Trust continues to operate a Gold Command/IMG system in response to the Covid pandemic. This approach ensures that rapid decision making can be taken in response to the rapidly changing environment. The Trust is also contributing towards the development of a bespoke Mental Health & Learning Disability OPEL framework which contains key measures and metrics linked to staff absences/ availability and service pressures	
1853 SA5	Due to the effects of global warming there is a risk to human health and the environment caused by carbon omissions impacting on current and future generations. The delivery of the Green Plan is paramount to reduce the impact of climate change.	Risk remains the same	James Duncan

1.3. Risk Escalations to the BAF/CRR

There have been no risks escalated to the BAF/CRR in the quarter.

1.4. Risks to be de-escalated.

There have been no risks de-escalated to the BAF/CRR in the quarter.

1.5. Emerging Risks.

There are no new emerging risks.

1.6. Recommendation

The Trust Board are asked to:

- Note the changes and approve the BAF/CRR.
- Note the risks which have exceeded a risk appetite.
- Note the summary of risks in the Locality Care Groups/Corporate Directorate risk registers.
- Provide any comments of feedback.

Lindsay Hamberg
Risk Management Lead
6 January 2021

Internal Audit Plan					
	2020/2021				
Review Area	**Q1**	**Q2**	**Q3**	**Q4**	**BAF/CRR Ref**
Governance, Risk and Performance					
Risk Management & Board Assurance Framework				*	All
Organisation Strategy					5.5 - 1692
Self Care Adherence with Policies & Procedures					
Managing Conflicts of Interest					
Information Sharing					
Business Plans					
Lone Working					
Policy & Procedure Framework					
Finance, Contracting & Capital					
NHS-Led Provider Collaborative					
Reference Costs					
Patients Monies and Belongings - North Cumbria					
Cashiering Services - North Cumbria					
Procurement					
Key Finance Systems					4.2 - 1687
Human Resources & Workforce					
Psychiatry Fellowship Programme					
Disciplinary & Grievance					
Managing Sickness Absence					
Annual Performance Appraisal					
Clinical Supervision					
Employment Checks					
Data Quality					
Performance Management & Reporting					
Delivering the Data Quality Improvement Plan					
Quality Account (testing undertaken on behalf of Extenal Audit				*	
IM&T Systems & Projects					
Firewall Security & Management Controls					
UK CRIS System IT General Controls					
Safeguard System IT General Controls					
Network Devices Security & Management Controls					
Patient Network Security Controls					
Data Centre Physical & Environmental Security					
OmniCell System IT General Controls Audit					
Cyber Security - Server Operational Management					
Information Governance					
DSP Toolkit				*	
Quality & Clinical Governance					
Mental Health Act - Tribunal Reports					5.2 - 1691
Mental Health Act - Renewal of Detention /CTO					5.2 - 1691
Clinical Assurance					
Infection, Prevention and Control (IPC)					
Medication Discharge Summaries & Discharge Letters					5.5 - 1692
Follow Up Audits					
Management of Medical Devices					5.5 - 1692

Internal Audit Plan 20-21. As we are in unprecedented times with the Covid-19 pandemic, a decision was made by the Audit Consortium to suspend internal audit activity for quarter 1, with internal audit staff redeployed to support our members front-line services.

Prior to re-commencing the internal audit work in quarter 2, we met with the Execs to undertake a formal review of the plan and where appropriate re-prioritise audits with the Trust, the outcome of which was the removal of the following audits:

- Organisational Strategy
- Safer Care Policy Adherence
- Information Sharing
- Business Plans
- NHS Led Provider Collaborative
- Reference Costs
- Disciplinary and Grievance
- Annual Performance Appraisal
- Sickness Absence Management

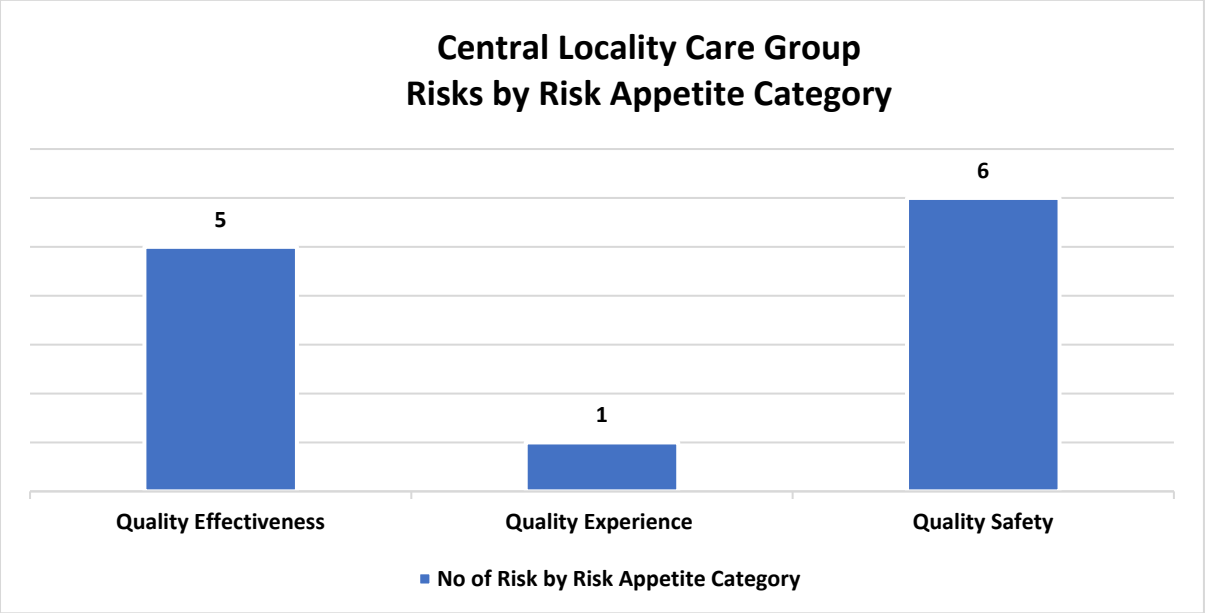
Appendix 3

Clinical Locality Care Groups and Executive Corporate Trust Risk Registers.

The below charts show a summary of the number of risks by risk appetite category held by each Locality Care Group (Group Locality Risk Register) and Executive Corporate risk registers. Safeguard Web Risk Management and Risk appetite has been fully implemented throughout the group risk registers/executive corporate risk registers and risk continue to be monitored at the CDT Risk Management Sub-Group monthly.

Clinical Groups

1.0 Central Locality Care Group



In total as at end of December 2020 Central Locality Care Group hold 12 risks, 1 risk within the risk appetite and 11 risks which have exceeded the risk appetite. All risks are being managed within the Central Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 7 risks on the Central Corporate Group risk register. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1038v.19	Medication information not accurately recorded at discharge and discharge summaries not issued in a timely manner. There is a potential risk of harm to service users if medication information is incorrectly communicated to GPs or the receipt of that information is delayed.	Quality Safety (6-10)	12	4	3	Karen Worton

1284v.25	Following an internal audit there is a risk around the monitoring arrangements for lone working which could result in reduced compliance and staff safety issues.	Quality Safety (6-10)	15	5	3	Karen Worton
1513v.19	Access and Waiting times within the ADHD and ASD Service. The service is commissioned as an Adult Neuro-disability service and provides an autism diagnosis service and ADHD diagnosis and treatment monitoring service across the six trust localities. Agreed service specification is not available and the baseline for expected demand at the time of commissioning is therefore unclear. Weekly activity reports are provided for both ADHD and ASD services. The weekly activity reports indicate that there has been no significant improvement in flow and the waiting lists are not reducing. Discussions regarding capacity and demand have taken place with commissioners, however, no further investment has been confirmed to date. This poses a potential impact on service delivery and the effectiveness of treatment.	Quality Effectiveness (6-10)	15	3	5	Karen Worton
1665v.13	Staffing pressures due to vacancies and difficulties recruiting and retaining medical staff within the Central Locality Care Group. This poses a potential impact on service delivery and the effectiveness of treatment.	Quality Effectiveness (6-10)	16	4	4	Karen Worton
1737v.8	Access and Waiting Times within CYPS Community Services - Significant work has been undertaken with regard to waiting times within this service however there remains a significant issue in regard to waiting times. There is a risk to service delivery and the effectiveness of treatment delivered to our service users.	Quality Effectiveness (6-10)	12	4	3	Karen Worton
1763v.10	Current staffing pressures within the Secure Care service currently being experienced due to each of the secure care learning disability	Quality Safety (6-10)	15	5	3	Karen Worton

	wards having at least 1 complex patient who requires the support of additional staff resource. This poses a potential impact in the effectiveness of treatment and the safety of patients, staff and visitors					
1830v.4	Numerous incidents of environmental damage have occurred within the seclusion suites in the Secure Care CBU. The environmental damage impacts on the locking mechanism as well as the fabric of the seclusion room. There is a potential risk to patient safety if staff cannot enter the seclusion room and also a potential risk of escape and injury if staff cannot safely exit seclusion and lock the door behind them.	Quality Safety (6-10)	12	4	3	Karen Worton

1.2 Central Locality Corporate Business Units

The four CBU's within the central locality currently hold a total of 5 risks.

1.3 Community Central CBU

Community Central CBU has 3 risks which have exceeded risk appetite and are listed below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1457v.25	Increased demand has seen an increase in waiting times, leading to a significant delay in assessment and treatment across the CBU. An increase demand for secondary care mental health has seen an increase in waiting times and assessment in treatment across Central Community CBU. The impact is we're not as responsive to our client group as we would like to be	Quality Effectiveness (6-10)	12	4	3	Anna Williams
1673v.13	There is a safety and security risk due to the current CAV environment and as such we to ensure Community staff have processes in place to support their safety	Quality Safety (6-10)	12	4	3	Anna Williams
1761v.8	Access and waiting times within Learning Disability Psychology	Quality Effectiveness (6-10)	12	4	3	Anna Williams

	services. The service continues to report a number of over 18 week waits for clients. There is a risk to service delivery and the effectiveness of treatment delivered to our service users. Risk to be reviewed quarterly					

1.4 Inpatient Central CBU

Inpatient Central CBU has 1 risk within the risk appetite.

1.5 Secure Care Services CBU

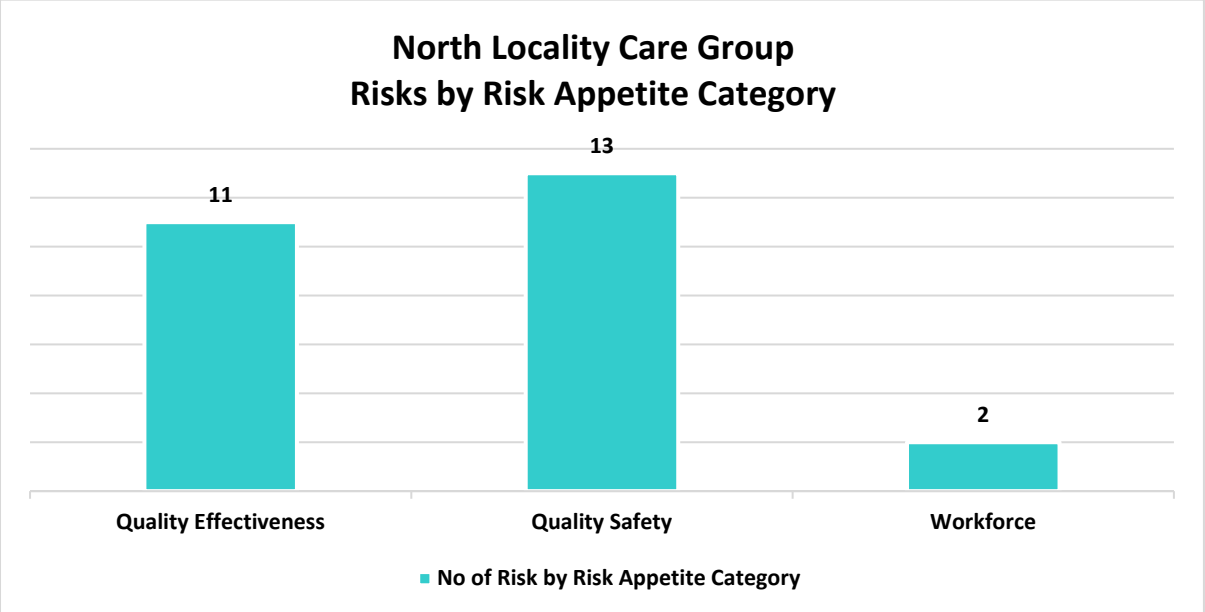
Secure Care Services CBU has 0 risks.

1.6 Access Central CBU

Access Central CBU currently holds 1 risk which has exceeded risk appetite and is below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1308v.7	Environmental issues identified for S136 suites SNH via CQC inspection and Royal College that are not able to be met within the current footprint and would require significant investment to meet standards. No private room for assessment, no shower facility, private space for physical examinations and no sleeping facilities. Risk impact: to patient experience whilst in the suite. Additional risk impact linked to compliance which was previously held on Executive operational risk register	Quality Experience (6-10)	12	4	3	Rachael Winter

2.0 North Locality Care Group



North Locality Care Group as at end of December 2020 hold 26 risks, 8 risks within the risk appetite and 18 risks which have exceeded the risk appetite. All risks are being managed within the North Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 4 risks on the North Corporate Group risk register. 4 risks are exceeding the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1176v.48	Significant staffing pressures due to vacancies and difficulties recruiting and retaining permanent medical, nursing, SALT staff within the North Locality. Operational Risk - significant impact on the continuity of care.	Quality Effectiveness (6-10)	20	4	5	Kedar Kale
1198v.40	Sickness absence levels have risen in the last month however continue to be lower than the previous year currently at 6.1%. We continue to monitor monthly via Workforce Meeting.	Quality Effectiveness (6-10)	12	4	3	Vida Morris
1287v.31	Medication pages on RiO are not being kept up to date as per NTW Policy. Information transferred to the MHDS may not be accurate	Quality Safety (6-10)	16	4	4	Kedar Kale

1809v.9	CCTV coverage within St Georges Park site is extremely limited, the system is over 15years old and of poor quality. The wards only have coverage at the door entry system and does not cover reception and admin areas. The lack of/poor provision makes SGP an outlier within the Trust in terms of security and compromised patient safety.	Quality Safety (6-10)	16	4	4	Pam Travers

2.1 North Locality Corporate Business Units

The four CBU's within the North locality currently hold a total of 22 risks.

2.2 Community North CBU

Community North CBU is currently holding 3 risks – 1 risk is within the risk appetite and 2 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1336v.13	The WAA and LD services have experienced significant pressures as a result of difficulties in recruiting substantive Consultant Psychiatrists over the last 12 months.. The WAA teams have 1 of 4 substantive medics and no substantive medic in Berwick. In LD we have no substantive consultants. The gaps have been covered where possible with locum capacity but this adds to the financial pressure and impacts on waiting times, psychiatric outpatient diagnosis and reviews resulting in increased complaints from service users and GP referrers. This has been raised to Directors for discussions at BDG.	Quality Effectiveness (6-10)	12	4	3	Rebecca Campbell
1347v.11	Increased burden of physical health investigations for those service users who are prescribed antipsychotic medication alongside general physical health awareness monitoring across all conditions. This is required despite the lack of additional resources to deliver this.	Quality Effectiveness (6-10)	12	3	4	Rebecca Campbell

	In addition, some team areas have lack of skilled practitioners to deliver the wide range of health interventions or have access to fit for purpose treatment rooms. This has a wider impact on clinical capacity in the west and north of the county. This is also an issue in North Tyneside					

2.3 Inpatient North CBU

Inpatient North CBU is currently holding 6 risks. 4 risks are within risk appetite and 2 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1392v.22	Patients smoking on wards and on site	Quality Safety (6-10)	12	4	3	William Kay
1642v.18	At times, there is a delay in response, or the alarm system across the St George's Park site does not show exact location where alarm was activated, leading to potential delay in response team attending	Quality Safety (6-10)	15	3	5	William Kay

2.4 Specialist Children and Young People's CBU

Please note: Specialist Children and Young Peoples CBU has moved to North Cumbria Locality from 1 December.

Specialist Children and Young Peoples CBU is currently holding 8 risks – 2 risks are within the risk appetite and 6 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1612v.17	The clinical environment of Alnwood (CAMHS MSU) has been identified as being inappropriate to provide safe, effective, responsive, caring and well led services to the young people who are patients there. In 2016 the CQC assessment of NTW identified that in the long term CAMHS MSU Services needed to be re-provided in a	Quality Safety (6-10)	12	4	3	Lisa Long

	more appropriate clinical environment. The limitations of the building at Alnwood have been identified by staff and young people as leading to boredom, frustration and increased levels of stress and aggression by young people towards others and themselves. Issues relating to the environment at Alnwood continue to be highlighted through MHA CQC Visits and Place Assessments.					
1613v.20	Young people with autism (with or without an LD) who require bespoke environments when admitted to Hospital. Providing these bespoke environments has an impact on the environmental and staffing resources of teams that can negatively impact on the patient experience and the ability of the ward to facilitate future admissions. Environmental issues may also lead to increased levels of violence and aggression, and deliberate self harm.	Quality Safety (6-10)	12	4	3	Lisa Long
1704v.13	Clinical services within CAMHS at Cumbria are increasingly being reported as being under-resourced due to ongoing staff recruitment issues. These have been noted on an individual case basis, particularly in regards to planning robust discharge arrangements for children and young people from Cumbria. There is a risk that due to these service issues, young people from Cumbria have / are:- 1) admitted inappropriately 2) inappropriate discharge arrangements / delayed discharge 3) increased risk of readmission	Quality Safety (6-10)	16	4	4	Lisa Long
1725v.7	Environment at PICU (Ferndene) is limited in terms of accessibility to therapeutic space for young people, access to seclusion facilities and	Quality Safety (6-10)	12	4	3	Lisa Long

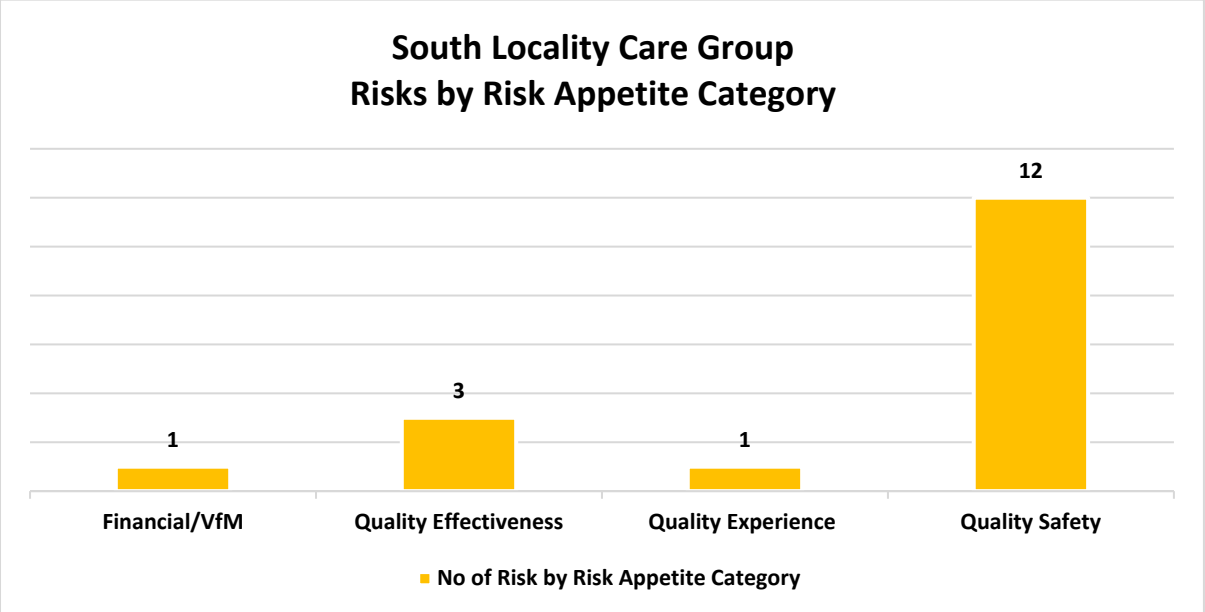
	appropriate staff meeting areas / clinical rooms. These limitations present a risk in our ability to admit patients, impacts on existing patient care and raises a potential risk of having to send patients out of area due to the environment.					
1734v.7	Reduced capacity within the NTW and TEWV footprint due to the closure of Newberry and suspension of admissions to TEWV SEDU and LSU Units. This has resulted in increased pressure to admit to the Ferndene site from NHSE. This could result in NTW young people being admitted out of the NTW area which potentially could impact on their experience, mental health and also their length of hospital stay	Quality Safety (6-10)	12	3	4	Lisa Long
1798v6	Based upon reported incidents from Aycliffe Secure Centre it has transpired that there are cultural differences and opinions of LADO (Local Authority Designated Officer) referral thresholds. There is also a lack of clarity as to how Local Authority management within Aycliffe have been addressing the concerns which have been reported.	Quality Safety (6-10)	12	4	3	Lisa Long

2.5 Access North CBU

Access North CBU is currently holding 5 risks – 1 risk is within risk appetite and 4 risks are exceeding risk appetite. Risks which have exceeded risk appetite are documented below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1701v.22	Environments in both Greenacres and Sextant House are not fit for purpose and pose a number of safety concerns for both Service Users and staff. No high risk rooms or anti barricade doors. Inadequate staff attack system and CCTV. Greenacres require controlled access point to Interview rooms. Windows require strengthening.	Quality Safety (6-10)	12	4	3	Chloe Mann
1795v.4	There was a significant fire at the Wallsend NTRP. The fire has rendered the building uninhabitable for staff and service users.	Quality Safety (6-10)	20	5	4	Chloe Mann
1816v.3	Due to no clinical base unable to undertake our usual screening including BBV testing due to risk of contamination/no clinical setting	Quality Effectiveness (6-10)	16	4	4	Chloe Mann
1861v.1	Due to long term sickness and vacancies in the team there is an increased pressure on existing staff to meet the needs of the service. The impact of this is potential staff burnout, a potential for a delay in response times for assessment and appointments for service users.	Quality Effectiveness (6-10)	12	3	4	Chloe Mann

3.0 South Locality Care Group



In total as at end of September 2020 the South Locality Care Group hold 17 risks, 2 risks lower than the risk appetite, 4 risks within the risk appetite and 11 risks which have exceeded the risk appetite and one below the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 7 risks on the South Corporate Group risk register – 1 risk within the risk appetite and 6 risks that that have exceeded the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1160v.16	There are pressures on staffing due to vacancies particularly Community CBU and RGN's at Walkergate Park which may impact on the quality of service, patient safety and experience.	Quality Effectiveness (6-10)	12	4	3	Andy Airey
1279v.17	Sickness absence levels are currently above the trust standard therefore there is a risk to the impact and quality of care that is delivered to our service users.	Quality Safety (6-10)	12	4	3	Andy Airey
1288v.24	Medication page's on RiO are not being kept up to date as per CNTW policy. Information transferred to the MHDS may not be accurate.	Quality Safety (6-10)	16	4	4	Andy Airey
1497.v19	Staffing pressures due to vacancies and difficulties recruiting and retaining medical	Quality Experience (6-10)	16	4	4	Andy Airey

	staff within the South Locality Group					
1769v.6	Lack of formal commissioned pathways for inpatient detox into the Acute Trusts resulting in delays to patient care and potential deterioration in health	Quality Safety (6-10)	12	3	4	Andy Airey
1866v.1	No communication from CGL regarding their operational model, mobilisation plan or timescales. Workforce unsettled due to lack of communication from CGL and therefore, looking for other employment. The service would find it difficult to backfill posts due to the transfer (TUPE) leaving the service unsafe. Limited time to transfer patient data to new provider safely - continuity of service and safety of service users would be compromised.	Quality Safety (6-10)	15	5	3	Andy Airey

3.1 South Locality Corporate Business Units

The four CBU's within the South locality currently hold a total of 10 risks.

3.2 Community South CBU

Community South CBU is currently holding 2 risks. 1 risk within the risk appetite and 1 which has exceeded the risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1833v.4	Blood results not recorded in Physical Health Form in RiO from Emis. This would lead to Patient information not being updated on RiO and will mean information does not pull through electronically to a discharge letter. Non-compliant with KPI	Quality Safety (6-10)	15	3	5	Suzanne Miller

3.3 Inpatient South CBU

Inpatient South CBU is currently holding 3 risks, 1 risk is below the risk appetite and 2 risks are exceeding the risk appetite. Information in relation to the breach risks are given below:-

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1388v.22	Trust sites smoke free; risks with service users secreting cigarettes and lighters, smoking in bedrooms and on site. Increase of fire risks on some wards. Related incidents of aggression when service users are asked not to smoke Service users leaving the ward more regularly to have cigarettes; at times staff encountering difficulty adhering to access, egress and engagement policy - potential risk to service users	Quality Safety (6-10)	12	3	4	Denise Pickersgill
1720v.11	Risk of increased bed pressures within the South adult pathway. (Acute and Rehabilitation) as a result of bed reductions in the Northumberland and Central Localities. Risk of an increase in admissions from other localities and over spill in to other pathways such as PICU and Older Persons.	Quality Effectiveness (6-10)	12	4	3	Denise Pickersgill

3.4 Neurological and Specialist Services CBU

Neurological and Specialist Services CBU is currently holding 5 risks, 1 risk is below the risk appetite, 2 risks are within the risk appetite and 2 risks are exceeding the risk appetite. Information in relation to breached risks are given below:-

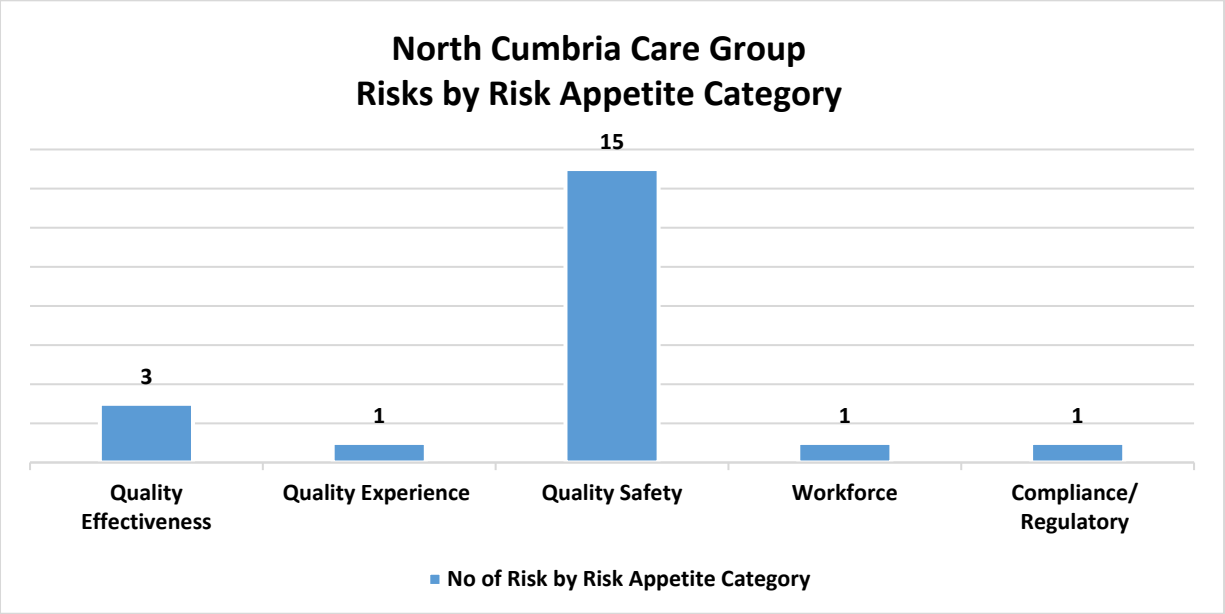
Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1660v.31	Benfield House houses several services with varying needs and at times insufficient space to provide quality experience for patients. This can impact the therapeutic alliance between patients and clinicians where there is a lack of space and privacy to engage and concentrate during therapeutic conversations. This can increase the likelihood of mistakes being made it can also change the risk signature of some patients which can directly impact on their safety.	Quality Safety (6-10)	12	4	3	Andrew McMinn

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1822v.6	Lengthy waits increase the distress caused by Gender Dysphoria leading to potential deterioration and impacting on the patients wellbeing.	Quality Safety (6-10)	12	4	3	Andrew McMinn

3.5 Access South CBU

Access South CBU has no risks.

4.0 North Cumbria Locality Care Group



In total as at end of December 2020 the North Cumbria Locality Care Group hold 21 risks, 7 risks within the risk appetite and 14 risks which have exceeded the risk appetite and one below the risk appetite. All risks are being managed within the South Locality Care Group and no requests to escalate to BAF/CRR have been received.

There are 9 risks on the North Cumbria Corporate Group risk register –3 risks are within the risk appetite and 6 risks that that have exceeded the risk appetite. Below are the risks which have exceeded a risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1793v.7	Because there is a shortage of clinical capacity (within the CAMHS service) there is a risk that this will lead to delays in routine reviews, emergency assessments and MHA work. This could lead to inability of the service to meet the health needs of our patients.	Quality Safety (6-10)	15	5	3	David Muir
1799v.10	Due to upcoming retirement and departure of several medical staff, there is a risk that there will not be a sufficient level of consultant cover across many services in North Cumbria. If not addressed services will struggle to operate at a level which is safe and/or timely in order to meet patient need.	Quality Safety (6-10)	12	4	3	Stuart Beatson
1800v.8	Because there could be staff identified as lone workers who	Quality Safety (6-10)	12	4	3	David Muir

	have not yet received lone worker device training, there is a risk that staff involved in a potentially harmful incident cannot contact their colleagues for help quickly. Risk of personal harm, delayed response to an emergency.					
1815v.8	Because the Care Group Management currently has insufficient visibility in relation to drug safety procedures around the prescribing of sodium valproate, there is a risk that women of childbearing potential could be being prescribed sodium valproate without the pregnancy prevention programme being met. The impact of this risk materialising could lead to neurodevelopmental disorders (approx. 30-40% risk) and congenital malformations (approx. 10% risk).	Quality Safety (6-10)	15	5	3	Stuart Beatson
1837v.6	Whilst the Oakwood Ward is used in its current state, patient dignity is effected and it is not possible for the Trust to meet demand in relation to a CQC must do action, namely, "the provider must ensure that plans to relocate Oakwood ward are progressed and the use of dormitory style accommodation on both is either no longer used or a robust assessment and mitigation of risk is put in place".	Quality Experience (6-10)	12	3	4	David Muir
1859v.2	CNTW shares some NHS sites with NCIC and as such COVID secure risk assessments are not always being done jointly and in a coordinated manner. Therefore, COVID secure risk assessment carried out by CNTW on these shared premises do not reflect the real threat in terms of voume of staff and patients who occupy these shared buildings i.e. coming from both CNTW and	Quality Safety (6-10)	15	5	3	David Muir

	NCIC, not just CNTW. Whilst there is no coordinated approach to these risk assessments there is a risk that (due to number of people who may be using these buildings), staff and patients on these sites cannot socially distance effectively in order to reduce the threat of spreading COVID-19.					

4.1 North Cumbria Locality Corporate Business Units

The 2 CBU's within the North Cumbria locality currently hold a total of 12 risks.

4.2 Community/ Access North Cumbria CBU

Community/ Access North Cumbria CBU currently hold 11 risks, 4 risk is within the risk appetite and 7 risks are exceeding risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1789v.5	Due to an inability to recruit clinical staff and unable to deliver on the contract requirements there is a potential risk that we are unable to meet the demands of the service which may impact on individuals and family having to wait and additional pressure to staff to manage workload and services. There is also an impact on Mental Health and Social Care whilst awaiting diagnosis.	Quality Safety (6-10)	12	3	4	Jean Hamilton
1803v.1	136 suites: serious injury to staff; physical damage to 136 suite and Trust property; can restrict use of other areas of hospital; risk of harm to other patients and members of public; damage to 136 suite may result in it being unusable for a period of time; risk to other patients due to depleted staffing whilst assisting incidences in the 136 suites; Risk to Trust of possible claims	Quality Safety (6-10)	15	5	3	David Storm

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	and litigation also cost of repairing damaged property					
1804v.1	Service delivery will cease as there will be no staff to deliver. Patient care will be impacted on	Quality Effectiveness (6-10)	12	3	4	David Storm
1805v.1	Risk of increased wait for patients, wait for diagnosis in reasonable time, delay in seeking appropriate support and intervention; reputational risk to trust	Quality Effectiveness (6-10)	12	4	3	David Storm
1849v.2	Care coordinators, assessment coordinators and some clinical leads do not have the skills and training to be able to assess clinical risk in relation to service user eating disorder. They are unaware of the guidelines pertaining to eating disorder (NICE & Kings College) and unaware of the full risk spectrum. Care coordination within North Cumbria for eating disorder can bring benefits or harm to eating disorder service users because it is all being delivered differently; there is no standardised approach Service users are at risk from unnecessarily high physical health complications, severe harm or death	Quality Safety (6-10)	16	4	4	June Begg
1850v.2	The team is not sufficiently resourced to allow safe cover for service users with eating disorder. For example, there is one eating disorder practitioner in North Cumbria, if this person is off work, there is no replacement. There are two part time medics to cover eating disorder. There is no clinical leadership and no dedicated psychological staff. There is no clinical governance structure. This leads to disjointed and ad hoc	Quality Safety (6-10)	16	4	4	June Begg

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	provision for service users with eating disorder in North Cumbria and will lead to poorer outcomes					
1851v.2	At times, GP's in North Cumbria refuse to compete physical health checks as per King's College guidelines. CMHART staff are not trained to be able to complete these checks. This means that essential service user physical health information can be overlooked leading due to poorer physical health outcomes or harm	Quality Safety (6-10)	16	4	4	June Begg

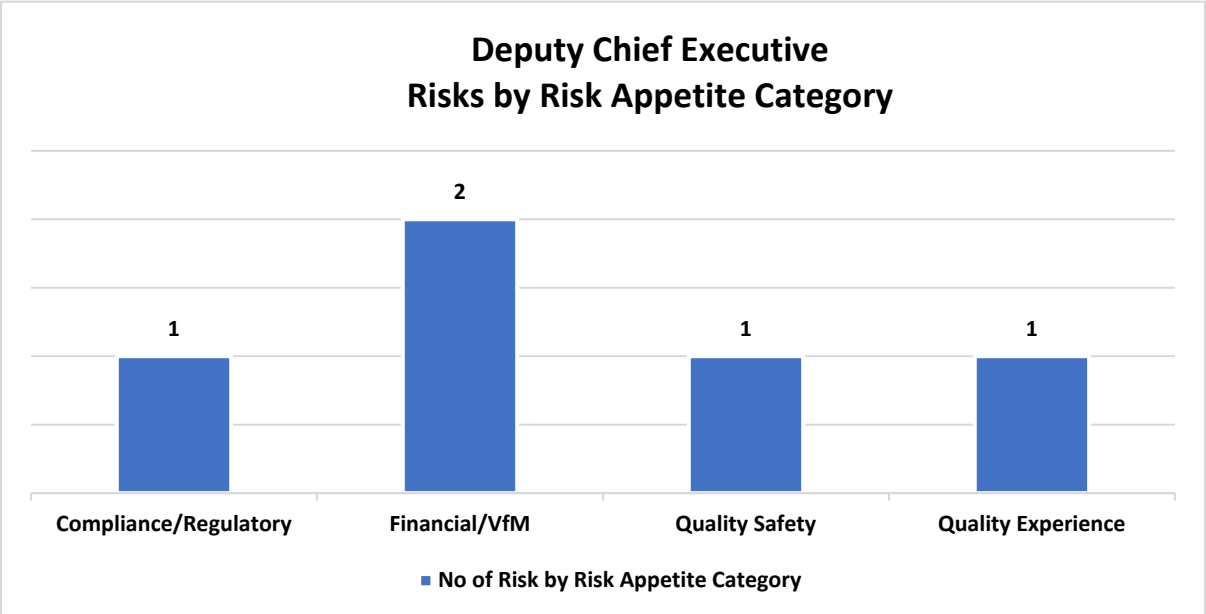
4.3 Inpatient North Cumbria CBU

Inpatient North Cumbria CBU is currently holding 1 risk which is within the risk appetite.

5.0 Executive Corporate

The Chief Executive as at end of December 2020 holds 1 risk. 1 risk is within the risk appetite All risks are being managed within the Chief Executive's Office and no requests to escalate to BAF/CRR have been received.

6.0 Deputy Chief Executive



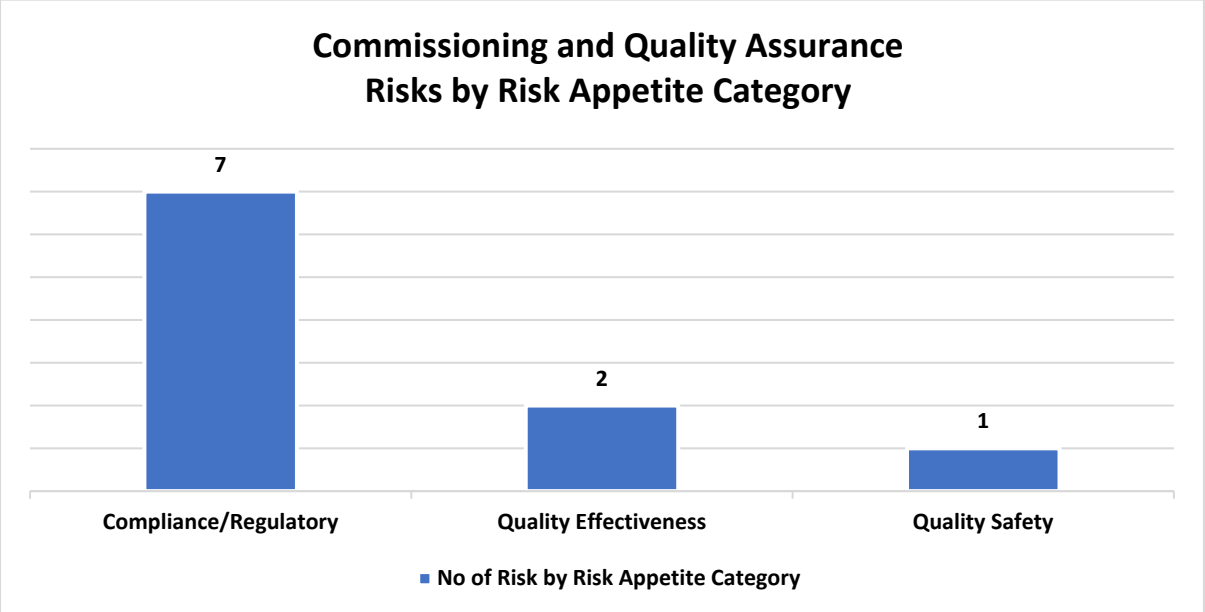
The Deputy Chief Executive as at end of December 2020 holds 5 risks, 1 risk lower than the risk appetite, 3 risks within the risk appetite and 1 risk exceeding the risk appetite. All risks are being managed within the Deputy Chief Executive Directorate and no requests to escalate to BAF/CRR have been received.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1741v.1	There are a number of specialist systems within the Finance service where there are only one or two people can access or process financial information, Cost Master, TAER, and Oracle - Budgets. There is a risk that if specific staff were unavailable then there are core tasks that would not be able to be completed. That would risk delivery of the Trust's financial reporting.	Quality Experience (6-10)	12	3	4	Chris Cressey

7.0 Corporate Medical

The Executive Medical Director as at end of December 2020 holds 5 risks, 5 risk are within the risk appetite. All risks are being managed within the Medical Directorate and no requests to escalate to BAF/CRR have been received.

8.0 Commissioning and Quality Assurance



The Executive Director of Commissioning and Quality Assurance as at end of December 2020 holds 10 risks, 5 risks within the risk appetite and 5 risks which have exceeded a risk appetite. All risks are being managed within Commissioning and Quality Assurance Directorate and no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1172 v.22	Increased risk of security threats coupled with increasing type and range of device access to the network linked to technology developments increasing attack vectors and increased sophistication of exploits.	Compliance/ Regulatory (6-10)	12	4	3	Jon Gair
1576 v.1	Data leakage risk of Trust Users transferring sensitive information via insecure methods or to untrusted destinations. This is likely to be via data sharing methods such as unencrypted USB drives, e-mail or personal cloud storage facilities (such as dropbox, google drive, personal onedrive etc)	Compliance/ Regulatory (6-10)	15	5	3	Jon Gair
1655 v.19	Subject Access Requests: There is a risk of non-compliance with the reduced time frame (1 month). In the	Compliance/ Regulatory (6-10)	12	3	4	Angela Faill

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	absence of electronic systems, the task is labour intensive and wholly reliant on human resource. Therefore, increasing the risk of not meeting the legislation timeframe and error during the process which in turn breaches confidentiality or serious harm.					
1719 v.11	A number of systems that are relied upon by the Trust are running on unsupported software that is no longer receiving security updates or patches. There is a risk that unknown exploits take over this machine, bypassing any security controls in place. The systems this includes are the following NTW-SP which is running an old version of Windows server and SQL database, currently running Sharepoint service for Informatics staff.	Compliance/ Regulatory (6-10)	12	4	3	Jon Gair
1755v.8	The Trust has agreed to continue using the Galatean Risk and Safety Technology (GRIST) clinical risk assessment tool across the North Cumbria services as part of the RiO and IAPTus clinical record. This system was originally procured via Cumbria Partnerships a number of years ago and the following risks have been identified on assessment by CNTW informatics staff :-- No formal contractual arrangement is in place with the supplier so no service level agreement availability which could impact on accessibility to the system. - System and data is hosted on Aston University servers	Compliance/ Regulatory (6-10)	16	4	4	Jon Gair

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	with no formal contracted levels of security in place to secure access to data.- Free text fields exist within the system which may contain sensitive or personally identifiable information. - No audit trail exists to identify who is making changes to GRIST data, increasing the risk of unexpected changes that are not accountable to individuals. - All changes to the data are made via parameter-based URL calls so with knowledge of the API and session ID, records could be manipulated or deleted by end users.					

9.0 Workforce and Organisational Development

The Executive Director of Workforce and Organisational Development as at end of December 2020 holds 3 risks. There are 2 risks that are within the risk appetite and 1 risk exceeding the risk appetite. No risks to escalate to the BAF/CRR have been received.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1715v.5	Sickness absence continues to remain above trust target of 5%. Reduced staff available resulting in increased use of temporary staff having both impact on quality of consistency in care and financial impact	Quality Experience (6-10)	12	3	4	Michelle Evans

10.0 Nursing & Chief Operating Officer

The Nursing & Chief Operating Officer as at end of September 2020 holds 7 risks. 2 risks are within the risk appetite and 5 risk which exceed the risk appetite. All risks are being managed within Nursing & Chief Operating Officer Directorate and there have been no requests to escalate to BAF/CRR have been received. Risks which have exceeded a risk appetite are documented below.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1220v.23	Women of childbearing age are prescribed valproate without appropriate awareness of the risks involved. Risk identified in POMH-UK 15a Bipolar Disorder audit results, baseline assessment of NICE CG192 and MHRA Patient Safety Alert NHS/PSA/RE/2017/002	Quality Safety (6-10)	15	5	3	Gary O'Hare
1611v.19	It is important to identify patients who have a swallowing difficulty and the risk it poses. Patients who have a swallowing risk require appropriate assessment and for staff to recognise the potential risk off dysphagia therefore accessing and referring to the SALT team. The impact of this risk is on patient safety.	Quality Safety (6-10)	15	5	3	Gary O'Hare

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1758v.8	Due to several incidents occurring whereby, patients have been able to remove light fittings and gain access to a wire in the seclusion room and in a number of ward areas a ligature risk has been identified. The potential risk could result in serious harm to the patient	Quality Safety (6-10)	15	5	3	Gary O'Hare
1821 v.5	Due to several incidents occurring whereby, patients have been able to insert knotted items into plug holes in sinks, fill with water causing the knot to swell and anchor into position, a ligature risk has been identified. The potential risk could result in serious harm to the patient	Quality Safety (6-10)	15	5	3	Gary O'Hare
1860v.1	Identifying carers, assessing carers' needs (carer assessments): identifying and supporting carers and families is critical as without joined up working and understanding of the family dynamic or environment, the identification process forms part of the informed risk assessment without which the service user could return to services and a possible risk to carers (that could be of a catastrophic nature) could be missed as well as vital access to support not being provided. NICE NG150 guidance statements within standards 1.2 (Identifying carers) and 1.3 (Assessing carers' needs).	Quality Safety (6-10)	15	5	3	Gary O'Hare

12. Emerging Risks

There are no new emerging risks in the Locality Care Groups and Executive Corporate risk registers that are not mentioned in the report.

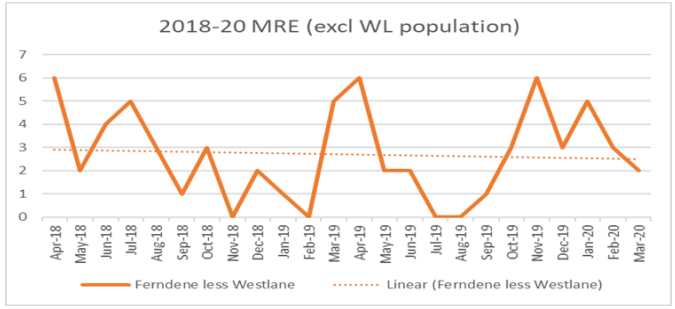
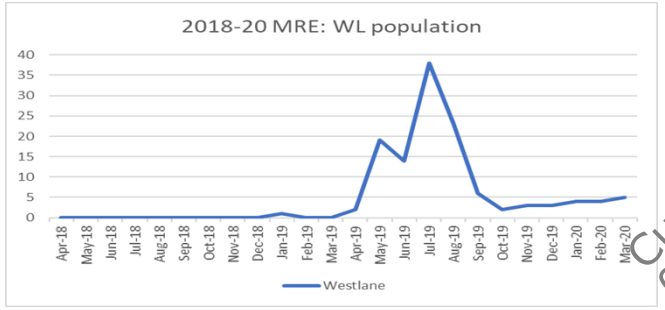
Lindsay Hamberg
Risk Management Lead
7 January 2021

Factual accuracy comments log for an inspection report

Please fill in **all parts** of this form and return by email to:
HSCA_Compliance@cqc.org.uk or by post to:
CQC HSCA Compliance, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Account Number:	RX4/RX4CA
Our reference:	INS2-9678351641
Provider name:	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Provider address:	St Nicholas Hospital Jubilee Road Gosforth Newcastle upon Tyne NE3 3XT

Page number *e.g. Pg 4*	**Outcome**	**Suggested changes with explanation** *e.g. change last sentence from 10 staff to 15 staff*	**CQC decision** ✓or X	**CQC comments** *e.g. explanation of decision*
2, 1st bullet point		The services inspected have had to change significantly due to services supporting young people in the ICS footprint closing, namely West Lane. This has meant the functioning of Ferndene has changed and now supports young people with Eating Disorders and those with a higher level of security needed in the Mental Health pathway. Due to this significant change it is not appropriate to compare one year's raw data with another without looking at this	x	Thank you for your comment and supporting evidence. However, this has not been changed in the report. The figures have increased each year as detailed below 2017/18 - 90 incidents of MRE

		significant factor. It is true that if you look at the raw data there has been an increase, however it is also possible to demonstrate there has been a sustained reduction in the use of MRE in the 'like for like' population. This is something we highlighted in the Positive and Safe Annual Report this year which was presented to the Quality and Performance Sub-committee of the Board and the Board of Directors meeting. Please see attached. At this core service level please see below a graphical representation of the MRE data for West Lane population and Ferndene excluding West Lane population.   		2018/19 - 203 (relates to 22 patients) 2019/20 - 241 (relates to 25 patients) This does not affect the rating

		The first graph shows that the low level of MRE has been sustained over a two-year period on a 'like for like' population, with no more than 6 incidents per month and a linear trend of 3 moving to slightly less than 3 incidents per month over the two year period. The second clearly shows the impact of the Eating Disorder and Mental Health Low Secure population being admitted to Ferndene, with a significant reduction in this population too. It is not statistically appropriate to draw a conclusion that the use of MRE as gone up since our last inspection looking at total numbers as the use of Ferndene has changed so significantly. At the point of our last inspect and up to the concerns raised about West Lane, Ferndene was not commissioned and did not accept Eating Disorder or MH Low Secure admissions. I hope this additional level of information helps explain this change which can be viewed alongside the individual case studies already submitted.		
2, 2nd bullet point		The Trust is aware that debriefs had not taken place to the level expected. There is evidence of monthly audits undertaken and that audits show that some limited debriefs did take place during May and June. The reports also show improvements have occurred month on month. We have included a minute extracts report providing evidence of the debriefs being discussed through locality management meetings and evidence to show this was a new approach for Ferndene, with the improvement being monitored through the 'Children and Young People's	Partial	Thank you for your comment This has been changed on the report Governance systems had identified that limited formal debriefs were taking place. Managers had started to implement changes to address this. However, at the time of the inspection the level of formal debriefs taking place was not in line with trust policy.

		Positive and Safe Care Meeting' and 'Quality Standards Meeting'. On page 26 of the Positive & Safe Annual Report (attached in section 1) you will also find evidence of Fraser Ward being part of the 'Reducing Restrictive Practice QI Collaborative'.		This does not affect the rating
2, 3rd bullet point		The role of the Trust wide 'Positive and Safe Group' is an implementation and mobilisation group. Its documented purpose within it's Terms of Reference is to: 'Oversee the implementation of the Trust Positive and Safe Strategy.' It is not a 'management' group, as you will see in the Governance Chart attached below, the group provides assurance to the Quality and Performance Sub-committee of the Board on the delivery of the Strategy. The Governance Chart also shows (shaded in Blue) the management forums where management challenge occurs on Quality (and other) standards. The extract report looks at meetings in Groups, in Trust wide management forums and at Board and it's sub-committee Q&P, this provides evidence of where Locality and Trust wide oversight and scrutiny takes place. The extracts are April-October, this evidences that whilst we have been responding to the pandemic the focus on restraint has continued.	Partial	Thank you for your comment This has been changed on the report with the following Although there was evidence of oversight and scrutiny of the use of restrictive practice within the trust management forums, the trust had not maintained a continued reduction in restrictive practices within services for children and young people. This does not affect the rating

4, 6th bullet point		The Trust is aware that debriefs had not taken place to the level expected. There is evidence of monthly audits undertaken and that audits show that some limited debriefs did take place during May and June. The reports also show improvements have occurred month on month. We have included a minute extracts report providing evidence of the debriefs being discussed through locality management meetings and evidence to show this was a new approach for Ferndene, with the improvement being monitored through the 'Children and Young People's Positive and Safe Care Meeting' and 'Quality Standards Meeting'. On page 26 of the Positive & Safe Annual Report (attached in section 1) you will also find evidence of Fraser Ward being part of the 'Reducing Restrictive Practice QI Collaborative'.	Partial	Thank you for your comments This has been changed on the report to reflect the improvements. Limited debriefs had taken place between May 2020 and September 2020. However, there was evidence of some improvement taking place in October 2020. This does not affect the rating
4, last bullet point		The role of the Trust wide 'Positive and Safe Group' is an implementation and mobilisation group. Its documented purpose within it's Terms of Reference is to: 'Oversee the implementation of the Trust Positive and Safe Strategy.' It is not a 'management' group, as you will see in the Governance Chart attached below, the group provides assurance to the Quality and Performance Sub-committee of the Board on the delivery of the Strategy. The Governance Chart also shows (shaded in Blue) the management forums where management challenge occurs on Quality (and other) standards. The extract report looks at meetings in Groups, in Trust wide management forums	✓	Thank you for your comment. Reference to the Positive and Safe Group has been removed. The trust had failed to sustain a reduction in restrictive practice. At our previous inspection the trust had achieved a significant reduction in restrictive practices. At this inspection there has been a significant increase in all types of

		and at Board and it's sub-committee Q&P, this provides evidence of where Locality and Trust wide oversight and scrutiny takes place. The extracts are April-October, this evidences that whilst we have been responding to the pandemic the focus on restraint has continued.		restrictive practice. There was evidence of scrutiny and discussion about the levels of restrictive practice at local and trust wide meetings. However, there was little evidence to show what interventions had been put in place to challenge the high levels of restrictive practice being used, including mechanical restraint or that the least restrictive approaches were being considered for those patients that were subject to the use of restraint, including mechanical restraint. This does not affect the rating
4, 5th bullet point		**Summary** 1. The Trust is committed to reducing restrictive practices. It continues to look for initiatives to support it's comment. Examples of such are included in the Annual Report. Additional areas have been explored through 2020 including the 'Hopes' model. 2. The Trust has effective Governance arrangements in place. The combination of a new approach for Ferndene and a pandemic has led to improvements not being as quick as expected, however through our Governance we are aware of this and monitoring improvements regularly.	x	Thank you for your comment. However, this has not been changed on the report. Although there is evidence that governance systems now have oversight of the issues within the CAMHS service there continues to be a rise in the use of restrictive practice. This does not affect the rating

		3. There is robust oversight, scrutiny and supportive challenge at the various levels of management within the Trust in the expected forums. The positive and safe group are focused on implementation and mobilisation as per their terms of reference.		

(Include additional rows if required)

Completed by (name(s))	Lisa Quinn
Position(s)	Executive Director of Commissioning & Quality Assurance
Date	18th December 2020

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

St Nicholas Hospital
Newcastle Upon Tyne
NE3 3XT
Tel: 01912466800
www.ntw.nhs.uk

Date of inspection visit: 2 - 4 November 2020
Date of publication: 15/01/2021

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Requires Improvement**

Our findings

Child and adolescent mental health wards

Inspected but not rated

We carried out a responsive, unannounced inspection over three days. This was because of information we had received giving us concerns about the safety and quality of the services.

This was a focused inspection looking at safe effective and well led key questions. We did not rate key questions at this inspection. However, due to a regulatory breach in well led this domain has been limited to requires improvement.

Summary

- The use of restrictive practices had increased significantly since the last inspection, including the use of mechanical restraint.
- Governance systems had identified that limited formal debriefs were taking place. Managers had started to implement changes to address this. However, at the time of the inspection the level of formal debriefs taking place was not in line with trust policy.
- There was evidence of oversight and scrutiny of the use of restrictive practice within the trust management forums. However, the trust had not maintained a continued reduction in restrictive practices within services for children and young people.

However,

- The wards had enough nurses and doctors. Staff usually assessed and attempted to manage risks well.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff felt respected, supported and valued by local leaders.

How we carried out the inspection

We visited four wards at Ferndene and two wards at Alnwood. We spoke with 23 staff members including clinical managers, nurses, support workers and members of the multidisciplinary team, four young people, two carers and reviewed 15 care records and attended three meetings. We also spoke to the advocate and commissioners before the inspection.

What people who use the service say

We were able to speak to four young people who all said that they felt safe on the wards and that staff supported them. The young people said that staff had spoken to them after incidents of restraint, but one young person felt that they weren't listened to about their experience of a restraint.

Our findings

Is the service safe?

Inspected but not rated

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The service had vacancies for one band six nurse, 14 band 5 nurses and 21 support workers, however, shifts were covered by bank and agency staff who were familiar with the wards.
- Training compliance for Prevention and Management of Violence and Aggression was below the trust target due to the cancellation of face to face training during the covid pandemic. Staff were being supported to attend training courses during November 2020 and this was a trust wide risk on the risk register. At the time of the inspection there were eight members of staff who had not completed Prevention and Management of Violence and Aggression training and they were placed on other duties until they could complete the training.
- Staff usually assessed and managed risks to patients and themselves well and attempted to use de-escalation to manage challenging behaviour. However, we found that incidents of restraint were high and had increased significantly since the last inspection. Staff reported that the acuity on the wards had increased since the last inspection and the use of restrictive practices had increased to manage incidents. Records showed that staff used restraint and seclusion after attempts at de-escalation had failed and the ward staff participated in the provider's restrictive interventions reduction programme. However, debriefs were not always taking place to review practice and discuss alternative interventions.
- The incidents of mechanical restraint (the use of a device such as belts or cuffs) had increased in the two years since the last inspection to 241 in 2019/20.
- Staff told us that the use of mechanical restraint was only used in an emergency to transport the young person to a place of safety or back onto the ward from outside areas. Records showed that staff followed the trust policy before mechanical restraint was used and director approval was sought. However, formal debriefs were not always taking place after incidents allowing the team to consider other strategies and interventions which may have avoided the use of mechanical restraint.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff had introduced a new system for patients coming back from leave in response to patients absconding when returning to the ward. This was individually risk assessed for each patient.

Is the service effective?

Inspected but not rated

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. Care plans contained examples of the activities patients enjoyed and trigger words that should be avoided with patients.

Our findings

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide care and treatment to children and young people. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff including agency staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation including education and social services.

Is the service well-led?

Requires Improvement 

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- However, our findings from the safe domain demonstrated that governance processes did not always operate effectively.
- The use of mechanical restraint and opportunity to explore alternative approaches through formal debriefs did not always take place. Debriefs should be completed after the use of restraint including mechanical restraint in line with trust policy. Limited debriefs had taken place between May 2020 and September 2020 at Ferndene. However, there was evidence of some improvement taking place in October 2020.
- The trust had failed to sustain a reduction in restrictive practice. At our previous inspection the trust had achieved a significant reduction in restrictive practices. At this inspection there has been a significant increase in all types of restrictive practice. There was evidence of scrutiny and discussion about the levels of restrictive practice at local and trust wide meetings. However, there was little evidence to show what interventions had been put in place to challenge the high levels of restrictive practice being used, including mechanical restraint or that the least restrictive approaches were being considered for those patients that were subject to the use of restraint, including mechanical restraint.

Our findings

Areas for improvement

The trust must review the use of restraint and mechanical restraint in the children and young person's inpatient services. The use of mechanical restraint should be used as a last resort in line with Department of Health *Positive and Proactive Care* . There should be a clear debrief process for the team after an incident and for the person who has been restrained.

Regulation 17 (2) (b)

Our inspection team

The team that inspected the service comprised of three CQC inspectors and a specialised advisor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	CQC focussed inspection of Child and Adolescent Mental Health Wards – Final Inspection report
Report author(s)	Vicky Grieves, CQC Compliance Officer
Executive Lead (if different from above)	Lisa Quinn, Executive Director of 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	27/01/21
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	25/01/21
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	X	Environmental	x
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
SA5.1 That we do not meet and maintain our compliance standards including NHSI, CQC and legislation
SA5.2 That we do not meet statutory and legal requirements in relation to Mental Health Legislation

CQC focussed inspection of
Child and Adolescent Mental Health Wards – Final Inspection report
Board of Directors
3rd February 2021

1. Executive Summary

Between the 2nd and 4th November 2020 the CQC undertook a series of unannounced visits as part of a focussed inspection of Child and Adolescent Mental Health Wards. Two locations were visited within the Specialist Children and Young People's Services CBU.

Ferndene, Prudhoe – Ferndene PICU, Fraser, Redburn, Stephenson
Alnwood, St Nicholas Hospital – Ashby, Lennox

These visits were prompted by concerns raised by a whistle blower about staffing issues, patient safety and the quality of care and treatment offered to patients. The inspection focused on the Safe, Effective and Well-led domains.

The draft report from the focused inspection was received on the 4th December 2020. The Trust had a period of 10 working days to undertake a factual accuracy check of the report and respond back to the CQC; the factual accuracy report (attached as appendix 1) was submitted to the CQC on 18th December 2020 within the required timescales.

The final report received from the focused inspection was received by the Trust on 12th January 2021 (a copy has been included as appendix 2).

2. Findings

The unannounced focused inspection looked at three specific areas of the following key questions which have been rated as follows:

Safe Inspected but not rated (remains **Good**)

Effective Inspected but not rated (remains **Outstanding**)

Well-led **Requires Improvement** (a change from Outstanding in previous report)

This has led to the overall rating for this core service to change from "outstanding" to "good".

The CQC inspectors have highlighted one area for improvement which the provider MUST take to improve:

> The trust must review the use of restraint and mechanical restraint in the children and young person's inpatient services. The use of mechanical restraint should be used as a last resort in line with Department of Health Positive and Proactive Care. There should be a clear debrief process for the team after an incident and for the person who has been restrained.

An action plan to address this area for improvement is being developed and will be provided to the Board next month.

3. Recommendations

The Trust are required to provide regular updates to the Care Quality Commission on progress against any areas for improvement and as such it is necessary for the Trust Board to have oversight of progress and be assured that these concerns are being addressed.

The Board are asked to:

- Note the content of the inspection report.

Name of author:
Vicky Grieves, CQC Compliance Officer

Name of Executive Lead:
Lisa Quinn, Executive Director of Commissioning and Quality Assurance

21 January 2021

Report to Board of Directors
3rd February 2021

Title of report	**Update on CQC Must Do Action Plans (Quarter 3)**
Report author(s)	**Vicky Grieves, CQC Compliance Officer**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of Commissioning and 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	27/01/2021
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	25/01/2021
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	X	Environmental	X
Financial/value for money	X	Estates and facilities	X
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
SA5.2, SA1.4, SA5.1, SA5.5, SA1.2, SA4.2

Update on CQC Must Do Action Plans
3rd February 2021

1. Executive Summary

This report provides an update on the 35 remaining areas of improvement (Must Do action plans) which were received following inspections undertaken during 2015, 2017, 2018, 2019 and 2020. Between August and November 2020 the Board of Directors agreed to close 11 of the 46 areas of improvement identified from these inspections.

Action plans specific to the North Cumbria Locality and those relating to the focused inspection of wards for people with learning disabilities or autism continue to be monitored through the Locality Care Groups and Trust governance structures and seeks approval from the Board of Directors that there is sufficient evidence and assurance to close one action plan listed as **appendix 1**.

The remaining action plans were due to be completed by 31 December 2020 and a verbal discussion will take place at the Board meeting to consider a proposed extension date for the remaining action plans. Work continues to address each of the remaining action plans and the key pieces of work identified in the Quarter 3 update (**appendix 2**) will help to mitigate against the risks which have been raised. A verbal discussion will take place at the Board meeting

Quarterly updates on all action plans will continue to be reported to the Executive Directors, Corporate Decisions Team – Quality Sub Group, Quality and Performance Committee and Board of Directors.

2. Risks and mitigations associated with the report

The Care Quality Commission has raised all of the issues within this report as areas of concern and as such are potential risks to the Trust in relation to safe care and treatment of those who use our services and those who work for the organisation. There is a risk of non-compliance with regulatory and legal requirements and potential risk to trust reputation should we fail to achieve completion and implementation of the action plans included within this report.

3. Recommendation

The Trust are required to provide regular updates to the Care Quality Commission on progress against each of these actions and as such it is necessary for the Trust Board to have oversight of progress and be assured that these concerns are being addressed.

The Board are asked to:

- Approve the closure of one action plan listed in appendix 1 recognising the Trust will continue to monitor the impact of previous actions through appendix 2.
- Note the Quarter 3 updates on all 46 CQC must do action plans listed within appendix 2.

Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained **under the Mental Health Act 1983** **Treatment of disease, disorder or injury**	**Regulation 17 HSCA (RA) Regulations 2014 Good Governance**
	How the regulation was not being met:
	The provider must ensure that clinical audits are effective in identifying and addressing areas of improvement within the service.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
The North Cumbria Locality will ensure appropriate clinical audits are in place within wards and teams.	
Who is responsible for the action?	Jose Robe, Group Nurse Director
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Clinical audits will be monitored through the Group and Trust governance arrangements.	
Who is responsible?	Jose Robe, Group Nurse Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
None.	
Date actions will be completed:	31st December 2020
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
Risk to patients and staff.	
Comments including good practice:	
• The North Cumbria locality has significant evidence of audit, action plan and re audit. The Trust has significant evidence of audit process up to committee stage. • A tracker has been created which will allow the locality to manage the oversight of audit actions that are applicable to the locality. Tracker was discussed and agreed at North Locality Operational Management Group on 1st December 2020. • The tracker will be maintained by the Nurse Manager for Quality who started on 14 December 2020.	
Evidence Submitted	
Inpatient Quality Agenda and Minutes North Cumbria Ops Agenda and Minutes – February 2020 Safer Care Report – Month 9 - December 2020 Safer Care Report – Month 10 - January 2020 Safer Care Q3 Report – January 2020 Inpatient Work Plan, Job Plan and Audit Cycle	

Blanket Peer Audits
Safer Care Q4 Report – May 2020
Locality Quality and Performance Report – July 2020
Safer Care Q1 Report – July 2020
Clinical Audit 20/21 Programme – July 2020
Locality Quality Standards Minutes and Agenda – 1 September 2020
Safer Care Q2 Report – October 2020
OMG Agenda and Minutes – 1 December 2020

The outcome of achieving this must do will increase local oversight of actions resulting from audits, supporting the achievement of audit actions between the audit and re-audit stages. This will be measured by the achievement/non achievement of audit actions reported to the Audit Committee as reported through the embedded Trust reporting systems.

Recommendation:

Complete. Evidence that practice has been mainstreamed with the North Cumbria Locality.

Must Do Theme: (1) Personalisation of care plans	**Lead: Vida Morris, Group Nurse Director**
Planned timescale for closure: 31 December 2020	
Community LD Year: 2015 Org: CPFT	The trust must ensure that care plans are person-centred, holistic and presented in a way that meets the communication needs of people using services that follows best practice and guidance.
Community OP Year: 2017 Org: CPFT	The trust must ensure that all patients have comprehensive and up to date care plans and risk assessments. Care plans and risk assessments must be regularly reviewed, and information must be used to inform each document.
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that care planning takes place with young people and is recorded in an accessible format that young people can understand. Care plans must be shared with young people and their carers where appropriate.
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that care plans contain the relevant supporting information, reflective of current need, regularly updated and that staff are aware of these and follow plans accordingly.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Individual pieces of work have been undertaken across the localities in relation to care planning to address concerns raised at ward level. However this work had been paused by the COVID-19 response.	
Actions taken at core service level during Quarter 1 (April, May & June):	
Community LD Community OP Community CYPS	The North Cumbria locality has embedded the monitoring of the patient care metric related to care planning, these are now supported by actions plans and trajectories.
LD & Autism wards	• Monthly Care Plan Audit is completed by designated Clinical Lead. • All Qualified Staff have received the Care Planning training and are aware of the expectations relating to the standards. • Care planning added to team meetings and supervision meetings as a standard meeting agenda.
Actions taken Trust-wide during Quarter 2 (July, August & September):	
A Trust-wide Group has been established, meetings are scheduled fortnightly and specific areas of improvement have been identified and will be benchmarked against the must dos. There are essential Trust-wide standards being agreed across all localities and sitting below these service specific / pathways and standards will be agreed by Task and Finish Groups. The project management group are meeting on a 2 weekly basis.	
Actions taken at core service level during Quarter 2 (July, August & September)	
• Action noted on Mitford rectified immediately (care plan on RiO did not match paper based copy on ward / with patient). • Monthly Health Care Record reviews for Edenwood, Rose Lodge and Mitford Ward continue to be completed during July, August and September. • A template for care plans has been introduced to aid collaborative care planning. For patients who lack capacity, it is acknowledged in the care plan that decisions have been made in their best interests. The language used is simple, easy to understand and in the first person. • Rose Lodge are working towards pictorial care plans for patients and carers. • Secure services continue to implement the "model of care" and enable collaborative care planning with patients.	
Actions taken at core service level during Quarter 3 (October, November & December):	
• Monthly Health Care Record reviews for learning disability and autism wards continue to be monitored through completion of monthly audits.	
Actions taken Trust-wide during Quarter 3 (October, November & December):	
• The Task and Finish Group met during Quarter 3 to finalise booklet and visual materials. Audit and training programme to be rolled out during Quarter 4. • The following materials have been produced:	

- Care planning booklet for staff to promote the principles of collaborative and patient centred care planning with all staff. Requires a review with patient involvement team and animations/design to be added in preparation for roll out.
- Poster campaign to promote the principles of collaborative and patient centred care planning with all staff. This is currently sitting with our patient information centre team/communications team to add animation.

- Audit completed and being tested to ensure it is fit for use in January 2021.

Planned future actions during Quarter 4 (January, February & March)

- Roll out of visual materials i.e. posters and booklet.
- Completion of training materials to roll out. The first phase has been completed and a framework for the package agreed. Clinicians have been invited to contribute to this and intent to develop a standardised package which will then have standardised pathway specific adaptations as well as adding in interactive features including videos, role play and practice examples.
- Audit to be undertaken.

Evidence of Impact:

The metric for the number of current service users who have discussed their care plan has improved during Quarter 3:

- North Cumbria Locality – 79% (September), 80% (December)
- North Locality – 93% (September), 94% (December)
- Central Locality – 92% (September), 92% (December)
- South Locality – 88% (September), 89% (December)

Status:

Ongoing further action required to make improvements.

Must Do Theme: (2) Blanket restrictions	**Lead: Karen Worton, Group Nurse Director**
Planned timescale for closure: 31 December 2020	
Adult Acute wards Year: 2018 Org: NTW	The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.
Adult Acute wards Year: 2019 Org: CPFT	The trust must ensure that blanket restrictions are all reviewed and individually risk assessed.

Actions taken Trust-wide during Quarter 1 (April, May & June):

Each ward maintains a blanket restriction register on identification or implementation of restrictions. An audit tool for all wards to complete on a quarterly basis forms part of the policy. All individualised blanket restrictions are risk assessed and reviewed through ward processes and documented accordingly in RiO.

Actions taken at core service level during Quarter 1 (April, May & June):

As per Trust-wide response.

Actions taken Trust-wide during Quarter 2 (July, August & September)

Policy reviewed and considered at BDG on 17 July 2020. Comments received by Identified Lead prior to BDG ratification.

A task and finish group established to review:
1) Locality restricted practice/blanket restriction registers and Peer Review process.
2) The blanket restrictions identified by MHA reviews and compliance with the Blanket Restriction Policy.

1) The task and finish group, with representation invited from each locality, met on 28 August 2020.

Outcome:
All inpatient services

- To ensure blanket restriction registers are current and reviewed.

- To recommence restrictive practice audit and quarterly peer audit cycles.
- To ensure that online incident form is completed when a blanket restriction is applied or identified.
- Management and governance of blanket restrictions escalation process to be followed as per policy.

2) On 31 August 2020 a dashboard was created by the Patient Safety showing all blanket restrictions/restrictive intervention incidents reported since January 2019. It is refreshed on a daily basis (currently available to the Operational Support Managers and Task Group Chair).

Outcome:
- Blanket restrictions and restrictive practice to be separated into two separate filters for the purposes of incident reporting.
- Triangulation of blanket restrictions incident data with the MHA.
- Reviewer visit reports do not correlate, indicating that blanket restrictions are not consistently being reported.

3) Blanket restrictions training has been incorporated into centrally delivered Mental Health Legislation Training as per policy. Update training is now available via e-learning however induction training for new starters is not yet available but is work in progress.

Actions taken during Quarter 3 (October, November & December):

1) Consultation of Blanket Restriction Policy was undertaken.
2) Mental Health Legislation Training, which covers blanket restrictions, will be available for new starters from January 2021. In the meantime wards are to include in local inductions.
3) Review of intended purpose of Blanket Restrictions/Restrictive Practice section of Safer Care Intranet has been completed.
4) A sample audit of ward blanket restriction registers against incident reporting data was completed.
5) Policy ratified at BDG on 18 December 2020.

Planned future actions during Quarter 4 (January, February & March)

1) Bespoke communication package to be disseminated on policy changes.
2) Blanket Restriction risk registers to be held on Safer Care Intranet page.
3) A sample audit of restrictions with reason care plans against ward blanket restriction registers to be completed.

Evidence of Impact:

Blanket restrictions were identified in 3 of the 7 wards visited by MHA Reviewers during Quarter 3. Examples of the type of blanket restrictions were:
- Issues with search policy
- Concerns around sexual safety on mixed sex ward
- Patients did not have access to a bedroom key

Status:

Ongoing further action required to make improvements.

Must Do Theme: (3) Restrictive practices, seclusion and long term segregation	**Lead: Ron Weddle, Deputy Director – Positive and Safe**
Planned timescale for closure: 31 December 2020	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff complete body maps and carry out and record physical observations following the use of restraint and ensure that there is a rationale recorded for any 'as required' medication being administered following the use of restraint.
LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that the patients in long term segregation and seclusion have the appropriate safeguards in place in accordance with the Mental Health Act Code of Practice and these are documented clearly in patients' records

LD & Autism wards Year: 2020 Org: CNTW	The trust must review and reduce the use of mechanical restraint within their learning disability services and ensure that its use is in line with best practice guidance and the appropriate authorisation and recording is in place

Actions taken Trust-wide during Quarter 1 (April, May & June):

Incident reports require all physical interventions by staff to be recorded, showing what staff member controlled what part of the patient's body during episodes of restraint. Any physical harm is also recorded on a body map when appropriate. Incident reports are a 'must do' in any tertiary response situation. Notes on RiO also capture these incidents, as well as incidents that did not require a tertiary response. Audit of physical observation during and after any restraint situation is carried out as well as situations that include rapid tranquilisation. The Positive and Safe team have updated the previous PMVA Policy with the Restraint Reduction Policy - a policy to meet the requirements of Seni's Law.

- There is a Trust-wide Seclusion Steering Group that supports adherence to national and local policies, identifying any issues and rectifying quickly.
- The weekly audit for Long Term Segregation now incorporates additional flag to ensure the review of independent and 3 monthly external reviews, as stipulated by Trust Policy and MHA Code of Practice.
- Trust wide electronic recording implemented March/April 2020.
- The pilot of the wall/floor covering continues with a suite on Mitford ward. The covering is proving to be robust however small cracks have appeared within distinct areas of the suite. The wall coverings integrity remains intact and the room operational however the Trust is exploring fully the cause of the identified issue before agreeing a roll out.
- Seclusion suite within Rose Lodge is intact.
- The Trust has encountered difficulties with regards to the installation of the Oxy Health system, which has resulted in delay.

- The Trust to undertake a review of the use of MRE.
- The current MRE PGN has been updated to reflect the findings from the report and recent national documents related to restraint reduction.

Actions taken at core service level during Quarter 1 (April, May & June):

Autism and Learning Disability services are required to follow Trust guidance set out in the Trust-wide position. There is an audit system that requires incidents to be monitored by Ward Managers, Clinical Managers and Associate Directors at core service level. Audit of physical observation during and after any restraint situation is carried out as well as situations that include rapid tranquilisation. This is a requirement at ward and locality level as well as a Trust-wide expectation.

- Discussions in core and ward team meetings for patients in Long Term Segregation and seclusion implemented.
- Audits for seclusion have taken place regularly and show no outstanding actions or areas for improvement.
- Individualised care plans reviewed and in place evidencing patient and carer involvement.
- Attention in care plan drawn to safeguards around use of Long Term Segregation. Outlining its rationale for use, environment, daily occupation, staff support and aims.
- Training update: MHA/Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) training: 77.1%, Seclusion training: 87%.
- Clinical Lead Nurse providing scrutiny and case load supervision to improve compliance with safeguards and embed review process.

Actions are applicable to Rose Lodge and Mitford wards but learning is shared across the core service.

- Positive and Safe approach to all restrictive interventions in place.
- MRE audit tool developed to support delivery of standards against guidance. MRE reduction reviewed in MDT.
- Positive and Safe approach is active and in use staff work with patients, carers/relatives and IMHA to tailor talk first interventions for the individual.
- Debrief following each occasion of MRE evidences areas that went well and alternatives that could be implemented to prevent escalation of need and reduce recurrence.

- Positive and Safe face to face training was paused due to COVID-19. This has now recommenced, and staff training level are expected to improve through the next quarter.
- Clear evidence within duty sheets established, MRE trained staff on duty are clearly highlighted with a minimum number of staff per shift.
- As a further safeguard Kenneth Day Unit control room has a daily plan of all MRE trained staff on the Northgate site.
- To support staff being on shift with MRE training, the ward rotas have been reviewed.

Actions taken Trust-wide during Quarter 2 (July, August & September):

Live dashboard development is currently ongoing to support overview of this and other parameters, and will be shared locally through insight reports on a quarterly basis which will provide assurance. There is a Clinical Incident Lead who has an overview of all incidents in the Trust.

- An Independent Review of LTS practice has commenced. In September 5 of the 7 Independent Reviews took place with a further 2 patient reviews planned for October.
- Review of policy to take into account independent review recommendations.
- Issues have been identified in seclusion data handling between two otherwise optimised data systems. The systems are RiO's 'green book' audit of seclusion, run by Ruth Jordan, and the other is the Incident Reporting (IR)/dashboard/Safeguard. The latter over counts due to lack of cancelled seclusions. We have a solution which is that IRs will trigger Clinical Nurse Managers to clean up impossible "two seclusions at once" type errors. This has support at the highest level, and the issues seem to pertain partly to over-reporting due to incidents not being stopped. That in turn may create unticked boxes for governance per incident. A Use of Force leaflet to support adherence to the Use of Force act is in the final stages of production, it will support patients and their families with up to date information soon.

Positive and Safe Team supporting the reduction in use of MRE by supporting individual teams and localities to look at alternative methods, these include the introduction of safety pods Trust-wide (except older people's services currently).

Actions taken at core service level during Quarter 2 (July, August & September):

- Long Term Segregation audits continue to take place for Rose Lodge. Registered Nurses via caseload supervision provide scrutiny to ensure that this documentation is completed. The standard of documentation has improved however the timely submission of care plans and recording of monthly and 3-monthly independent reviews is an area for improvement.
- Mitford ward Long Term Segregation audits continue and show no outstanding actions or areas for improvement.
- Individualised care plans in place and evidence patient and care involvement.
- Wall/floor coverings on Mitford and Rose Lodge remain intact.
- Central inpatients are undertaking a service improvement project in collaboration with the Positive and Safe Team and AHP colleagues; the overall aim is to improve the experience of seclusion for patients and staff and to ensure that a robust debrief for all is available following seclusion. Feedback from patients and staff of their experience of seclusion is being collated using qualitative questionnaires. Good practice examples from other areas to improve patient's experience of seclusion are being considered and implemented. Work is underway to have data, activities and a training package available for staff with a view to launch the service improvement md-December 2020. The aim of the project is to:
  - Reduced use of seclusion
  - Reduce the time patients spend in seclusion
  - Improved de-escalation within the MDT
  - Increased access to activities, music, TV, radio in seclusion
  - Increased access to family contact using iPads
  - Therapy to continue in seclusion (OT, Psychology, Exercise Therapy, etc)
  - Staff feel more confident in managing seclusion
  - Robust debrief following seclusion for all involved
- Staff at Rose Lodge have had training in use of Safety Pods and have used them successfully on 4 occasions with patients who have previously needed the use of MRE to safely move them into seclusion. The Safety Pods appear to have aided calming, possibly due to sensory benefits.

- There have been no episodes of MRE use at Rose Lodge since July 2020 and MRE use at Mitford has reduced during Quarter 2. Mitford has one active MRE care plan in place.

Actions taken at core service level during Quarter 3 (October, November & December):

- In October 2020 the CQC published findings from their review of restrictive practices called Out of Sight, Who Cares? The report identified 17 recommendations, 10 of which are identified as "national system changes" and 7 are focussed on restrictive practices. The Associate Directors for the Specialist Learning Disability services have been looking at the recommendations and will focus upon the areas relating to reducing restrictive practice. A number of actions have been identified that should enable the sharing of best practice and frameworks such as HOPEs to define our pathways and create services that are individualised, co-produced and enhance the patient experience. In addition the Trust has started to have conversations with its commissioning colleagues to consider how we influence change for people who access Hospital Based Rehabilitation, Assessment and Treatment as well as Autism services. Work will continue during Quarter 4 in relation to these pathways becoming clearly defined and needs led.
- Mitford was an early adopter of the Safety Pods, with the MDT quickly identifying several patients that would likely benefit from introduction into their care. A local operating policy and individualised care plans were created to support implementation.
- Mitford ward continues to have one active MRE care plan in place.
- There were 4 episodes of MRE use involving 2 patients during Quarter 3. All incidents were granted by Group Director or Director on-call and care plans were updated and de-briefs carried out.

Actions taken Trust-wide during Quarter 3 (October, November & December):

- An Independent Review of 7 patients has been completed and a report will be produced with individual and Trust-wide recommendations from the Medical Director.
- The Trust has engaged with Mersey Care NHS Foundation Trust since early October and have facilitated training on their HOPE Clinical Model of Care to reduce LTS and MRE. To date 4 awareness raising sessions have taken place for front line clinical staff from a broad range of our inpatient service areas and two x 2 days bespoke training events for Medical Directors / Nurse Directors / Consultants and senior clinicians.
- Use of force leaflet has been completed and is available.
- Safety Pods - this has now moved on from the original pilot and to date 28 wards now have at least one safety pod that they are actively using with more wards seeking to adopt this approach. The safety pods are not being used in older people's services. Feedback to date is that the pods support a more person centred approach to supporting people when they become highly distressed and or aggressive. The use of the pods is being monitored and tracked and full debriefing is provided for both patients and staff. Work will continue to refine and support the training, the use and wider understanding of the pods. We have also seen a couple of individuals purchasing pods as part of a transition package to support a move back to the community.
- Oxehealth - Oxevision, with its contact-free optical sensor, gives teams the clinical insights around a patient's physical health i.e. breathing rate, pulse etc without the need for direct contact. The project has now moved to installation phase and is expected to be fully functional across the three pilot wards (Beckfield, Longview and Shoredrift) at the end of December.

Planned future actions during Quarter 4 (January, February & March)

- The Trust to undertake a random sample audit of a maximum of 20 restraint incidents per ward over the past year. Investigating if there is a corresponding entry on RiO which details the body map. The body map must detail the holds and any markings or injuries.
- Dependent on the findings of audit a CAS alert reminding colleagues to complete body maps as per policy and details regarding the appropriate recording within the RiO system.
- Re-audit during Quarter 4.

- 7 cases were reviewed during August – November 2020 by a panel of clinicians and subject matter experts chaired by Medical Director. The panel made recommendations to enhance the quality of care including termination of restrictive conditions such as LTS or seclusion where appropriate. The results of these reviews were feedback in a meeting with the CQC.
- Trust-wide recommendations were made in relation to specific core training such as human rights, trauma based care and HOPES model.

- Recommendations were also made for oversight and governance in relation to the management of these cases. These recommendations will now be delivered to a newly established programme Board which will be jointly chaired by the Medical Director and Executive Director of Nursing and Chief Operating Officer, the first meeting of which has been planned for February 2021.

- Develop a training programme that is sustainable and scalable. CNTW Training Academy will be liaising with Mersey Care NHS Foundation Trust to develop a "train the trainer" programme that will enable us to progress the understanding and implementation of this model to a broader cohort of clinical staff. A clear expectation being that we will develop metrics and patient outcomes that can demonstrate positive progress over time.
- Efforts have been made to reduce levels of MRE use within the Trust. This has included changes in policy to ensure the use of MRE is never unplanned and authorisation of any planned use is from a Director.
- There has been a specific focus on supporting wards to implement safer ways of engaging in tertiary interventions when episodes of violence and aggression or self-harm make this this level of intervention proportionate to ensure the safety of the patient or others.
- Progress update on the Out of sight, who cares? report to be considered at the February QRG by our commissioners.
- Safety Pods have been introduced to 30 wards (older people's wards are excluded from using them currently), after a trial introduction that commenced in December 2019.
- With regards to the Oxehealth Digital Care Assistant, Longview is fully operational however due to an outbreak of COVID-19, Beckfield and Shoredrift are now expected to be operational by mid-February.

Evidence of Impact:

- Since the focused inspection in March 2020 there have been similar issues flagged from the Integrated Care Treatment Review (ICTR) process.

- Current episodes of Long Term Segregation per core service:
  - Child and Adolescent Mental Health Wards – 4
  - Wards for people with a learning disability or autism – 3
  - Forensic inpatients or secure wards – 1
  - Acute wards for adults of working age and PICU – 1
  - Long stay rehabilitation ward for working age adults – 1
  - Wards for older people with mental health problems – 1

- Current episodes of Prolonged Seclusion per core service:
  - Acute wards for adults of working age and PICU – 1
  - Forensic inpatients or secure wards – 2

- MRE usage per ward (Wards for people with a learning disability or autism) during Quarter 3:

	July	Aug	Sept	Oct	Nov	Dec
Edenwood	0	0	0	0	0	0
Mitford Bungalows	1	0	0	0	0	0
Mitford	11	8	8	5	6	8
Rose Lodge	3	0	0	4	0	1
Tweed (LD Hospital based rehabilitation)	0	0	0	0	0	0
Tyne (LD Long term conditions)	0	0	0	0	0	0

(1 service user)

Status:

Ongoing further action required to make improvements.

Must Do Theme: (4) Appraisal and training	**Lead: Marc House, Head of CNTW Academy**
Planned timescale for closure: 31 December 2020	
Community LD Year: 2015 Org: CPFT	The trust must ensure that all staff have an annual appraisal.
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that staff complete the mandatory training courses relevant to this service in line with trust policy to meet the trusts training compliance targets.
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that staff complete their mandatory and statutory training.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Community LD	The requirement to complete appraisals was paused as part of the response to COVID-19. In the last 4 weeks the message has gone out to all staff that they should be recommence appraisals and clinical supervision.
Community CYPS	The requirement to complete essential training was paused as part of the response to COVID-19. In the last 4 weeks the message has gone out to all staff that they should be recommence training where available. Training that is available via e-learning has been advertised widely. PMVA training has recommenced for staff who have joined the trust in the last 3 months and who have previously not received any training. Teams has been utilised to deliver MH Legislation training.
LD & Autism wards	
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 2 (July, August & September):	
Community LD	The New appraisal policy has not been ratified as further changes were required due to the People Plan and this has meant that the updated training package has not been developed.
Community CYPS	Reviewed common issues for staff accessing training. Tutorial videos for accessing e-learning developed in response to this and posted in Academy intranet site. Training has been delivered by Teams. Safeguarding Children level 3 has been made available via e-learning as has conflict resolution in place of breakaway for community staff.
LD & Autism wards	Training is planned via Teams in July and August to support staff to be able to access e-learning successfully and the portfolio of training available via Teams will be increased to include clinical supervision and clinical risk.
Actions taken Trust-wide during Quarter 3 (October, November & December):	
Community LD	The New appraisal policy has not been ratified as further changes were required due to the People Plan and this has meant that the updated training package has not been developed.
Community CYPS	CNTW Academy continue to act on feedback concerning any difficulties with accessing training and offer support where required.
LD & Autism wards	PMVA training continues to be delivered face to face with a move towards update training. The portfolio of training delivered by Teams will continue to be delivered and expanded where appropriate.
Planned future actions during Quarter 4 (January, February & March)	

Community LD	Workforce colleagues have indicated a January rollout for the New appraisal policy following an imminent consultation period. Training will be developed to reflect the new policy once there is a final version.
Community CYPS	Essential training to continue to be made available via e-learning and Teams where e-learning isn't available or appropriate. Support continues to be offered where staff have difficulties accessing courses and weekly updates on any known issues are shared with staff across the localities.
LD & Autism wards	

Evidence of Impact:

The standards for the following training courses have improved during Quarter 3:

- Clinical Supervision

North Cumbria Locality – 43.3% (September), 66.7% (December)
North Locality – 80.4% (September), 83.8% (December)
Central Locality – 81.1% (September), 81.9% (December)
South Locality – 76.9% (September), 83.9% (December)

- The following training courses remain below standard in the North Cumbria Locality but continue to improve:
  - Clinical Risk – 65.5% (December)
  - Clinical Supervision
  - Medicines Management – 75.8% (December)

- Fire has improved and is above the standard in all localities with the exception of North Cumbria Locality – 82.4% (December)
- MHCT Clustering has improved however is below the standard in North Cumbria and Central localities
- MCA/MHA/DOLS has improved however is below the standard in all localities
- Seclusion has deteriorated and is below the standard in all localities with the exception of South Locality
- PMVA Basic has deteriorated and is below the standard in all localities
- PMVA Breakaway has improved however is below the standard in all localities
- Information Governance has deteriorated and is below the standard in all localities with the exception of South Locality

Appraisal compliance has improved during Quarter 3:

- North Cumbria Locality - 63.2% (September), 75.1% (December)
- North Locality - 79.7% (September), 78% (December)
- Central Locality - 74.6% (September), 74.2% (December)
- South Locality - 82.7% (September), 85.4% (December)
- Support and Corporate - 60.4% (September), 81.5% (December)

Status:

Ongoing further action required to make improvements.

Must Do Theme: (5) Clinical supervision	**Lead: Esther Cohen-Tovee, Director of AHPs & Psychological Services**
Planned timescale for closure: 31 December 2020	
Community OP Year: 2017 Org: CPFT	The trust must ensure that all staff receive clinical and management supervision and that it is documented. The trust must ensure that supervision figures are shared appropriately with senior managers.
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues its development of staff supervision and the board have clear oversight of both quantity and quality of supervision.

LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff receive regular supervision.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Community OP	For Clinical Supervision this is a Trust policy requirement, and is monitored by managers via dashboard reports in North, Central and South. The dashboard reports are accessible to senior managers. Preparations made to roll out on-line recording system in North Cumbria locality.
LD & Autism wards	This is a Trust policy requirement, and is monitored by managers via dashboard reports in North, Central and South. Preparations made to roll out on-line recording system in North Cumbria locality.
Trust-wide	The policy was revised in 2019-20 to address findings from previous audit, to reduce scope to exclude medical staff and to harmonise with North Cumbria policy.
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 2 (July, August & September):	
Trust-wide	• IT have addressed requested system improvements. On-line recording system has been rolled out across North Cumbria. • Bespoke training sessions and twice weekly training sessions (booked through the CNTW Academy) have taken place throughout September via MS Teams. The training on the recording system is primarily for North Cumbria Locality staff but also a refresher for other localities. • Clinical supervision refresher training now available on MS Teams and via a workbook option. See Must Do Theme 20 for an update on management supervision. • Trust-wide clinical supervision audit has been initiated in September.
Actions taken Trust-wide during Quarter 3 (October, November & December):	
Community OP LD & Autism wards Trust-wide	• Rollout of training has continued during October, November and December. • Online recording system has been introduced in North Cumbria. • Trust-wide audit initiated in September and closed in November, 913 staff have participated. Audit timescales were adjusted due to timescale for implementation of the online recording system in North Cumbria. • Analysis of audit data carried out during December.
Planned future actions during Quarter 4 (January, February & March)	
• Audit report and recommendations to be completed. • Recommendations for any further improvements arising from Trust-wide audit to be agreed and shared with CBUs for action as appropriate. • Proposed that clinical supervision dashboard reports for all services are reviewed at CBU workforce meetings; implementation plan put forward.	
Evidence of Impact:	
Clinical supervision figures have deteriorated during Quarter 3: • North Cumbria Locality – 64% (September), 42% (December) • North Locality – 52% (September), 40% (December) • Central Locality – 57% (September), 38% (December) • South Locality – 61% (September), 50% (December)	
Status:	
Ongoing further action required to make improvements.	

Must Do Theme: (7) Documentation of consent to medical treatment	Lead: Dr Patrick Keown, Group Medical Director
Planned timescale for closure: 31 December 2020	
Community OP Year: 2017 Org: CPFT	The trust must ensure that consent to treatment and capacity to consent is clearly documented in patient's records.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Work had been paused due to COVID-19 response.	
Actions taken at core service level during Quarter 1 (April, May & June):	
The North Cumbria locality has embedded the monitoring of the patient care metric related to capacity recording, these are now supported by actions plans and trajectories.	
Actions taken Trust-wide during Quarter 2 (July, August & September):	
The North Cumbria locality has evidenced an overall improvement in compliance in the memory and later life pathway.	
Actions taken Trust-wide during Quarter 3 (October, November & December):	
• Memory and later life pathways from all localities to provide update on documentation of consent to treatment and capacity to consent. • Data on rates of consent to treatment under the Mental Health Act in each locality has been collated. This is information is monitored by Mental Health Act office and included within the activity report which is taken to Mental Health Legislation Steering Group. There has been some improvement, but monitoring is to continue. • Data on recording of initiation and review of the use of antipsychotics in patients with dementia by locality has been collated. It was noted that recording appears to be different across the localities. Further work to establish potential reasons for differences and request to the localities to provide information on how this will be addressed.	
Planned future actions during Quarter 4 (January, February & March)	
Data received with regard to capacity to consent (initiation and review of antipsychotics) to be circulated to Locality Leads for Older People's Services with a request that this is reviewed and narrative provided with regard to how this is will be addressed. Analysis to be undertaken to see if it can be established the reasons for differences in recording across the localities.	
Evidence of Impact:	
There has been a deterioration during Quarter 3 for the metric - service users who had a discussion recorded at the point of their detention • North Cumbria Locality – 53% (September), 33% (December) • North Locality – 51% (September), 60% (December) • Central Locality – 60% (September), 58% (December) • South Locality – 61% (September), 64% (December)	
Status:	
Ongoing further action required to make improvements.	

Must Do Theme: (9) Environmental issues	Lead: Paul McCabe, Director of Estates and Facilities
Planned timescale for closure: 31 December 2020	
Adult acute wards Year: 2019 Org: CPFT	The provider must maintain premises in good condition and suitable for the purpose for which they are being used.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure that the health-based places of safety promote the privacy and dignity of patients in Carlisle and Whitehaven. The trust must ensure they take action in response to regulatory requirements and the findings of external bodies.

LD & Autism wards Year: 2020 Org: CNTW	The trust must ensure that the environment at Edenwood is improved including the provision of specialist furniture which meet the needs of the patient using this service
Planned timescale for closure: 31 October 2020	
Long stay / rehab wards Year: 2015 Org: CPFT	The trust must ensure that the first floor of the building has clear lines of sight and an alarm call system that can be easily accessed to summon assistance.
OP wards Year: 2019 Org: CPFT	The provider must ensure that plans to relocate Oakwood ward are progressed and the use of dormitory style accommodation on Oakwood is either no longer used or a robust assessment and mitigation of risk is put in place.
Planned timescale for closure: 30 April 2021	
Community OP Year: 2017 Org: CPFT	The trust must ensure that all premises and equipment are safe and suitable for patients and staff. Premises must be reviewed in terms of access and reasonable adjustments to meet the needs of service users and staff. Medical equipment must fit for purpose and records kept to ensure it is well maintained.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Adult acute wards	The premises are maintained under contract with NCIC and the performance of this contract is monitored by NTW Solutions on behalf of the Trust. There are areas of improvement that are required and these include some must do's and once completed this will be satisfied.
LD & Autism wards	• Approval of £200k investment into the improvement of the facilities on Edenwood has been granted. • All areas that required refurbishment have been completed, flooring has been replaced and walls repainted in one colour in all main areas and bedroom. External garden completed. • Gradual introduction of furniture includes sofa, chairs, table and new bed on order. • Safety pod in place. • Appropriate seating, mattress and bean bags in place. • Table top in place for activities.
Long stay / rehab wards	Plans are being drawn up to look the feasibility of installing nurse call alarms systems across wards in the Trust that do not currently have them.
OP wards	Robust assessment and mitigation of risk recorded on Risk log re dormitory provision. Currently (during COVID) the dormitory rooms are being used for single accommodation.

Community OP	Investigation into available options to improve the accommodation has been carried out. This has resulted in additional space been identified at Lillyhall, this will relieve overcrowding at Whitehaven. A longer term solution to move Community services off the Whitehaven site will be explored.
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 2 (July, August & September):	
Adult acute wards	Ongoing monitoring of contracts.
MH crisis teams	A detailed assessment has been undertaken of the places of safety in Carlisle and Whitehaven. Business Advisor has completed a business case for submission to CDT-Business.
LD & Autism wards	• All outstanding works on Edenwood now complete, appropriate furniture in place, seating and an outdoor area. • All Edenwood staff have completed Safety Pod Training. • Plans in place for modular extension of Edenwood with further refurbishment of ward areas once patient currently there has been discharged.
Long stay / rehab wards	The environment of Acorn is no longer used by this core service.
OP wards	Bid submitted and approved to address the provision of dormitory beds and will convert them into single room accommodation for Oakwood (Carleton Clinic), Castleside and Akenside (Centre for Ageing and Vitality) and Tweed (Northgate).
Community OP	
Actions taken Trust-wide during Quarter 3 (October, November & December):	
Adult acute wards	• Ongoing monitoring of contracts. Additionally NTW Solutions were looking to undertake PLACE LITE inspections during October / November to assist in understanding current environments. These inspections were put on hold due to COVID-19 restrictions. • Review of ligature free doors at Alnmouth was carried out and a potential problem with the bottom bracket was identified. NTW Solutions have been working with the company as they seek to develop a solution which has resulted in a redesign of the bracket. A further review is on-going and should be complete by the end of January 2021 and then a paper will be presented to BDG- Safety for approval and then to CDT-Business for funding approval.
MH crisis teams	• The works at Carleton Clinic were minor in nature and have been completed. • For Whitehaven costs have been provided to the service and once submitted to CDT-Business and approved the works will be scheduled in.
LD & Autism wards	• Patient was discharged from Edenwood as planned. The additional refurbishment of Edenwood to ensure it is fit for purpose has been put on hold as it was necessary to utilise Edenwood as a temporary decant for staff from old Ruskin (IT and some NCIC staff) and that was required to allow the Dormitory works to proceed. It is expected that the Edenwood refurbishment will be undertaken when the de-cant moves out. This is also tied in with a proposed Business Case to upgrade old Ruskin into a management suite. • The Edenwood Modular building is awaiting final approval for funding which is expected by Mid January 2021 and if approved will be complete by April 2021. The upgrade of Edenwood is tied in with other site development plans which will be looked at over the next 3 months.
Long stay / rehab wards	Paper was submitted and approved at CDT-Business. Work will be completed by the end of March 2021 for the wards which were approved.

OP wards	Work on Oakwood was delayed due to COVID-19, work will commence at the end of January 2021 and complete by March/April 2021.
Community OP	Community services were expected to move into Lillyhall by October 2020. This move was delayed for a number of reasons which related to the physical condition of the building and this work was undertaken by the landlord prior to occupation, expected move date is Mid January 2021 (assuming COVID-19 does not impact on the ability to move).
Planned future actions during Quarter 4 (January, February & March)	
Adult acute wards	• Complete assessment of anti-ligature en-suite door and put in place recommendations subject to financial approval. • Currently the Yewdale ward has had the en-suite door curtain rails replaced and standardised, this is an interim position and if the "saloon" style doors are approved then wards in Cumbria will be fitted with this type.
MH crisis teams	The service to submit to CDT-Business the business case for the place of safety works at Whitehaven.
Long stay / rehab wards	Approval has been given to ensure the following wards have nurse call systems, where systems are required then work will be undertaken to put these in place. The timing of the work will partly be dependent on COVID-19 restrictions. • Hadrian Unit • Edenwood Unit • Rowanwood • Yewdale (West Cumberland)
OP wards	Work on Oakwood which was delayed due to COVID-19, work will commence at the end of January 2021, complete by March/April 2021.
Community OP	• Brookside and Park Lane refurbishment work is underway along with the creation of a Patient Toilet at Portland Square. • Lillyhall will be occupied.
Evidence of Impact:	
To further develop the evidence of impact.	
Status:	
Adult acute wards	Ongoing further action required to make improvements.
MH crisis teams	
Long stay / rehab wards	
OP wards	
Community OP	
LD & Autism wards	Closed at Board of Directors on 4 November 2020.

Must Do Theme: (10) Risk assessment and record management	**Lead: Andy Airey, Group Director**
Planned timescale for closure: 31 December 2020	
Community LD Year: 2015 Org: CPFT	The trust must ensure that staff complete and record patient's risk assessments consistently evidencing contemporaneous care records for patients who use services.
Community CYPS Year: 2017 Org: CPFT	The service must ensure that all young people receive a thorough risk assessment which is recorded appropriately in accordance with the trusts policies and procedures to ensure safe care and treatment.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established to maintain the records of each patient accurately, completely and contemporaneously.
LD & Autism wards Year: 2020	The trust must ensure that risk assessments are regularly updated to reflect current risk and needs of patients

Org: CNTW	
Actions taken Trust-wide during Quarter 1 (April, May & June):	
A baseline assessment has been undertaken across all CBU's within the 4 localities. Audits and records checks are undertaken routinely across all localities. For Specialist services commissioned by NHSE completion of a risk assessment within the last six months is a performance metric and monitored via the dashboards.	
Actions taken at core service level during Quarter 1 (April, May & June):	
Community LD	As per Trust-wide response.
MH crisis teams	
Community CYPS	A Waiting Times protocol has been agreed across CYPS (Trust-wide) which includes a first letter following Triage, a 12 week wait letter and phone call follow up contact at 18 weeks, 25 and 35 weeks. Each CBU will arrange an audit process to ensure this protocol is embedded.
LD & Autism wards	• Risk assessments are updated within MDT meetings on a minimum of a weekly basis. In addition, these are updated after significant risk incidents. • Risks are clearly defined in historic and current risks. • Individual Supervision addressing areas from the Health Care Record Audit that do not meet the standard has been implemented. Monthly Health Care Record audits have been carried out during April, May and June.
Actions taken Trust-wide during Quarter 2 (July, August & September):	
There have been Trust-wide Groups established with corporate and operational representation to look at the following:- • Review of Risk Assessment documentation (leads Stuart Beatson and Damian Robinson) • Record Keeping Standards (leads Jonathan Richardson and Eilish Gilvarry) Links have been made with these groups and Operational Support Manager for South Locality is to attend as a member of the above groups on behalf of Group Director to ensure that the issues raised through CQC inspections are fed into these groups and help to inform any decisions which are made. Audits and records checks continue to be undertaken. For Specialist services commissioned by NHSE completion of a risk assessment within the last six months is a performance metric and monitored via the dashboards.	
Actions taken at core service level during Quarter 2 (July, August & September):	
Community LD	As per Trust-wide update. In addition audits and records checks continue to be undertaken.
MH crisis teams	
Community CYPS	As per Trust-wide update. Also, each CBU will arrange an Audit process to ensure this protocol is embedded. Audits have commenced across the CBU's.
LD & Autism wards	As per Trust-wide update. In addition the following continue to take place: • FACE risk reviewed in each MDT and for each episode of leave. Audit tool is in place to ensure current and historic risk factors are differentiated. • Monthly Health Care Record reviews for Rose Lodge and Mitford Ward completed during July, August and September. • In Secure Services FACE risk assessments reviewed alongside HCR 20 assessments. FACE reviewed in CTR's, ICTR's and as part of Section 17 leave. • Risk assessments reviewed following incident reporting, within initial reports, LAAR's.

	• Risk is reviewed and care plans amended to reflect changes, these are also incorporated in Recovery Goals and Formulation.

Actions taken Trust-wide during Quarter 3 (October, November & December):

- To continue to raise these issues through the relevant Trust-wide forums mentioned above ensuring that any decisions made help to address the issues which have been raised.
- The data below shows that North Cumbria continues to make improvements with regards to compliance with all other localities maintaining achievement of Trust set targets.

Planned future actions during Quarter 4 (January, February & March)

- To continue to raise these issues through the relevant Trust-wide forums i.e. Trust-wide Record Keeping Group and Risk Clinical Reference Group.
- To continue to monitor compliance with the metrics below for improvement.

Evidence of Impact:

CPA service users with a risk assessment undertaken/reviewed in the last 12 months at Quarter 3:

- North Cumbria Locality – 15% (September), 28% (December) FACE risk assessment only (GRIST) not pulling through information
- North Locality – 99% (September), 98% (December)
- Central Locality – 97% (September), 97% (December)
- South Locality – 97% (September), 98% (December)

Service users with identified risks who have at least a 12 monthly crisis and contingency plan at Quarter 3:

- North Cumbria Locality – 98% (September), 94% (December)
- North Locality – 98% (September), 96% (December)
- Central Locality – 95% (September), 97% (December)
- South Locality – 95% (September), 97% (December)

Clinical risk and suicide prevention training standards at Quarter 3:

- North Cumbria Locality – 33% (September), 66% (December)
- North Locality – 85% (September), 86% (December)
- Central Locality – 86% (September), 85% (December)
- South Locality – 86% (September), 86% (December)

Status:

Ongoing further action required to make improvements.

Must Do Theme: (12) Physical health and Rapid tranquilisation	**Lead: Anne Moore, Group Nurse Director and David Muir, Group Director**
Planned timescale for closure: 31 December 2020	
Adult acute wards Year: 2018 Org: NTW	The trust must ensure that staff monitor the physical health of patients following the administration of rapid tranquilisation
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff monitor patients' physical health including, following rapid tranquilisation, in accordance with national guidance, best practice and trust policy.
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all staff review patients' observations following the use of rapid tranquilisation to comply with the provider's rapid tranquilisation policy and National Institute of Health and Care Excellence guidance.

Actions taken Trust-wide during Quarter 1 (April, May & June):

Results of completed audits in July 2019, November 2019 and July 2020 were taken to Trust-wide Physical Health and Wellbeing Group for approval. This work had been delayed to COVID-19 response.

Actions taken at core service level during Quarter 1 (April, May & June):
As per Trust-wide response.
Actions undertaken Trust-wide during Quarter 2 (July, August & September):
• A task and finish group to undertake a review of practice and the implications for multi-disciplinary practice, risk management and implications for training has been set up. • Rapid Tranquilisation and post administration monitoring is now included in the Junior Doctor Induction Programme.
Actions undertaken Trust-wide during Quarter 3 (October, November & December):
• Discussed at the Extra-ordinary Resuscitation and Medical Emergencies Group on 7 October 2020. • Task and finish group met for 1st time on 9 December 2020. This group has reviewed previous audit and has developed and confirmed the action plan. Group have agreed to reschedule the next Trust Audit during March 2021. Group has agreed to meet again to keep the focus on the subject.
Planned future actions during Quarter 4 (January, February & March)
Trust re-audit planned for March 2021.
Evidence of Impact:
Results of re-audit.
Status:
Ongoing further action required to make improvements.

Must Do Theme: (14) Staff engagement	**Lead: Michelle Evans, Acting Deputy Director of Workforce and Organisational Development**
Planned timescale for closure: 31 December 2020	
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure staff working on Rowanwood feel supported, valued and respected following serious incidents beyond ward level.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
The Rowanwood ward is required to undertake staff development regarding culture, values and behaviours. The CBU can demonstrate this work through its approached to business planning, however direct evidence related to Rowanwood is required.	
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Actions undertaken Trust-wide during Quarter 2 (July, August & September):	
• The Associate Director for AHPs is the lead the Team development programme, supported by the Clinical Manager for the PICU. The process has been designed and planned out, however has been delayed. Work has constantly been underway to support Rowanwood and management and senior clinicians are a continual presence on the ward. • Baseline survey to be completed by December 2020.	
Actions undertaken during Quarter 3 (October, November & December):	
Chief Executive visited Rowanwood alongside all other services on Carleton Clinic site on the 1 October 2020. The Team development programme has been designed as a two-phase process. Phase one: Individual assessment and interviews to understand personal experiences and gather intelligence on staff priorities. Phase Two: Team development. Taking a listening, learning and action by all approach. Phase one: • Stress Risk Assessment completed by nearly all staff and follow up interviews conducted. This has been completed except for a couple of members of staff. • Analysis of the Stress Risk Assessment tools, themes identified and report written. This has been delayed due to COVID-19.	

• A facilitated session based on the individual assessments, interviews and themes, and staff survey results, and focused on enabling staff to reflect on their experience. This session will revisit the CNTW values and what these mean to the whole staff group and the creation of shared compact developed by the team. This has been delayed due to COVID-19.
Planned future actions during Quarter 4 (January, February & March)
• Phase one: completion of the facilitated session as per above. • Phase two: A facilitated listening and learning event for the Team to identify improvement ideas and projects. This was due in January 2021 but has been delayed due to COVID-19.
Evidence of Impact:
Baseline survey results.
Status:
Ongoing further action required to make improvements.

Must Do Theme: (15) Medicines Management	Lead: Tim Donaldson, Chief Pharmacist/Controlled Drugs Accountable Officer
Planned timescale for closure: 31 December 2020	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all medicines used are labelled and that risk assessments are always in place for the use of sodium valproate in female patients of child bearing age.

Actions taken Trust-wide during Quarter 1 (April, May & June):

1. Labelling of medicines:
A Pharmacy-led series of CQC assessments is underway across inpatient units to identify any unlabelled medicines (e.g. creams, inhalers). Lloyds Pharmacy SOPs have been obtained to ensure that national pharmacy professional standards for labelling dispensed have been incorporated

2. Valproate:
- Trust valproate prescribing guideline (PPT-PGN-25, Safe Prescribing of Valproate) was reviewed and approved by the MOC in July 2020 (currently undergoing a 2-week Trust-wide consultation).
- Data collection for a POMH-UK national benchmarking audit of valproate prescribing (Topic 20a) to commence in September 2020 (delayed from March, due to COVID-19). The audit has been registered with Clinical Audit department and a medical lead will be assigned by BDG. Patients will be identified via a combination of RiO searches (using CRIS & SNOMED-CT) and requests to community teams (including forensic services) irrespective of age and sex.
- Following the appointment of an R&D Informatics Project Co-ordinator, a CRIS search of RiO care records was re-run to include the North Cumbria locality (July 2020); data cleansing carried out.
- The Clinical Audit team has analysed the CRIS search results to identify women and girls of childbearing age who are currently prescribed valproate. RiO records will be flagged (via SNOMED-CT coding) to support patient identification during the forthcoming POMH-UK valproate prescribing Trust-wide audit.
- An updated list of RiO patient identity numbers sent to clinical leads for the four localities with a request to ensure that all relevant patients have received an annual clinical review in the past 12 months, have the appropriate risk assessment paperwork in place (with copies having been sent to GPs) and are being actively recalled for annual review.
- Localities asked to nominate leads for the POMH-UK valproate audit.

Actions taken at core service level during Quarter 1 (April, May & June):

As per Trust-wide response.

Actions undertaken Trust-wide during Quarter 2 (July, August & September):

1. Labelling of medicines:
- Pharmacy colleagues have undertaken CQC self-assessment on all inpatient units to address labelled medications, August 2020. Report to be presented to CQC QCG September 2020.
- Lloyds Pharmacy SOPs obtained to ensure labelling of medicines is appropriately addressed.

2. Valproate:
- Harmonised PPT-PGN-25, Safe Prescribing of Valproate was ratified by BDG, September 2020.
- Further CRIS data interrogation by Clinical Audit colleagues completed in August 2020; Clinical Audit Facilitators do not have write authority for RiO therefore localities tasked with updating SNOMED-CT valproate entry as part of POMH-UK QIP Topic 20a data collection.
- Lead for North Cumbria identified, August 2020.
- Medic lead for POMH-UK QIP Topic 20a Valproate assigned by BDG, August 2020.
- Additional questions added to the POMH-UK Topic 20a data collection tool to assess compliance against standards contained within PPT-PGN-25, August 2020.
- Locality valproate leads sent final list of CRIS RiO numbers (patients open to community teams) and POMH-UK Topic 20a data collection tool (with separate guidance for staff on how to complete), August 2020. Data collection to begin immediately. POMH-UK Topic 20a to include up to 20 male patients/locality to assess valproate prescribing and monitoring standards in addition to Pregnancy Prevention Programme for females of childbearing age.

- Localities identified parties to assist with data collection for POMH-UK QIP Topic 20a and begin data collection immediately, August 2020.
- CNTW Pharmacy teams to undertake POMH-UK Topic 20a data collection for all inpatient females of childbearing age during September and October 2020. Data collection tool and guidance distributed August 2020.
- Valproate issue considered as a deep dive at Quality and Performance Committee in September.

Actions taken Trust-wide during Quarter 3 (October, November & December):

- POMH-UK Topic 20a data collection to be continued by localities and pharmacy teams throughout October. Data collection ended 6th November 2020.
- Pharmacy colleagues to cleanse POMH-UK Topic 20a data and input on RCPsych website by end of October 2020. Data cleansed and entry complete 6th November 2020. N=124 (51%) known cases of females who are currently receiving valproate submitted to POMH.
- Pharmacy to request SNOMED-CT report be run following completion of POMH-UK data collection and compared against original CRIS results to validate accurate completion of this RiO flag. Report detailed n=172 females with SNOMED-CT valproate alert in current use; significant variation found between CRIS, POMH submissions and SNOMED RiO cases. Total number of women and girls within CNTW likely to be taking valproate possibly up to n=242. Quarterly automated report built with Informatics colleagues which identifies SNOMED alert on RiO, by locality.
- Operational Risk Register entry to be updated with work done to date. Updates sent 15/10/2020 & 19/11/2020 to Risk Management Lead.
- Initial results of POMH-UK Topic 20a with regard to additional questions added to the POMH-UK Topic 20a data collection tool to be shared with localities and MOC (completion of prescriber's checklist, SNOMED-CT alert, copy of annual risk assessment sent to GP and next annual risk assessment diarised). POMH-UK interim data received and outline progress considered at BDG on 11 December 2020.
- Pharmacy colleagues to scope possibility of adding current valproate treatment in women and girls of childbearing age to the alert banner on RiO. Option incorporated into BDG paper for 11 December 2020 meeting

Planned future actions during Quarter 4 (January, February & March)

- Presentation of BDG paper to MOC January 2020 for information.
- Presentation of POMH Topic 20a trust report to MOC once received from POMH in Q1 2021/22.

Evidence of Impact:

- Raised awareness of prescribing standards contained within PPT-PGN-25.
- Accurate completion of SNOMED-CT alert on RiO will create contemporaneous register of females of childbearing age who are receiving valproate within CNTW services.
- Compliance against PPT-PGN-25 standards will ensure annual risk assessment documentation is copied to the patient's GP and next appointment diarised.

Status:

Ongoing further action required to make improvements.

Must Do Theme: (16) Nurse Call Systems	**Lead: Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: 31 December 2020	
Adult acute wards Year: 2018 Org: NTW	The trust must ensure patients have access to a nurse call system in the event of an emergency.

Actions taken Trust-wide during Quarter 1 (April, May & June):

Following the introduction of Nurse Call Systems into the former NTW Urgent Care. Inpatient facilities work has commenced on developing a current state for the remaining CNTW inpatient areas.

Actions taken at core service level during Quarter 1 (April, May & June):

As per Trust-wide response.

Actions taken Trust-wide during Quarter 2 (July, August & September):
A full analysis of the remaining facilities has been undertaken. Initial costings have been obtained and a briefing has been developed for consideration.
Actions taken Trust-wide during Quarter 3 (October, November & December):
Following discussion with the Locality Group Nurse Directors a phased implementation of the nurse call systems will take place over the coming year subject to priorities identified on the capital programme. At the November CDT-B this approach was agreed. The provision of nurse call systems into facilities at North Cumbria (Hadrian, Edenwood, Rowanwood and Yewdale) and Gibside ward, St Nicholas Hospital, Newcastle was deemed to be the priority. This work will take place during Quarter 4 2020/21.
Planned future actions during Quarter 4 (January, February & March)
• Completion of previously described priority work. • Further conversations between NTW Solutions and the clinical service areas will take place to identify the next phase of work to be considered against other priorities on the capital programme.
Evidence of Impact:
Assurance of completion of work.
Status:
Ongoing further action required to make improvements.

Must Do Theme: (18) Section 17 Leave	**Lead: Dr Patrick Keown, Group Medical Director**
Planned timescale for closure: 31 December 2020	
OP wards Year: 2019 Org: CPFT	The provider must ensure that all section 17 leave forms are individually completed for each patient and show consideration of patient need and risks.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
The Mental Health Legislation team have reviewed records in the North Cumbria older adult wards. A review of records of detained patients in Central, North and South localities has been undertaken and all had individualised Section 17 leave forms which accurately reflected leave. Risks are not routinely identified on the Section 17 form itself but this is identified in leave care plans and FACE risk assessments.	
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 2 (July, August & September):	
• Task and Finish Group to be set up to continue with work to ensure Section 17 leave forms link with individualised care plans and risk assessments, focusing on personalisation and evidencing that patient and/or families received a copy of the Section 17 leave forms. • Issues around risks and care planning will be addressed with the named nurses and MDTs.	
Actions taken Trust-wide during Quarter 3 (October, November & December):	
• Task and Finish Group members to be invited to Mental Health Legislation Steering Group on 17th September 2020 and set timeframes for group. • Task and Finish Group had meeting. This reviewed rates of compliance of section 17 leave forms by CBU. • Recommendation was made that the end date is mid-week and when consultant is at work, factor in annual leave and cross cover, avoid using end of month as this can fall on a weekend or Bank Holiday. Further monitoring required. • Discussion was held regarding difference between escorted and accompanied leave – see attachment. • CBU Representatives were asked to feedback the recommendation made and the difference between escorted and unescorted leave to the RC's with their localities. A further piece of work is to be undertaken – small group to meet to look at leave policy. • In December members of the Task and Finish Group will be reviewing the RiO records of two patients to see how well the section 17 leave form, the FACE risk assessment and the Inpatient Risk Management plan correspond with each other. Audits have been completed and received from North and South Older People's Services. To chase up audits from North Cumbria and Central. Further analysis and evaluation to take place once all audits have been received.	

• Feedback in relation to the above issues is to be taken at the Mental Health Legislation Steering Group on 14th January 2021. Information included above was discussed at Mental Health Legislation Steering Group on 14th January 2021.
Planned future actions during Quarter 4 (January, February & March)
• Outstanding audits to be returned and evaluation to be undertaken with any actions to be taken forward by relevant individuals. • To ask CBU Representatives to take back to the RC's the recommendations of the task and finish group follow the findings from the data (i.e. compliance poor if falls on bank holiday or weekends) – to continue to monitor compliance with S17 leave through the Mental Health Legislation Steering Group. • Small group to meet to discuss accompanied and escorted leave and to review the leave policy. • Work on-going with RiO team to look at the possibility of setting up an alert system to assist with compliance.
Evidence of Impact:
Evaluation of audit results.
Status:
Ongoing further action required to make improvements.

Must Do Theme: (19) Clinical audits	**Lead: Dr Kedar Kale, Group Medical Director**
Planned timescale for closure: 31 December 2020	
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that clinical audits are effective in identifying and addressing areas of improvement within the service.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
The North Cumbria locality can demonstrate it has embedded the Trust-wide approach to clinical audit and re-audit. The trust overall has a significant amount of evidence regarding a robust approach to clinical audit.	
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 2 (July, August & September):	
The North Cumbria locality has significant evidence of audit, action plan and re audit. The Trust has significant evidence of audit process up to committee stage.	
Actions taken during Quarter 3 (October, November & December):	
• A tracker has been created which will allow the locality to manage the oversight of audit actions that are applicable to the locality. Tracker was discussed and agreed at North Locality Operational Management Group on 1st December 2020. • The tracker will be maintained by the Nurse Manager for Quality who started on 14 December 2020.	
Evidence of Impact:	
Locality and Trust-wide governance structures. Locality cycle of meetings. Locality tracker.	
Status:	
Submitted to Board under Appendix 1 for closure.	

Must Do Theme: (20) Management supervision	**Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance**
Planned timescale for closure: 31 December 2020	
Community OP Year: 2017 Org: CPFT	The trust must ensure that all staff receive clinical and management supervision and that it is documented. The trust must ensure that supervision figures are shared appropriately with senior managers.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Limited work has been done to progress this action however a snapshot of the position was captured through the weekly question mechanism.	

Actions taken at core service level during Quarter 1 (April, May & June):
As per Trust-wide response.
Actions taken Trust-wide during Quarter 2 (July, August & September):
Process for collecting records in relation to management supervision has been developed. Management Supervision PGN has been developed and is out for consultation.
Actions taken during Quarter 3 (October, November & December):
Communicate to staff the new system and process (through October). Start reporting against the 85% standard (October onwards). Agree a timescale for full compliance across the Trust. PGN has been ratified by BDG.
Planned future actions during Quarter 4 (January, February & March)
Continue to monitor compliance although not applying standard in Quarter 4 due to wave 3 of pandemic. Each area will continue to make incremental improvement.
Evidence of Impact:
The proportion of staff with a management supervision recorded in the past 3 months during Quarter 3: • North Cumbria Locality – 51% (December) • North Locality – 40% (December) • Central Locality – 40% (December) • South Locality – 45% (December)
Status:
Process in place to record now actions are to focus recording in the first instance and then compliance.

Must Do Theme: (6) Risk registers	**Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance**
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it continues to make progress against the trust risk register and board members and members of staff understand the process of escalating risks to the board through the board assurance framework.
Crisis MH teams Year: 2019 Org: CPFT	The trust must ensure systems and processes are established and operating effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Trust-wide	Following the CQC inspection there were identified weakness in the approach to risk escalation, risk management and assurance within CPFT. Following the transfer of services, the North Cumbria Locality adopts and implements fully the Risk Management Policy. Evidence that risk register is effectively reviewed and managed in line with the Trust Policy and that there is evidence of a clear link between the register and the Board Assurance Framework.
MH crisis teams	The North Cumbria Locality has provided evidence of adopting CNTW governance structures, evidence of actions, reports completed and sharing of information and cycle of meetings. The CNTW board reported provides evidence of communication processes from Ward to Board. There are standardised agendas in use in team meetings at Group level and these are replicated at CBU level.
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Planned future actions:	
No further action required.	
Evidence of Impact:	
Cycle of risk register review through CDT-R Review and update of Risk Management Strategy received by Board in November 2020 Development of future Strategy proposed	
Status:	
Closed by Board of Directors on 5 August 2020.	

Must Do Theme: (8) Collecting and acting on feedback from service users and carers	Lead: Allan Fairlamb, Head of Commissioning & Quality Assurance
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that quality monitoring takes place to measure service performance, outcomes and progress and ensure feedback from young people and their carers is incorporated into this.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
The Access and Community CBU has provided evidence patient and carer involvement via a locality 'Together' meeting. The North Cumbria Locality is undertaking work to understand the involvement of carers 'Getting to Know You' process. There is evidence that practice has been mainstreamed within the North Cumbria Locality.	
Actions taken at core service level during Quarter 1 (April, May & June):	
As per Trust-wide response.	
Planned future actions:	
No further action required.	
Evidence of Impact:	
Quarterly report to Board on patient feedback	
Status:	
Closed by Board of Directors on 5 August 2020.	

Must Do Theme: (11) Staffing levels	Lead: Anne Moore, Group Nurse Director
Planned timescale for closure: 30 September 2020	
Community CYPS Year: 2017 Org: CPFT	The trust must ensure that there are a sufficient number of appropriately skilled staff to enable the service to meet its target times for young people referred to the service.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure there is always a dedicated member of staff to observe patients in the health-based places of safety.
LD & Autism wards Year: 2019 Org: CPFT	The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.
Planned timescale for closure: 31 December 2020	
Adult acute wards Year: 2019 Org: CPFT	The trust must deploy sufficient numbers of qualified, competent, skilled and experienced staff to meet the needs of patients care and treatment.
Actions taken Trust wide in Quarter 1 (April, May & June)	
Community CYPS	The North Cumbria Locality has medical vacancies within the CAMHS team, the locality has embedded new roles such as nurse prescribers to support the functioning of the team. The service can demonstrate minimal waits to treatment.
Adult acute wards	The North Cumbria Locality can demonstrate a robust approach to ward shift staffing and reporting of breaches. It is acknowledged there is a shortage of substantive staff for all shift, however the ward can evidence how these shifts are covered by a mix of overtime, bank and agency. The ward is able to clearly articulate how many breaches against it set staffing and can demonstrate ward to board reporting.
MH crisis teams	The North Cumbria Locality has provided evidence of the completion and implementation of a standard operating process of the staffing of the place of safety at Carlton Clinic and Yewdale. In addition, the night co-ordinator role has been implemented. There is evidence that the SOP has been agreed at CBU and Group level.
LD & Autism wards	The North Cumbria Locality has provided multiple sources of evidence regarding activities across all inpatient wards. There is evidence of events

	and timetables that are appropriate for the ward type/environment. There is evidence of patient facing information and displays of the events. There is evidence of continuous improvements at a team level via action planning.
Actions taken at core service in Quarter 1 (April, May & June)	
As per Trust-wide response.	
Actions taken Trust wide in Quarter 2 (July, August & September)	
Community CYPS	The North Cumbria Locality have adopted identical systems and processes for all CYP services including those linked to children learning disabilities and ADHD assessment service. The Locality now also monitors the wait to 3rd appointment, which gives additional insight into the CAMHS pathway waits. The locality will continue with the Central Values Based Recruitment for both community and adult services and continue with ongoing recruitment. Currently reviewing the possibly of further nurse consultant appointments e.g. liaison and crisis. From a medical perspective we will be settling in our international medical recruits. Rowanwood has attracted a new psychiatrist subject to background checks and working notice period.
Adult acute wards	
MH crisis teams	No further action required.
LD & Autism wards	No further action required.
Evidence of Impact:	
Reduction in CYPS waiting times Vacancy levels	
Status:	
Community CYPS	Closed by Board of Directors on 4 November 2020.
Adult acute wards	Closed by Board of Directors on 4 November 2020.
MH crisis teams	Closed by Board of Directors on 5 August 2020.
LD & Autism wards	Closed by Board of Directors on 5 August 2020.

Must Do Theme: (13) Governance	Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance
Planned timescale for closure: 30 September 2020	
Trust-wide Year: 2019 Org: CPFT	The trust must ensure it reviews and improves its governance systems at a service level to ensure they effectively assess, monitor and improve care and treatment.
MH crisis teams Year: 2019 Org: CPFT	The trust must ensure that systems and processes are established and operating effectively to assess monitor and improve the quality and safety of services.
Actions taken Trust-wide during Quarter 1 (April, May & June):	
Trust-wide	Following the CQC inspection there were identified weakness in the approach to governance within the CPFT model. Following the transfer of services, the North Cumbria Locality adopts and implements fully the governance structures within CNTW.
MH crisis teams	North Cumbria Locality adopted the governance arrangements of CNTW from 1 October 2019.
Actions taken at core service level during Quarter 1 (April, May & June):	
Trust-wide	As per Trust-wide response.
Actions undertaken Trust-wide during Quarter 2 (July, August & September):	
Trust-wide	No further action required.
MH crisis teams	The North Cumbria Access and Community CBU can now demonstrate that Crisis teams have named representative at the CBU meetings. The CBU meeting follows a repeating pattern each month, the agenda cover operational, patient involvement, quality and service sustainability. These agenda have been imported from other localities and the meetings are support by the latest information from trust dashboards The CBU has provided the latest agendas as evidence.
Evidence of Impact:	
Trust-wide governance structures. Agreed terms of reference and policies in place.	
Status:	
Trust-wide	Closed by Board of Directors on 5 August 2020.
MH crisis teams	Closed by Board of Directors on 4 November 2020.

Must Do Theme: (17) Bed Management	Lead: Andy Airey, Group Director
Adult acute wards Year: 2019 Org: CPFT	The trust must continue to look at ways of reducing out of area placements and the management of bed availability to ensure this meets the needs of people requiring the service.
Actions taken Trust wide in Quarter 1 (April, May & June)	
Implemented new process and policy which has led to positive feedback from North Cumbria CCG regarding the reduction in out of area placements as a result of the introduction of a new bed management function and policy.	
Actions taken at core Service in Quarter 1 (April, May & June)	
As per Trust-wide response.	
Planned future Actions:	
No further action required.	
Evidence of Impact:	
The number of OAP days during Quarter 3 has increased from 128 in Quarter 2 to 161 in Quarter 3. OAP days have increased in the following localities: • Newcastle Gateshead – 36 (Quarter 2), 48 (Quarter 3) • Northumberland – 29 (Quarter 2), 59 (Quarter 3) • Sunderland – 0 (Quarter 2), 16 (Quarter 3)	
Status:	
Closed at Board of Directors on 5 August 2020.	

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	**Consultation on CQC's Strategy for 2021 and beyond**
Report author(s)	**Vicky Grieves, CQC Compliance Officer**
Executive Lead (if different from above)	**Lisa Quinn, Executive Director of 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	01/02/21
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	X	Environmental	X
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
SA5.1 That we do not meet and maintain our compliance standards including NHSI, CQC and legislation
SA5.2 That we do not meet statutory and legal requirements in relation to Mental Health Legislation

Consultation on CQC's Strategy for 2021 and beyond

Board of Directors

3rd February 2021

1. Executive Summary

The Care Quality Commissioning (CQC) is approaching the completion of its 2016-2021 strategy and has recently launched their consultation for their strategy for 2021 and beyond. In the document, CQC sets out how it plans to develop its approach in line with a changing health and care landscape taking into account the context and learning from COVID-19, the development of system working and greater use of digital technologies. CQC has identified a need to transform and ensure its regulatory model is relevant and fit for purpose in an evolving system.

The strategy identifies four key areas of focus, which set out how CQC plans to change its approach to regulation. Throughout the four themes, a common thread focuses on their ambition to understand how health and care systems are working together to reduce inequalities. See Appendix 2 for the full strategy document.

2. Findings

A brief outline on each of the four key areas of focus is provided below:

People and communities

- They identify a need to improve their capacity and capability to get the most out of feedback, by identifying more and better ways of gathering experiences, and changing the way they record feedback so it can be used to quickly identify changes in quality of care.

- The draft strategy stated that it would not be possible to achieve a rating of good or outstanding without evidence of best practice in encouraging and enabling people to speak up, and acting upon it. This has been amended to a commitment to improve the way CQC assesses how services encourage and enable people to speak up and how they act on it – however the strategy states that it will not be acceptable for providers not to be doing this.

- Providing a clearer definition of what good and outstanding care looks like, based on what people say matters to them, which is accessible to everybody and underpins CQC's assessments of services, and these definitions will be easy to understand and access. They will change the outputs they produce and how information is provided so that it is more relevant, up to date and meaningful for people using services.

Smarter regulation

- While acknowledging that site visits are a vital part of performance assessments and essential in some settings to observe the care people receive, CQC will aim to take a more dynamic approach to regulation, moving away from relying on a set schedule of inspections to a more flexible approach using all regulatory methods, tools and techniques to assess quality continuously.

- Continuing to use inspections when appropriate, in response to risk, when specific information is needed, to observe care, and as part of checks on the reliability of their view of quality.

- They will use the best information they can get to keep ratings and information about quality up to date, rather than relying on the outcome of periodic all-inclusive inspections. This includes a better understanding of people's feedback and experiences, coupled with a combination of targeted inspections, national and local data from other organisations, insight from their relationships with providers and partners, and providers' own self-assurance and accreditation.

- The strategy describes how a combination of IT systems that can handle large amounts of data, artificial intelligence and innovative data analysis methods will enable CQC to be alert and ready to act quickly in a targeted way where needed.

Safety through learning

- Assessments of safety will have a sharper focus on checking for open and honest cultures, with learning and improvement at their core.

- Looking for processes to show that leaders and staff are committed to involving people in their own safety throughout their health and care journey, and checking that people have the information they need to help them be equal partners in their care and play a part in their own safety.

- Increasing their safety expertise and expecting services to do the same, using training and insight to ensure staff are familiar with the most up-to-date safety concepts, and how system design can influence safety practice. They will challenge and highlight provider and system failures, and support services to learn and improve.

- Seeking to understand where there is a lack of support and expertise for safety, and work with others to develop solutions to ensure all services have support and leadership during difficult times and the right tools to provide safe care. They will use insight and independent voice to promote a conversation about safety across the health and care sector.

Accelerating improvement

- Establishing and facilitating national sector-wide improvement coalitions with a broad spectrum of partners within health and care, including those representing people who use services, which would work collaboratively to improve the availability of support for improvement.

- Developing collaborative relationships with providers to help them find their own route to improvement, pointing them to sources of guidance, best practice and other organisations, rather than 'telling them what to do', enabling CQC to support services without compromising their core regulatory role.

- Being proactive in understanding changes on the horizon and working with health and care services to develop ways of regulating innovations and new technology effectively, including mitigating risks of technology creating or exacerbating inequalities in care.

The strategy also describes how they will seek to ensure services in local areas are working together to improve outcomes:

- As well as assessing individual services, CQC will look at how services work with each other and in partnership with communities, to make improvements, including how effectively they involve people in designing and improving services, how they embed equality, diversity and inclusion, and corporate social responsibility in everything they do to benefit local health and wellbeing, society, the economy and the environment.

- CQC will hold local care systems to account for the quality of care in their area, and call out issues in services and systems as well as highlighting good practice. Likewise, CQC will consider it 'unacceptable for providers not to work as part of the system.'

- As part of their approach to regulating services, they will look at how they work with other services in the system, and with local people and communities, as part of their improvement.

The CQC would like views on their proposals for their future regulation as they implement their five year strategy. The consultation period closes on 4th March 2021. See appendix 1 for consultation questions.

3. Recommendations

The Board are asked to note the document and consider questions.

Lisa Quinn
Executive Director of Commissioning and Quality Assurance
25 January 2021

People and communities

1a. To what extent do you support the ambitions set out in this theme?
1b. Please give more details to explain why you chose this answer.

Smarter regulation

2a. To what extent do you support the ambitions set out in this theme?
2b. Please give more details to explain why you chose this answer.

Safety through learning

3a. To what extent do you support the ambitions set out in this theme?
3b. Please give more details to explain why you chose this answer.

Accelerating improvement

4a. To what extent do you support the ambitions set out in this theme?
4b. Please give more details to explain why you chose this answer.

Core ambitions

In each of the four themes in this strategy, we have an ambition to improve people's care by:

- Assessing how well health and care services work as a local system.
- Looking at how services and local systems are acting to reduce inequalities.

5a. To what extent do you support our ambition to assess health and care systems?
5b. Please give more details to explain why you chose this answer.

6a To what extent do you think the ambitions in the strategy will help to tackle inequalities?
6b. Please give more details to explain why you chose this answer.

Measuring the impact on equality

7. We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our draft equality impact assessment. For example, you can tell us your thoughts on:

Whether the ambitions in the strategy will have an impact on some groups of people more than others, such as people with a protected equality characteristic.

Whether any impact would be positive or negative.

How we could reduce or remove any negative impacts.

Care Quality Commission

The world of health and social care is changing.

So are we.

We want to hear what you think of our new strategy.

We'll change how we regulate to improve care for everyone

We were established as an independent regulator with a clear purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve.

We'll always be committed to this purpose, it's as vital as ever. But the world in which we regulate has changed significantly since we were created. The COVID-19 pandemic has accelerated that change: new and innovative types of service started up using digital channels, and new restrictions have changed how services can deliver care.

In this new world, we must also transform. We need to make changes to the way we regulate so that it's more relevant and has positive outcomes for everyone, as people's expectations of care have changed. We need to be more flexible to manage risk and uncertainty. We've learned a lot from our response to the pandemic, and we're using this to put us in a better place for the future and support services to keep people safe.

We have a responsibility to change people's lives for the better.

As people get older, they often have multiple, long-term conditions. Delivering care is increasingly complex. The organisation of health and social care services is evolving rapidly, and many are working in partnership across different sectors. The crisis has emphasised just how vital this is. It's now more important than ever for health and care services to work together as a system to deliver care – to meet the needs of the local population and of each individual person.

But the approach of delivering care as a 'system' is very different to the 'single provider service model' that CQC was set up to oversee in 2009.

> **It's not enough to look at how one service operates in isolation.**

It's essential that people who use services, those who work in them, and health and care organisations work together as a system to design and deliver care. It's **how** services work together that has a real impact on people's outcomes. We need to adapt to this. Our assessment of people's care must look at every stage of their journey through the health and care system, looking at both individual services and across different providers and organisations.

The way people receive care has also changed – powered and supported through new technology. The growth of artificial intelligence, advances in data analytics and the increase in mobile communication all point to a future of care built on a dynamic partnership between health and care services and the people who use them. We need to understand where digital services can meet people's needs and improve their outcomes – and change the way we regulate them.

> **The pandemic has renewed the focus on inequalities in health and care.**

We've seen inequalities across different areas of the country and different groups of people. Reducing inequalities in people's outcomes is a fundamental part of our new strategy. We want everybody to have access to safer and better-quality care and we will champion this in everything we do. We want to understand why there's such variation across the country in how people get the care they need, so we can help to tackle it.

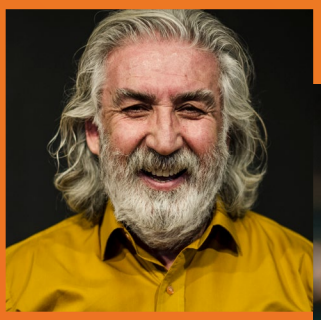
We're committed to reducing inequalities, eliminating discrimination, advancing equality, and protecting human rights. We want our new strategy to help health and social care providers and systems to do this.

Our strategy is built on four themes that together determine the changes we want to make. Running through each theme is our ambition to improve people's care by looking at how well health and care systems are working and how they're acting to reduce inequalities.

Our aim is to implement our new strategy over the next five years. To enable us to be as flexible as possible and adapt to changes in health and care, we'll review it when we need to.








People and communities

We want to be an advocate for change, with our regulation driven by people's needs and their experiences of health and care services, rather than how providers want to deliver them.

This means focusing on what matters to the public, and to local communities, when they access, use and move between services. Working in partnership, we have an opportunity to help build care around the person: we want to regulate to make that happen.

Listening and acting

People need to clearly understand how their voice can make a difference to the safety and quality of the services they use. We'll transform how we encourage and enable people to share their experiences of care with us in a way that works for them. We'll transform how we capture, use and analyse people's feedback. We want to build trust with the public and motivate people to share their experiences by showing how we've acted on what they told us.

- We'll enable people to give feedback in different ways that work for them – whether that's giving information to us directly, or speaking with our Experts by Experience, our inspectors, Mental Health Act Reviewers, Local Healthwatch or our local voluntary and advocacy partners. We'll also make it easier for people to give feedback using digital channels.

- We'll develop the skills and tools that we need to enable all people to share their experiences. But we'll have a specific focus on people who are the most disadvantaged in our society, have had distressing or traumatic experiences, and are more likely to experience poor outcomes and inequalities. This includes people with a learning disability, people with communication needs, people living in poverty, those whose voices are seldom heard, those who are detained under the Mental Health Act, and those who are at risk of abuse or other human rights breaches.

- A priority will be improving our capacity and capability to get the most out of feedback. We'll identify more and better ways to gather experiences from a wider range of people. We'll change the way we record and analyse people's feedback, so it's easier for us to quickly identify changes in the quality of care – both good and bad. This means building systems that enable us to track and prioritise people's experiences throughout our regulatory and other processes. We'll be clear about the value and weight we give to quantitative and qualitative information when using it with other evidence. This includes the stories that people tell us about their experiences of services and pathways of care.

People and communities want us to act on their feedback and understand how we've acted on it – and we want people to know how much we value their feedback.

- When we publish information about quality, we'll be clearer about how we've used people's experiences, and the action that we and others have taken as a result.

- When people take the time to share their experiences with us we'll provide a response to them that clearly explains how we've acted on what they tell us and how it has informed our view of how a service is performing. We'll provide our response in the way people need it.

We know that people are often afraid to speak up. We want to help build a new understanding among the public, health and care providers, and our partners, that welcomes, values and acts on feedback to improve care for all.

- We'll improve the way we assess how services encourage and enable people who use their services to speak up, and how they act on this feedback. It will be unacceptable if providers are not doing this. We'll also focus on this when we look at how local systems are listening to their local communities so they can improve access to services that meet people's needs.

People are empowered

To help empower people to drive change, it's important for them to know who we are and understand what we do. We want to put people at the centre of all conversations about the quality of care they receive. Having an agreed and shared view of quality will enable a joined-up approach that's applied to individual services, corporate providers, and across system boundaries in both health and social care. It will empower people to have more control in their care and encourage services to improve.

- We'll proactively raise public awareness of CQC and be clear about our role as a regulator. We'll invest in the most effective ways to do this within different population groups.

- We'll be clear what standards people can expect from their health and care services, and how their feedback can drive change. To do this, we'll provide a clearer definition of what good and outstanding care looks like, based on what people say matters to them. Everybody will be able to easily access, understand, and use these definitions. We'll use them as the basis for assessing services and the information that we collect as evidence.

We'll encourage people to use our information in ways that are relevant to their lives. Our up-to-date view of the quality of care in a service will help people and their families make informed decisions when they are choosing where to go for their care. This means they can be confident in the knowledge that our information reflects the quality of care that they can expect, on the day they receive it.

Providing independent, trusted and high-quality information about the quality of care is a fundamental part of our work.

We'll change how we provide information so that it's more relevant, up to date, and meaningful for people who use services, and reflects their experiences. We'll ensure people have access to information in the way they need it, through improved communication channels, and using clear and accessible language.

Prioritising people and communities

We know care is better when it's developed through the eyes of people who use services and delivered in partnership with them. We think the same of regulation. We want to regulate to drive more personalised and coordinated care.

We'll work closely with people who use services and those that represent them to understand their needs, and to co-design and develop how we work and the services we provide to the public. Any changes we make will start with understanding what people expect and need from care services and pathways, and from CQC. We want to involve people in a meaningful way, so we'll encourage and enable people to do this in ways that work for them.

Local health and care services and commissioners need to understand the diverse needs of their populations. They need to work together as a system to meet these needs and improve health and wellbeing. We need to ensure that services in local areas are working with other parts of their community to enable better outcomes and reduce inequalities.

When we assess services, we'll look at how they work with each other, and in partnership with communities, to make improvements. We'll look at how effectively they involve people in designing and improving services. We'll look at how they embed equality, diversity and inclusion, and corporate social responsibility in everything they do to benefit local health and wellbeing, society, the economy, and the environment.

- As well as assessing individual services, we'll assess how they work together as a system in an area. It will be unacceptable for services not to be working in this way. We'll focus on how well systems perform against the things that matter to people and communities and the outcomes for people in that community – important things such as being able to move easily between different services.

- We'll hold local care systems to account for the quality of care in their area and clearly call out issues when we see them. At the same time we'll highlight good practice.

We will identify and call out unwarranted variation and inequalities in health and care. We know that a person's health and wellbeing is significantly affected by factors outside health and care services.

- We'll support local systems to understand the needs of their local populations, especially those that face the most barriers to accessing good care or those with the poorest outcomes, enabling them to respond positively to inequalities.

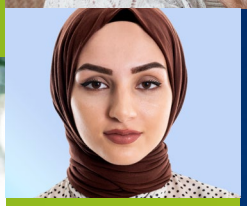
- We'll work with other agencies, voluntary and community organisations, system partners and other regulators to develop a shared understanding of the factors that contribute to inequalities, and the levers that we and they can use to tackle them.

What do you think?

1a. To what extent do you support the ambitions set out in this theme?

1b. Please give more details to explain why you chose this answer.



Smarter regulation

We will be smarter in how we regulate. We'll keep pace with changes in health and care, providing up-to-date, high-quality information and ratings for the public, providers and all our partners.

We'll regulate in a more dynamic and flexible way so that we can adapt to the future changes that we can anticipate – as well as those we can't. Smarter use of data means we'll target our resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure we're an effective, proportionate and efficient regulator.

Targeted and dynamic

We now have a baseline understanding of quality across health and social care. We know that the quality of care can vary from day to day. We want to provide a more consistent, up-to-date, and accurate picture of quality; using the best information will help us to keep people safe and to protect, respect and uphold people's human rights.

- We'll have a more dynamic approach to regulation. Inspections are not the only way to assess quality: we want to move away from relying on a set schedule of inspections to a more flexible, targeted approach. Site visits are a vital part of performance assessments and essential in some settings to observe the care people receive. But we want to use all our regulatory methods, tools, and techniques to assess quality continuously, rather than relying only on scheduled all-inclusive on-site inspection visits. We want our local teams to have a regular view of the services they manage, based on their continuous knowledge and not on a particular date in the calendar.

- We'll use our powers to visit services when we need to respond to risk, when we need specific information, when we need to observe care, and when sampling to check that our view of quality is reliable.

We want everyone we work with to benefit from our regulation. The way we regulate will become more relevant – using what we know to help services to tackle problems early and providing up-to-date, high-quality information and ratings.

- We'll use the best information we can get about a service to keep ratings and our information about quality up-to-date, rather than relying on the outcome of periodic all-inclusive inspections to change them. This includes a better understanding of people's feedback and experiences of care. We'll use this alongside a combination of targeted inspections, national and local data from other organisations and partners, insight from our relationships with providers and partners, providers' own self-assurance, and accreditation.

- We'll change our assessments to be more dynamic, and update ratings more often, so that everybody will have an up-to-date view of quality.

We now have IT systems that can handle large amounts of data, which will enable us to use artificial intelligence and innovative analysis methods. This replaces more manual handling of data and will ensure we interpret data in a more consistent way.

- We'll use our regulatory powers in a smarter, more proportionate way so we take the right action at the right time. Based on the best information available, and enabled by technology, we'll be proactive in using innovative analysis, including data science techniques, to support robust and proportionate decision-making. Combined with the experience, knowledge, and professional judgement of our inspectors, this means we'll be alert and ready to act quickly in a more targeted way and tailor our regulation to individual services and circumstances.

- We'll share the data and information we hold on services with voluntary and other organisations where it will help them in their own work to improve people's care.

Making it easier to work with us

We all have a common drive to improve people's care. From the point of registration, we want to develop ongoing, collaborative relationships with services, built on openness and trust. We want this to enable effective and proportionate regulation so we can focus our regulatory work where quality needs to improve. Digital channels will make it easier for services to work with us and other partners. Our aim is to gather information differently and reduce the duplication of requests by developing how we work with others. This will help staff to focus on providing care safely and finding opportunities to improve.

- We'll work with providers and other regulators and partners to coordinate data collections. To reduce the duplication and workload for providers in collecting and submitting data to us, and to other organisations, we'll only ask for the information we need and that we can't get elsewhere. We'll use information from other sources and share the information we gather ourselves through data-sharing agreements. We'll collect data once and use it many times.

- We want to explore how we can improve our digital interfaces with services. Where we do need to collect information directly, this will make it easier for services to give us the information we need and simpler to update what they've already told us. We'll also make it easier for services to access more of the information we hold about them by having it in one place.

- Being smarter with data will enable our regulation to be more proportionate and consistent. We'll have regular contact with services through our ongoing relationships, and spend more time monitoring and analysing data using technology. This means our visits will be more targeted and effective, with a sharper focus on what we need to look at. So, rather than spending time looking at paperwork when we're on site, we'll have better conversations with people who use services and care staff, and we'll have more time to observe how a service is delivering care.

Future proof and focused on what matters most

Like the services we regulate, we're evolving to adapt to changing models of care, such as integrated systems and digitally-enabled care. The move to looking at how services work together in a local system is a change in our approach; we think this is a smarter way to regulate. We'll work with providers and partners to understand how care is changing, ensuring that our regulatory model keeps pace with changes.

- The way we register services will allow us to make organisations more accountable for people's care. We'll expand our definition of what we consider to be a provider of care and what it means to carry on a regulated activity. This will make sure that we register all the parts of an organisation that are responsible for directing or controlling care; importantly, this will make sure they can be held accountable.

- We'll look at how services meet their social and ethical responsibilities, such as environmental sustainability.

- Our assessments will always focus on what matters to people as they access, use, and move between services. We'll also look more closely at aspects that we know have a positive effect on quality such as the culture of a service, how it works with other services in a local system, and how it drives improvement.

- We'll focus our assessments on how providers are working together to ensure fair access to health and care services for everyone. The information we gather will enable us to better understand risk relating to inequalities in people's health outcomes and we'll take action where we see a need for improvement.

- We'll add to our existing knowledge and experience, and build capability and capacity in our people, our systems, and our processes. We want to learn and improve to be a flexible and responsive regulator, while staying true to our purpose.

Relevant for all

We want our ratings and information to help people to make informed choices about their care, and to give services an assessment of their performance to encourage them to improve.

- We'll evolve our ratings. As well as ensuring they provide an up-to-date view on quality, we want to make ratings reflect how people experience care so they're more meaningful and focus on what matters most to them.

- We'll move away from long reports written after inspections, and instead provide information and data targeted to an audience. Information for the public will be easier to understand and more accessible. We want people to be able to get information in ways that suit them.

- We'll regulate in a smarter way by providing a clearer definition of quality and the standards people can expect, which is based on what people say matters to them. Everybody will be able to understand and use it as a reference for what good and poor care looks like. We'll explain clearly how we use this to assess the quality of services and the information that we collect as evidence. This definition will be at the heart of our regulatory processes and will help us improve consistency in what we do, so people can be confident that good means good wherever they are in the country and whichever service they are using.

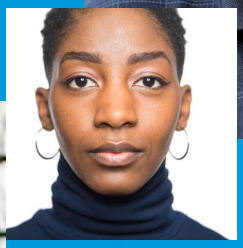
What do you think?

2a. To what extent do you support the ambitions set out in this theme?

2b. Please give more details to explain why you chose this answer.








Safety through learning

We want all services to have stronger safety and learning cultures. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern for us as it's consistently the poorest area of performance in our assessments.

It's time to prioritise safety: creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences, and taking clear and proactive action when safety doesn't improve.

The importance of culture

We know that the right organisational culture is crucial to safety. A strong safety culture needs everyone working in health and care and people who use services to play their part. In a strong safety culture, risks aren't overlooked, ignored, or hidden – and staff can report concerns openly and honestly, confident that they won't be blamed. In this type of culture, it's accepted that all incidents – positive, negative, and wholly avoidable – provide opportunities to learn and improve. We want this approach to be universal with leaders, staff and people using services all involved. Safety must be a top priority for all – regardless of seniority or role.

- There's no national agreement on what we mean by safety in different health and care sectors and services. We'll work with others to agree and establish a definition and language that explains what we mean by safe care and how this could apply in different services. This will create a better understanding of risk across all health and care – so that we know what's not acceptable – and therefore help to minimise harm. More clarity will enable services to prioritise the essentials and have clearer expectations when we assess them. When we talk about safety we'll make sure it reflects what's most important to people when they use services.

- Our assessments of safety will have a sharper focus on checking for open and honest cultures. We'll be looking for cultures that have learning and improvement at their core.

- We can do more to help services improve safety by sharing the insights, learning, and exemplary practices that we've identified. We'll use our independent voice to highlight the changes and improvement that services have made as a direct result of our regulatory action. We'll highlight trends and patterns across health and care so that services have the information they need to improve.

Building expertise

Knowledge is crucial to having the right safety cultures, but there are different levels of knowledge and expertise in different types of service and sectors. Shifts in safety culture won't happen without the right expertise at all levels across health and social care – including at CQC. Changing a safety culture also needs good leadership to make it happen. We all need to understand why safety is important at a practical level and how we can each individually improve it in our area of work, and to create an excitement and movement around it that motivates people every day to improve.

- When we assess services, we'll be looking at the type and levels of expertise in services. We'll check how they assure themselves that they have the right balance, and how they are investing in improving safety, including training, support and how they use data.

- We'll improve and increase our own safety expertise to ensure our approach is in line with the latest safety thinking – whether from health and care in England, from elsewhere, or from other industries and sectors. Together with our unique data and insight, this will enable us to challenge and highlight failures in services and in systems.

Involving everybody

People have a right to expect safe health and care services. We think that making sure people experience the safest care is everyone's job. To do this, leaders, their staff, and the people using their services all need to be involved. People should influence the planning and prioritisation of safety and be truly involved as equal partners in their care at all levels. This means that services need to actively take into account people's rights and their unique perspectives on what matters to them in the way they choose to live their lives and manage risk. This collaborative approach has the potential to transform safety and to ensure that people's human rights are upheld.

- In our assessments we'll look for processes to show that leaders and staff are committed to involving people in their own safety throughout their health and care journey, and the impact this has on their outcomes. We'll check that people have the information they need to help them be equal partners in their care and play a part in their own safety.

Regulating safety

We know that some of the greatest safety risks – both physical and psychological – happen when people struggle to access the right care, when they're transferred between services or after they're discharged. We also know that some services are more likely to have greater safety risks than others. Sometimes the care system works against health and care staff, making it hard to take the right and safest action.

With new ways of delivering care and more services working as part of a local system, we will change how we regulate safety in all services.

We'll focus more on the types of care setting where there's a greater risk of a poor culture going undetected. We'll develop ways to understand what's happening in these services as, we know that people are often unable to speak up for themselves, and more likely to be failed by a poor culture.

- Learning and improvement must be the primary response to all safety concerns in all types of service. Where we have concerns, we will directly make services respond and show us – and the people who use their service – what action they'll take to show they are learning and improving. We'll share this information with the public as part of our up-to-date view of quality.

- We'll review how effectively we are assessing and monitoring safety – from registration through to enforcement. We'll use our improved safety expertise to assure ourselves that we're taking the right approach. As part of this, we'll review how we gather data to ensure greater consistency across sectors regardless of who is responsible for reporting or receiving the information.

- Where we identify risks to people using a service, we'll intervene more quickly. If we have evidence of risks, including what people are telling us, we'll take action earlier to make sure that services are focusing on protecting people before they experience poor care and avoidable harm. This includes protecting people's human rights. To do this, we'll make better use of people's feedback on services. Key to this will be having the best comparable data and ensuring we are sharing it with our partners.

- Services that are not open to learning can't be safe. We'll use our powers and act quickly where improvement takes too long, or where change isn't sustainable. We'll take action where services are unable to identify systemic issues in their own organisational culture or fail to learn lessons from widely publicised failures happening across health and care.

- We'll check how well services work together – those that are truly focused on safety will be determined to ensure a safe journey of care for people moving between services.

- Where we see systemic safety issues in a local area, we'll speak out to encourage meaningful change. We'll share the learning from our insight on themes, trends, and best practice to help services and systems improve their safety. We'll also share our data and information about safety in health and care systems with regional organisations, to support their oversight of safety in a local area.

Consistent oversight and support

To improve safety, service providers may need support and guidance. In some sectors, there's a national team of experts who provide guidance and alerts about safety. But this type of national support and oversight doesn't exist in all sectors. Although there are bodies who might provide support or receive data about safety incidents, this oversight or champion role isn't joined up, meaning these sectors risk being left behind. It's crucial that all health and care services have consistent access to the right support and insight to help them on their journey to build strong safety cultures, learn from safety incidents, and improve their practice.

- We want to understand where there is a lack of support and expertise for safety. We'll work with others to develop solutions to ensure that all services have support and leadership during difficult times, and that they have the right tools to always provide safe care. We'll need to understand where this oversight is best placed and develop the right frameworks as needed.

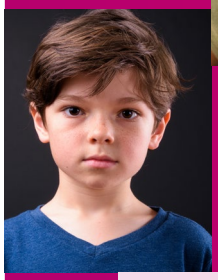
- We'll use our insight and independent voice to promote a national conversation on safety across health and care sectors and systems. We can use this to drive improvements in safety cultures and reduce harm.

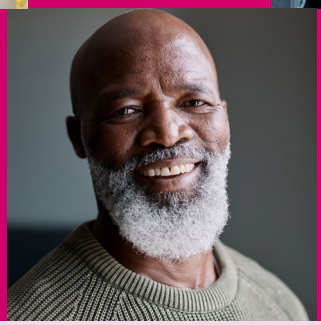
What do you think?

3a. To what extent do you support the ambitions set out in this theme?

3b. Please give more details to explain why you chose this answer.





Accelerating improvement

We will do more with what we know to drive improvements across individual services and systems of care. We'll use our unique position to spotlight the priority areas that need to improve and enable access to support where it's needed most.

We want to empower services to help themselves, while retaining our strong regulatory role. The key to this is by collaborating and strengthening our relationships with services, the people who use them, and our partners across health and care.

Collaborating for improvement

We want to see improvement within individual services, and in the way that they work together to make sure people get the care they need. Services and local areas that want to improve should get the support they need to make this happen.

Where individual services or a local health and care system need to improve, it's essential to get this right for the people who use and rely on them. This is important so that improvement happens in ways that people can recognise: easier movement between services and pathways of care, equal access to the most appropriate services at the right time, reduced inequalities, fewer avoidable mistakes, and better experiences and outcomes – all delivered by a diverse workforce that is thriving.

The support that's available to help services improve the quality of their care varies between and within health and care sectors and across England. Some services have limited access to support; we want all sectors to have equal and consistent access to the support they need to improve. We want to play a much more active leadership role in driving improvement, advocating for the issues that matter to people who use services.

- We want to establish and facilitate national sector-wide improvement coalitions with a broad spectrum of partners within both health and care, including those representing people who use services. These coalitions would work collaboratively to improve the availability of support, focusing on areas where there are gaps, both nationally and at a local system level. We'll champion consistent access to direct, tailored, hands-on support for all providers who need it.

- We'll encourage our national partners to offer support to local systems to help them improve. We'll also strengthen our ongoing relationships at a local level to promote collaboration on improvement across areas, working with partners from the relevant improvement coalitions. The aim is to ensure all parts of a local system are focused on improvement, including addressing health inequalities.

Making improvement happen

As health and care evolves, what was considered good a few years ago isn't good enough today; what is good today won't be good enough in the near future. People have higher expectations about safe, high-quality care – and so do we.

We'll do more to make improvement happen, taking action in priority areas that need support the most. We will hold improvement conversations with services and offer a range of resources to support them.

- We want to encourage continuous improvement in quality. We'll be clearer on the standards that we, and people who use health and care services, expect. We'll set a higher bar for what we expect of services rated as good, which should match what the public expects. As part of this, we'll expect services to keep on improving so that they remain good. We'll also expect services to contribute to improvement in their local health and care system.

- We'll identify the areas that need to improve as a priority – both at a local and national level. We'll work with partners to make change happen through programmes of activity based on evidence of what works. This will include using our independent voice to share good practice and examples of the factors that drive improvement, and the findings from our in-depth reviews. We'll prompt action through events and workshops, and by publishing guidance, tools, and frameworks that support improvement.

- We'll develop collaborative relationships with services, helping them to find their own route to improvement by pointing them to sources of guidance, best practice, and other providers and organisations that can offer advice and support. We'll hold improvement conversations with services to support them to decide for themselves the best way forward rather than 'telling them what to do'. This will enable us to help services who want to improve, while retaining our core regulatory role, which means using our powers to act where we see poor care.

- We'll empower providers and local systems to improve themselves by offering analysis and benchmarking data. This will enable them to self-assess how they're performing against similar services and areas, so they can use this to target improvements themselves. Our benchmarking information will also show us where we need to focus our work to drive improvement.

Encouraging innovation

Innovative practice and technological change present an opportunity for rapid improvement in health and care, but services don't always understand it or implement it well. Our regulation will keep pace with these changes and promote innovation that will improve people's care.

- We'll make sure we understand changes being developed to the way services deliver care. We'll then work with health and care services and

other stakeholders to understand how these can improve the quality of people's care. When we do this, we'll consider where using new technology might disadvantage some people and what services need to do so that nobody is left behind.

- We'll work in partnership with services and other stakeholders to develop a coordinated, effective, and proportionate approach to regulating new innovations and technology. We will encourage and champion innovation and technology-enabled services where they benefit people and where the innovation results in more effective and efficient services. We know the path to innovation is difficult; we want to use what we know as a regulator to create an environment where services can try new ways to deliver safe, high-quality care. We'll aim to support their efforts to innovate through clear advice and guidance.

An approach based on evidence

We have valuable knowledge and insight about improvement – we want to use this to inform our regulatory approach. Through all our work, we want to promote an improvement culture across health and social care.

This activity will be based on evidence about what really works.

- Through our assessments of services and local systems, and across all our work, we'll identify and investigate the things that are most important to ensuring good quality of care. We'll use the evidence we collect to support improvement.

- We'll invest in research and make better use of external evidence to have a better understanding of the conditions that drive quality improvement, including evidence and best practice from other industries.

- We'll use the best available evidence to inform our approach to regulation. We'll further develop and embed a culture of learning in CQC to maximise our impact on the quality of care and people's outcomes.

What do you think?

4a. To what extent do you support the ambitions set out in this theme?

4b. Please give more details to explain why you chose this answer.

Our core ambitions

In each of the four themes in this strategy, we have an ambition to improve people's care by:

- assessing how well health and care services work as a local system
- looking at how services and local systems are acting to reduce inequalities.

5a. To what extent do you support our ambition to assess health and care systems?

5b. Please give more details to explain why you chose this answer.

6a. To what extent do you think the ambitions in the strategy will help to tackle inequalities?

6b. Please give more details to explain why you chose this answer.

Measuring the impact on equality

We need to consider equality and human rights in all our work, so we've produced a draft equality and human rights impact assessment. It identifies the opportunities and risks for doing this through our new strategy. Importantly, it identifies the actions we'll take to minimise the risks and make positive change happen.

7. We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our draft equality impact assessment. For example, you can tell us your thoughts on:

- Whether the ambitions in the strategy will have an impact on some groups of people more than others, such as people with a protected equality characteristic.
- Whether any impact would be positive or negative.
- How we could reduce or remove any negative impacts.

How to respond to this consultation

Thank you for taking the time to tell us what you think about our proposals for our future regulation. It's important to get your feedback and thoughts so we can make our strategy work for everyone.

Please respond by 5pm on 4 March 2021.
The quickest and easiest way to respond is through our online form:

www.cqc.org.uk/Strategy2021

If you can't use the online form, you can respond by email to:
strategydevelopment@cqc.org.uk

Or you can post your response free of charge to:

Freepost RSLS-ABTH-EUET
Strategy 2021 Consultation
Care Quality Commission
Citygate
Gallowgate
NEWCASTLE UPON TYNE
NE1 4WH

Please contact us if you would like a summary of this document in another language or format.

CQC-468-012021

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	Quarter 3 update - NHS Improvement Single Oversight Framework
Report author(s)	Allan Fairlamb, Head of Commissioning & Quality Assurance Dave Rycroft, Deputy Director of Finance & Business Development
Executive Lead (if different from above)	Lisa Quinn, Executive Director of 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	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	25.01.21
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

Quarterly Report – Oversight of Information Submitted to External Regulators
3rd February 2021

1. Purpose

To provide the Board with an oversight of the information that has been shared with NHS Improvement and other useful information in relation to Board and Governor changes and any adverse press attention for the Trust during Quarter 3 2020-21

2. Background

NHS Improvement using the Single Oversight Framework have assessed the Trust for Quarter 3 of 2020-21 as segment 1 – maximum autonomy.

A summary of the Trust ratings since the start of financial year 2016-17 are set out below:

	Q1 & 2 16-17	Q3 & Q4 16-17	Q1 – Q4 17-18	Q1 –Q4 18-19	Q1 & Q2 19-20	Q3 & Q4 19-20	Q1 – Q3 20-21
Single Oversight Framework Segment	n/a	2	1	1	1	1	1
Use of Resources Rating	n/a	2	1	3	3	2	*2
Continuity of Services Rating	2 (Q1) & 3 (Q2)	n/a	n/a	n/a	n/a	n/a	n/a
Governance Risk Rating	Green	n/a	n/a	n/a	n/a	n/a	n/a

*Please note the Quarter 1 - 3 2020/21 Use of Resources Rating is related to Quarter 4 2019/20 due to suspension of this rating during COVID-19.

3. Key Financial Targets & Issues

A summary of delivery at Month 9 against our high level financial targets and risk ratings, as identified within our financial plan for the current year, and which is reported in our monthly returns is shown in the tables below (Finance returns are submitted to NHSI on a monthly basis):-

	Year to Date		
Key Financial Targets	**Plan**	**Actual**	**Variance/ Rating**
Risk Rating	n/a	n/a	n/a
I&E Surplus/(Deficit)	(£0.2m)	(£0.2m)	£0.0m
FDP - Efficiency Target	n/a	n/a	n/a
Agency Ceiling / Agency Spend	n/a	£11.5m	n/a
Cash	£65.3m	£70.0m	£4.7m
Capital Spend	£14.1m	£9.4m	(£4.7m)
Asset Sales	£0.0m	£0.0m	£0.0m

4. Risk Rating

The interim financial arrangements put in place during COVID-19 have resulted in the suspension of the Use of Resources rating including the requirement for a Board Assurance

statement to be completed if a trust is reporting an adverse change in its forecast out-turn position.

5. Workforce Numbers

The workforce template provides actual staff numbers by staff group. The table below shows a summary of the information provided for Quarter 3 2020-21. Workforce returns are submitted to NHSI on a monthly basis.

SUMMARY STAFF WTE DETAIL	M7	M8	M9
	Actual WTE	Actual WTE	Actual WTE
Total non-medical - clinical substantive staff	4,765	4,779	4,780
Total non-medical - non-clinical substantive staff	1,864	1,876	1,903
Total medical and dental substantive staff	386	407	388
Total WTE substantive staff	**7,015**	**7,062**	**7,071**
Bank staff	330	341	360
Agency staff (including, agency and contract)	328	308	342
Total WTE all staff	**7,673**	**7,711**	**7,773**

6. Agency Information

The Trust has to report to NHS Improvement on a weekly basis, the number of above price cap shifts and also on a monthly basis the top 10 highest paid and longest serving agency staff. However, the reporting of the top 10 highest paid and longest serving agency staff is suspended as part of the COVID-19 interim arrangements.

The table below shows the number of above price cap shifts reported during Quarter 3 2020-21.

	October	November	December
Staff Group	**5/10 – 1/11**	**2/11 – 29/11**	**30/11 – 3/1**
Medical	216	216	237
Nursing	663	773	864
TOTAL	**879**	**989**	**1,101**

At the end of December, the Trust was paying 9 medical staff above price caps (3 consultants, 3 associate specialists, 1 speciality doctor and 2 junior doctors). Two of the consultants are being paid over £100 per hour so are separately reported to NHS Improvement. The weekly average of shifts reported over the cap for December was 47 medical shifts, 108 qualified nursing shifts and 65 unqualified nursing shifts.

7. Governance

There is no longer a requirement to submit a governance return to NHS Improvement; however, there are specific exceptions that the Trust are required to notify NHS Improvement and specific items for information, it is these issues that are included within this report.

7.1 Board of Directors and Council of Governor Changes Q3 2020-2021

Board of Directors:

28th August 2020, Ken Jarrold confirmed his intention to stand for a further term of office as Chairman until 24th May 2023.

Council of Governors:

2 Governors left - 1 Carer Governor and 1 Staff Governor

Outgoing Governors:	Present vacancies
Nil	Carer Governor (Adult Services) Carer Governor (Neuro-disability Services) Service User Governor (Adult Services) Public Governor (Cumbria) Staff Governors (Clinical)

7.2 Never Events

There was one never event reported for North Cumbria during Quarter 3 2020 - 2021 as per the DH guidance document.

8. Other items for consideration

As well as the items noted in the report above the Trust also completes submissions to NHSI for the following data:-

Weekly
- Total number of bank shifts requested/total filled (from October 17)

Monthly
- Care Hours Per Patient Day.
- Estates and Facilities Costs

Annually
- NHSI request information for corporate services national data collection on an annual basis. This data includes information in relation to Finance, HR, IM&T, Payroll, Governance and Risk, Legal and Procurement. This information will be used to update information within Model Hospital on an annual basis.

Carter Review
- Community and Mental Health (Productivity) – Community services
- Corporate Benchmarking – First submission in 16/17.

9. Recommendations

To note the information included within the report.

Allan Fairlamb, Head of Commissioning & Quality Assurance
Dave Rycroft, Deputy Director of Finance & Business Development
January 2021

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	Trust Standing Financial Instructions and Scheme of Delegation and Reservation
Report author(s)	Sarah Jones, Director of Legal & Commercial Services, NTW Solutions Limited
Executive Lead (if different from above)	James Duncan, Deputy Chief Executive & Director of Finance

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	X
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	x
Workforce	x	Environmental	
Financial/value for money	x	Estates and facilities	x
Commercial	x	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

Report Title – Trust Standing Financial Instructions and Scheme of Reservation and Delegation
Trust Board Meeting
3rd February 2021

1. Executive Summary

The purpose of this report is to present the Trust Board the Trust's Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegation.

The SFIs are constitutional document of the Trust which must be reviewed on a regular basis. The previous SFIs were adopted in 2016. It is a requirement that the Trust Board approves any amendment to the SFIs.

The review of the SFIs was led by the Author of this Report at the request of the Deputy Chief Executive and Director of Finance and the Director of Communications & Corporate Affairs and Trust Secretary.

A number of colleagues across the Trust and NTW Solutions Limited were consulted with as part of the review. These included colleagues within Finance, Procurement, Estates & Facilities and Commissioning and Quality Assurance.

The amendments to the SFIs concentrated on the areas of procurement (tendering and contracting) and the governance relating charitable funds. The version of the SFIs attached to this report is a "clean" copy. A tracked changed version which shows each change is available if Board Members would like to review this.

The Scheme of Reservation and Delegation ("the Scheme") is a newly created governance document which merges the content of the documents referred to as the "Schedule of Matters Reserved to the Board" and the Decision Making Framework. The Scheme is referred to throughout the new SFIs.

What has been created is one document that sets out those decisions which the Board has reserved to itself (Part A) and those which it has delegated to individual Executive Officers, management sub-groups and other members of staff (Part B). The document also contains an annex which sets out authorised delegation limits for individuals.

The changes made to the former Schedule of Matters Reserved to the Board within Part A of the Scheme are highlighted in blue text, so that members of the Board can understand the level and type of change. Key changes include the removal of the column that anticipated other authorisations being required, as the Board is the ultimate decision making forum within the Trust; amendments to the column dealing with advice and assurance and the addition of a new column to confirm where the advice or assurance should be documented.

Part B of the Scheme is separated into decisions relating to Finance, Commercial & Estates, Workforce, and Clinical and Operational matters. The focus is on key decisions that have been delegated to either an individual Executive Director or a member of their team or to a management sub-group which has decision making powers through its Terms of Reference. Part B includes details of how the decision is documented.

The Annex to the Scheme sets out the Authorisation Levels that are to apply to officers across the Trust. These have been updated to increase the authorisation level of

Ward/Team managers (to £5k) and to include the Associate Director of Finance and the Technical Director of Trust Innovations.

The Scheme also includes a link at Appendix 1 to the Trust's Governance Structure, which is referred to in the Introduction to the Scheme.

A core group of colleagues has inputted into the creation of this document, including the Deputy Chief Executive and Director of Finance and his Deputy and Associate Director, the Director of Commissioning and Quality Assurance, the Director of Workforce and OD and her Deputy, the Director of Communications and Corporate Affairs, the Deputy Chief Operating Officer and the author.

2. Risks and mitigations associated with the report

This section should outline:

- If the SFIs had not been reviewed and amended it may have created a risk that the Trust would be operating under outdated Instructions that would not cover all situations where Instructions are now required;
- The Schedule of Matters Reserved to the Board and the Decision Making Framework also required a review and an update, so as to more clearly define the governance relating to decision making at the Trust and to how this is to be documented.

3. Recommendation/summary

The Board is requested to

- Consider the revised SFIs and the Scheme of Reservation and Delegation, and if agreed, to approve both documents.

Sarah Jones
Director of Legal & Commercial Finance
NTW Solutions Limited

James Duncan
Deputy Chief Executive and Director of

26 January 2021

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust ("the Trust") – Scheme of Reservation and Delegation

This Scheme of Reservation and Delegation ("the Scheme") is referred to in the Trust's Standing Financial Instructions (SFIs) and it forms part of the Trust's Corporate Governance Manual. The purpose of the Scheme is to summarise in one document the decision making system that applies at the Trust, including matters which are reserved to the Board of Directors (Part A) and those decisions that have been delegated to certain executives, sub-groups or individuals by the Board of Directors (Part B).

The Board of Directors of the Trust has established a number of direct sub-committees, which provide the Board of Directors with Assurance on specific areas of the Trust's business and operations. Decision making on management issues is delegated to the Executive Directors, who manage this through a number of sub-groups. The governance structure of the Trust, both in terms of assurance and management matters is set out in the diagram at Appendix 1 to this document.

The Trust's subsidiary company, NTW Solutions Limited has its own Scheme of Reservation and Delegation, under which certain matters are reserved to the Trust as the sole shareholder.

Part A - Decisions reserved to the Board of Directors

HR Decisions	What assurance from a Sub-Committee and/or advice from an Executive Director or other, should be made available for consideration by the Board before making its decision	How the assurance or advice is to be documented
Approve the basis (e.g. Agenda for Change regulations) for the determination of commencing pay rates, conditions of service, etc. for officers.	Advice of the DoF and the Director of Workforce and OD Assurance of RABAC RemCom for executive pay with advice from CEO and/or DWOD	Minutes of the RABAC and CDT-W
Appoint one of the NEDS to be the Senior Independent Director (in consultation with the Council of Governors) per Monitor's Code of Governance A4.1	Advice of Director of Workforce and OD Governors' Nomination Committee	Minutes of the Board and Governors meetings Any written advice from the DWOD
Finance & Commercial Decisions	**What assurance and/or advice should be made available for consideration by the Board before making its decision**	**How the assurance or advice is to be documented**
Approve annual financial plans (including high level budgets and the capital programme).	DoF RABAC	Minutes of RABAC and any written advice of DoF
Contracts over £6m (total contract value) for supply of goods, works and services to Trust (non-healthcare)	DoF RABAC	Business Case recommending the contract award Minutes of RABAC
Approval of new capital schemes (including acquisitions) above £6m.	DoF RABAC	Business Case Minutes of Board and RABAC

	Significant transactions, i.e. 10% of gross assets before transaction require COG approval NHS E/I significant transaction	
Approval of disposal of a Trust asset with a book or market value above £6m	DoF RABAC	Business case and Minutes of RABAC meetings
Approval of Business Cases with revenue implications above £6m per annum	DoF RABAC	Business Case document Minutes of RABAC meeting
Approval of Tenders for provision of services by the Trust with revenue implications in excess of £6m per annum	DoF RABAC	Business Case Document Minutes of RABAC meeting
Approval of variations to Trust PFI agreements or agreements with NTW Solutions Ltd with revenue implications in excess of £6m per annum, or capital implications in excess of £6m	DoF RABAC	Business Case Minutes of RABAC meeting
Writing off losses and/or approving special payments in excess of £50,000	DoF	Written advice/report of DoF
Clinical and Operational Decisions	**What assurance and/or advice should be made available for consideration by the Board before making its decision**	**How the assurance or advice is to be documented**
Agree Trust Level Performance Standards	To be agreed in conjunction with Groups and Corporate Directors in line with agreed strategic objectives	Minutes of Q&P meetings and evidence of engagement and input

	Advice from the Executive Director of Commissioning and Quality Assurance Assurance from Quality and Performance Committee	
Strategic or Service Development Decisions	**What assurance and/or advice should be made available for consideration by the Board before making its decision**	**How the assurance or advice is to be documented**
Define the strategic aims and objectives of the Foundation Trust and the strategic framework to deliver these aims and objectives.	DOF CEO Wider stakeholder engagement to be taken into account (including Groups and locality feedback) Assurance is provided by the Board's Sub-Committees	Trust Strategy document Minutes of Sub-committees and any reports produced
Identify the key strategic risks, evaluate them and ensure appropriate arrangements are in place to monitor and arrange this risk including ongoing Board oversight.	Director of Commissioning and Quality Assurance	Any written reports or advice of DCQA BAF/CRR
Approve the Annual Plan. This includes the incorporation of new business development proposals into trust wide strategic plan.	DoF RABAC	Minutes of RABAC meetings Annual plan submission document
Approve short term and long term financing arrangements, loans and working capital facilities.	DoF RABAC	Minutes of RABAC meetings Written advice of DOF Planning submissions Business case

Agree permanent / longer term closure of a ward or service	Chief Operating Officer Director of Commissioning and Quality Assurance Quality and Performance Committee	Minutes of meeting
Approve the establishment of legal partnerships, provider collaboratives, subsidiaries, joint ventures and other significant transactions (including mergers and acquisitions)	DoF RABAC Provider collaborative committee	Business Case Minutes of RABAC and Provider Collaborative committee
Regulation and Control **Decisions**	**What assurance and/or advice should be made available for consideration by the Board before making its decision**	**How the assurance or advice is to be documented**
Any matter for which the Board has delegated or statutory authority within its statutory powers.		
Amend the Trust's constitution. This is jointly with the Council of Governors. Where amendments are made to the powers or duties of the Council of Governors, this is subject to a vote by the members at the Annual Members Meeting to ratify the change.	Company Secretary Council of Governors to jointly agree this with Board	Minutes of Council of Governors
Approve: • Standing Orders and any variation and amendment (as Standing Orders are part of the Trust constitution); • Standing Financial Instructions for the regulation of its proceedings and business; • Investment Policy • Standards of Business Conduct and Conflicts of Interest Policy; and	As the SOs are part of Trust Constitution, these require joint approval with CoG. DoF to advise Board on SFIs and Investment Policy Audit Committee recommendation required for SFIs	Minutes of meetings and published documents

• any other guidance regarded as key to the corporate governance framework.	Company Secretary to advice on Standards of Business Conduct and Conflicts of Interest	
Suspend Standing orders	DoF & Company Secretary Audit Committee	Minutes of meetings
Ratify urgent decisions by Chair & CE	Chairman/Chief Executive recommendation	Minutes of meetings and reports
Require and receive the declaration of Board of Directors members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.	Company Secretary (in terms of advice) Chairman	Minutes of meetings
Adopt the organisation structures to facilitate the discharge of business by the Foundation Trust and to agree modifications, i.e. the structure of the Board of Directors and its sub-committees	Company Secretary	Minutes of meetings and publication of structures
Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention.	Company Secretary	
Approval of how the Trust's funds held on trust will be administered, e.g. through a corporate trustee or other independent body, and the administering organisation if external to the Trust.	DoF Charitable Funds Committee	Minutes of meetings
Approve the Trust's registration with the CQC.	Director of Commissioning and Quality Assurance Quality and Performance Committee	Minutes of Q&P meeting
Approve mandatory and statutory reports as required, e.g. Medical Revalidation Annual Report, Safer Staffing, etc	Director of Commissioning and Quality Assurance Medical Director Other executive director as appropriate	Minutes of meetings

	Quality and Performance Committee	
Decisions relating to Sub-Committees of the Board	**What assurance and/or advice should be made available for consideration by the Board required to consider before making its decision**	**How the assurance or advice is to be documented**
Establish and agree terms of reference for all sub-committees of the Board of Directors. These must include: • Audit Committee • Remuneration Committee Approve any amendments to existing Terms of Reference for the above.	Committee Chairs/ Executive Leads/ Company Secretary	Minutes of meetings where sub-committees are established and/or Terms of Reference are agreed. Agreed Terms of Reference for Sub-Committees
Disestablish any existing sub-committee of the Board of Directors	Committee Chairs/ Executive Leads/ Company Secretary	Minutes of meetings where sub-committees are dis- established
Take decisions on reports received from sub-committees that are established by the Board of Directors, including those that the Trust is required by the regulation to establish and to take appropriate action on.	Committee Chairs/ Executive Leads/ Company Secretary	Minutes of meetings
Decisions relating to Audit matters	**What assurance and/or advice should be made available for consideration by the Board required to consider before making its decision**	**How the assurance or advice is to be documented**
Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee	External auditors Audit Committee	Minutes of meetings and publication of documentation
Decisions relating to the Annual Report and Accounts	**What assurance and/or advice should be made available for consideration by the Board before making decision**	**How the assurance or advice is to be documented**

Receipt and approval of the Foundation Trust's Annual Report and Annual Accounts, Annual Governance Statement and Quality Accounts	DoF / Director of Commissioning and Quality Assurance/ Company Secretary Audit Committee	Minutes of the Audit Committee Annual Report and Accounts, Quality Account, Annual Governance Statement
Receipt and approval of the Annual Report and Annual Accounts for funds held on trust.	DoF Charitable Funds Committee Audit Committee	Minutes of the Board meeting where approval is given Publication of Annual Report and Accounts
Board Monitoring Arrangements	**What assurance and/or advice should be made available for consideration by the Board before making its decision**	**How the assurance or advice is to be documented**
Continuous appraisal of the affairs of the Foundation Trust by means of the receipt of reports as it sees fit from Board members, committees, and officers of the Foundation Trust. All **statutory** returns required by the Independent Regulator shall be reported, at least in summary, to the Board of Directors. Approval of all legal and regulatory requirements.	Director of Commissioning and Quality Assurance/ Company Secretary All sub-committees of the Board	Minutes of meeting and reports for Board

Part B – Matter Delegated by the Board of Directors to Executive Directors, Management Groups and members of staff

This Section B sets out the corporate decisions making powers that have been delegated by the Trust's Board of Directors to the Trust's Executive Directors and established sub-groups and those officers and employees of the Trust to whom the Executive Directors have in turn delegated certain of their decision making powers.

Many of the day to day decisions that are made by employees of the Trust do not feature in this document. Such decisions should be made within the context of the individual's role, profession and the Trust's Risk Strategy and Risk Management Policy and the Standing Financial Instructions. Where the employee requires support, the matter shall be referred to their line manager and ultimately to the relevant Executive Director(s) who is responsible for the business area(s) which are presented with the decision.

Decision makers must evidence that they have factored in the Trust's published Risk Appetite from time to time and that any decisions taken that will create a risk that exceeds the relevant threshold is reported and managed in accordance with the Risk Management Policy.

In order to support employees to understand the scope of their decision making powers a series of Decision Making Guides are to be produced to support this document.

Finance/Commercial/Estates Decisions

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Finance									
Levels of budget responsibility by reference to roles within the organisation	Postholders are delegated responsibility for financial management of		Levels are set out in the Annex	Levels are set out in the Annex	Levels are set out in the Annex	Levels are set out in the Annex	Levels are set out in the Annex	Levels are set out in the Annex	

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	resources and act as authorised signatories for commitments to spend Trust monies								
Authority to vary the Annual Financial Plan in respect of the amount of contribution delivered or budget allocated to a department. Resource allocation– expenditure (revenue)	Variations approved at relevant level of authorisation Movement of resources across staff and non-staff. Follow Trust Guidance note – Budgetary Control		Authorised to vary resource allocation across Trust	Authorised to vary resource allocation for cost centre and across CBUs / Depts	Authorised to vary resource allocation for cost centre and across CBUs / Depts	Authorised to vary resource allocation for designated CBU	Authorised to vary resource allocation for designated cost centre and across cost centres	Authorised to vary resource allocation for designated cost centre and across cost centres	
Authority to vary the	Variation of the agreed			Approval of the Director	Must be consulted				

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Annual Financial Plan is respect of income levels – income (revenue) contract with commissioners	income plan as approved by the board in the Annual Financial Plan. Follow Trust Guidance note – Budgetary Control			of Commissioning & Assurance	with by DC&QA				
Authority to vary the Resource allocation in the agreed Annual financial plan – capital – funding arrangements and expenditure	This delegation operates within the agreed resource allocation. To change the overall value of the Trust funded capital programme requires agreement of the Board.	CDT-B							CDT-B minutes.

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	Where external funding is made available for specific schemes this can be incorporated into the capital programme through agreement at CDT-B.								
Decision regarding banking arrange-ments, investments, and external loans			Approval through Director of Finance						Written decision and instruction to Bank
Commercial									
Authority to approve a waiver of	The SFIs set out the limited circumstanc		Only CEO or DoF may give approval to						Decision to be documented in writing using the

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
SFIs to enter a contract.	es where the SFIs may be waived and a contract with a third party supplier entered into SFI 8.10		waive SFI requirements and enter into a contract						SFI waiver document. Record of waivers is maintained by the Head of Procurement (NTWS)
Authority to agree and enter a contract – **to provide Healthcare services** to a commissioner body or customer	Agree and sign a contract to provide / deliver healthcare SFI – 7.3			Director of Commissioning & Quality Assurance approves and signs the contract	Triumvirate Director(s) consulted with by Director of Commissioning & QA				Minutes of meeting between D of C&QA and Triumvirate Director(s) Contract documentation
Authority to agree and enter a **contract with a third party healthcare provider**	Agree and sign a contract with a third party to provide healthcare services to the Trust			Director of Commissioning & Quality Assurance approves and signs the contract	Triumvirate Director(s) consulted with by Director of Commissioning & QA				Minutes of meeting between D of C&QA and Triumvirate Director(s) Contract documentation

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	SFI 8.3								
Launch a procurement and agree and enter a contract for Trust **to purchase services and/or goods** or to materially vary a contract for the same	Agree and sign a contract with a third party provider to deliver non-healthcare services and/or goods. SFI section 8 sets out the requirements and steps at different financial levels which must be followed to put in place a contract. NTWS Head of Procurement must be	All goods and services contracts between OJEU level and £6m to be approved at CDT-B before sign off by relevant Director or officer	CEO and DoF to jointly sign contracts > £2m - £6m CEO and DoF can each individually sign and authorise contracts with a value of >£500k - £2m In all instances following approval at CDT-B	Executive Directors other than CEO and DoF can sign and authorise contracts up to £500k – following CDT-B approval where this is required, and as set out in the Annex	Approve and sign contracts at the levels set out in the Annex – and sign contracts at those levels following CDT-B approval where this is required	Approve and sign contracts at the authority levels set out in the Annex	Approve and sign contracts at the authority levels set out in the Annex	Approve and sign contracts at the authority levels set out in the Annex	Business cases and reports presented to CDT-B. The minutes of CDT-B will evidence decision making Signed contracts Records of tender or procurement process retained by Head of Procurement or Officer

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	consulted with for contracts above £25k								
Authority to raise an order or multiple orders under an existing contract	Contracts are to be put in place in accordance with the SFIs		Authority levels are as per the annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Authorised up to the levels set out in the Annex	Requisitions and purchase orders
Authority to agree to enter into a contract for the provision by the Trust of **non-healthcare services**	This includes consultancy services such as those provided by Trust Innovation Group, commercial projects and joint ventures	CDT-B – has oversight and management of such contracts. Note that the Board of Directors has reserved powers for partnerships and joint ventures, as set out in Part A	Signature of contract by CEO and/or DOF at the authorisation levels stated in annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Signature of contract at authorisation levels set out in the Annex	Business Cases presented to CDT-B CFT-B minutes Signed Contracts

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Approval of a Business Case with revenue implications up to a value of £6m per annum	Business Cases are led by relevant CBU/Dept supported by subject experts. Follow Business Change process – Link to Business Change process Policy	All business cases submitted to CDT-B. Note that the Board has reserved powers to approve significant Business Cases at the value stated in Part A							Business Cases presented to CDT-B CDT-B minutes to document decision
Initiation and approval of a Tender submission with revenue implications up to a value of £6m per annum	Tenders are led by relevant CBU / Dept supported by subject experts. Follow Tender Process Policy for guidance on	CDT-B up to a value of £6m per annum. Trust Board has reserved powers to approve significant Tenders as							Business case to recommend decision to tender. CDT-B minutes to record decision Tender document and submission

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	the production of a tender– Link to process	set out in Part A							Project Log of Deputy Director of Finance
Disposal or acquisition of a Trust Asset with a book or net value up to £6m	Sale, Transfer or acquisition of a Trust asset. NTW Solutions advise the Trust on these matters	CDT-B up to £6m. Note that the Board has reserved powers for disposals or acquisitions above £6m	DoF to sign any contract documentation						CDT-B minutes and business case or report presented to CDT-B
Authority to manage and vary contracts with NWT Solutions with revenue implications up to £6m per annum, or capital implications	The Operated Healthcare Facilities Agreement and the Estates Management Services Agreement are the main agreements	CDT-B	DoF is the accountable Executive for the contracts with NTWS						Business cases presented to CDT-B Minutes of CDT-B Contract variation documents

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
up to £6m - and authority to approve matters that are reserved to the Trust in NTWS' own Scheme of Reservation and Delegation	between the Trust and NTWS. NTWS is also required to seek Trust approval to enter into leases in its own name.								
Approval of variations to Trust PFI with revenue implications up to £6m per annum, or capital implications up to £6m	NTW Solutions manages the PFI contracts on behalf of the Trust and will submit papers on these matters to CDT-B	CDT-B	DoF is the accountable Executive for the contracts with NTWS						Business cases presented to CDT-B Minutes of CDT-B Contract variation documents

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Property & Capital works									
Approval of Minor Works (below £5k) and capital works up to £25k in value	Follow Trust approved Minor Works process and Capital works process This process is managed by NTW Solutions on behalf of the Trust Link to minor works and capital works processes	Capital Programme meeting between Trust Deputy Director of Finance and NTW Solutions Reps Reported in to CDT-B and the Informed Client meeting	DoF is the accountable Executive Officer for minor works and overall Capital Programme						Reports produced by the Director of Estates & Facilities (NTWS or his delegate) for Informed Client meeting & CDT-B CDT-B Minutes Informed Client meeting minutes and Capital Programme meeting
The approval of purchases from third parties of utilities,	This process is managed by NTW Solutions on behalf of the Trust and as	CDT-B – which is the forum with responsibility for managing	Responsibility is delegated by CEO to DoF						Business cases and reports to CDT-B.

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
goods, capital works and or services that relate to the Estate/ Property up to £6m.	per SFI 8.2.6	the contracts with NTWS. Note that the Board has reserved powers for capital schemes with a value above £6m							CDT-B minutes Procurement and tender documentation Contracts with suppliers
Approval of new capital schemes (including acquisitions) up to £6m.	The Trust's capital programme is managed by NTW Solutions on behalf of the Trust	CDT-B Note that the Board has reserved powers capital schemes above £6m	DoF is the accountable Executive Officer for the Capital Programme						Business cases and reports to CDT-B. Capital programme report to CDT-B and CDT-B minutes
Agree a lease	All lease agreements are subject to approval through a business case to CDT-B. Lease	CDT-B which is the forum with responsibility for managing the contracts with NTW Solutions	DoF or his delegate are authorised to sign any lease agreements on behalf of the Trust						CDT-B business cases and reports Agreements for Lease Leases

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	Associate Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	matters are managed by NTW Solutions on behalf of the Trust and therefore they must be consulted with and engaged on these matters								

The delegate of the Director of Finance for any matters referred to in the SFIs is the Deputy Director of Finance and the Associate Director of Finance and in specific instances, the Director of Finance of NTW Solutions Limited.

Workforce Decisions

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	CBU Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
HR Decisions									
Appointment of staff outside general terms and conditions	Appointment on higher pay scale than AfC			DWOD					Evidence of experience, rationale for approval and recommended salary point to be provided to Executive Director of Workforce
	Appointment onto local pay		CEO/DOF	DWOD					Evidence of rationale
	Use of agency worker above cap		DOF	DWOD					Discussion with Medical Director / Director of WOD
Termination of employment									
	Termination through redundancy		DOF	DWOD	Would be consulted with by DWOD				Rationale for decision to be shared with Executive Director of Workforce

		Decision making Forum	Individual Decision Maker(s)						Document to evidence decision
Delegated responsibility	Detail	Meeting	Chief Executive & Deputy Chief Executive/Director of Finance	Executive Director	Triumvirate Director or Corporate Deputy Director	CBU Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
	Termination for SOSR (Some other Substantial Reason)			DWOD					
Amendments to terms and conditions	Development of local pay systems or implementing flexibilities outside of Agenda for Change			DWOD					
	Significant changes/development of a new role which potentially has impact on national A4C profile.		DOF	DWOD					

Clinical and Operational decisions

Clinical and Operational Decisions		Decision Making Forum	Individual decision makers					Document to Evidence Decision
Delegated Responsibility	Detail	Meeting	Executive Director	Triumvirate Director	Associate Director	Clinical Manager	Ward/Team Manager	
Emergency closure to admissions (<1 month)			Consultation with Executive Director of C & QA and COO	Triumvirate Director				Locality Management minutes
Variation to Group internal targets			Consultation with Executive Director of C & QA and COO	Triumvirate Director				Locality Management minutes
Close a ward/service due to urgent clinical risk				Triumvirate Director				
Agree changes to Trust wide Clinical protocols and standards		CDT						
Expansion of current service				Triumvirate Director				
Provision of services out with agreed pathways	For example where a patient with a learning disability or a child is admitted to an			Triumvirate Director				RIO patient record is evidence of conversation at bed management meeting for

Clinical and Operational Decisions		Decision Making Forum	Individual decision makers					Document to Evidence Decision
	acute adult ward - classed as a "never event"							the individual patient. Review of that decision via an SI
Delegated Responsibility	Detail	Meeting	Executive Director	Triumvirate Director or Corporate Deputy Director	CBU Director or Corporate Head of Service	Clinical Manager or Corporate Manager	Ward/Team Manager	
Change of service provision linked to OPEL framework – emergency planning/contingency	Often linked to staff availability or a surge in demand							Decisions made and documented as per escalation process for emergency planning
Amending ward/team skill mix to meet service need						Clinical Manager	Ward/team manager decision	Discussion between managers at these levels is documented in meeting notes

Appendix 1

(2021 version to be inserted)

Trust Governance Structures - Jan 20 v

Annex – authorisation levels

Delegating Authorisers	Authorisation Limits	
Post	**Revenue £000**	**Capital £000**
Executive Officers		
Chief Executive and Executive Director of Finance jointly	6,000	6,000
Chief Executive and Executive Director of Finance individually	2,000	2,000
Executive Director of Commissioning and Quality Assurance	500	1,000
Executive Medical Director	500	
Executive Director of Nursing and Chief Operating Officer	500	
Executive Director of Workforce and Organisational Development	500	
Chief Executive Directorate		
Deputy Director, Communications and Corporate Relations	50	

Delegating Authorisers	Authorisation Limits	
Post	**Revenue £000**	**Capital £000**
Nursing and Chief Operating Officer Directorate		
Deputy Chief Operating Officer	500	
Group Directors – operational, nursing and medical	500	
Deputy Director – NTW Academy Development	50	
Deputy Director – Positive and Safe	50	
Group Nurse Director – Safer Care	50	
Group Medical Director – Safer Care	50	
Director of AHPs and Psychological Services	50	
Associate Directors – Group CBU Teams	50	
Clinical Nurse Managers	5	
Ward / Team Managers	5	
Medical Directorate		
Chief Pharmacist	100	
Deputy Chief Pharmacists	100	
Director R&D Innovation and Clinical Effectiveness	100	
Director of Medical Education	50	
Commissioning and Quality Assurance Directorate		
Director of Informatics	100	100
	100	

Delegating Authorisers	Authorisation Limits	
Post	**Revenue £000**	**Capital £000**
Deputy Director of Commissioning and Quality Assurance Clinical Director of Informatics	50	
Deputy Chief Executive and Finance Directorate		
Deputy Director of Finance and Business Development	100	
Director of Audit One	100	
Associate Director of Finance	50	
Technical Director – Trust Innovations	50	
Workforce and Organisational Development Directorate		
Deputy Director of Workforce and Organisational Development	100	
Board of Directors	No limit	No limit

Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Document Title	Standing Financial Instructions			
Reference Number	CNTW(O)51			
Lead Officer	James Duncan, Deputy Chief Executive / Executive Director of Finance			
Author(s)	Director of Legal & Commercial Services (NTW Solutions Limited)			
Ratified by	Trust Board			
Date ratified	XX 2021			
Implementation Date	XX 2021			
Date of full implementation	XX 2021			
Review Date	XX 2023			
Version number	V03 dr.1			
Review and Amendment Log	**Version**	**Type of Change**	**Date**	**Description of Change**
			Nov 2020	Complete update of SFIs track changed version shows amendments

This document supersedes the following document which must now be destroyed:

Document Number	Title
CNTW(O)51 – V02.4	Standing Financial Instructions

Standard Financial Instructions

STATEMENT OF PURPOSE

Standard Financial Instructions (SFIs) explain the financial responsibilities, Policies and Procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the Law, Government Policy, the Department of Health and Social Care Guidelines and Policies laid down by the Independent Regulator (NHS England & NHS Improvement) of Foundation Trusts and Best Practice. This is in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the Trust.

The SFIs identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with any detailed department or financial procedure notes, e.g. Practice Guidance Notes (PGN's). All Financial Procedures must be approved by the Director of Finance.

1 Introduction

1.1 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust, its Directors, officers and agents in relation to all financial matters. They shall have effect as if incorporated into the Trust's Standing Orders (SOs).

1.2 They explain the financial responsibilities, Policies and Procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the Law, Government Policy, the Department of Health & Social Care Guidelines and Policies laid down by the Independent Regulator of Foundation Trusts and Best Practice. This is in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the Trust.

1.3 They identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with any detailed Department or Financial Procedure Notes, e.g. Practice Guidance Notes. All Financial Procedures must be approved by the Director of Finance.

1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of Director of Finance must be sought before acting.

The failure to comply with Standing Financial Instructions (and Standing Orders) can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.5 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shallbe reported to the Audit Committee for referring action or ratification. All members of the Board, and all staff, have a duty to disclose any non-compliance with these SFIs to the Director of Finance as soon as possible.

1.2 Interpretation and Definition of Terms

1.2.1 Interpretation and definitions are as follows:

- **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For the Trust this is the Chief Executive;

- **"Board of Directors"** means the Chairman, executive and non-executive directors of the Trust collectively as a body;

- **"Board Secretary"** means a person appointed to act independently of the Board of Directors to provide advice on corporate governance issues to the Board of Directors and the Chairman and monitor the Trust's compliance with the Law, SOs, Department of Health Guidance and the Independent Regulator;

- **"Budget"** means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

- **"Budget Holder"** means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

- **"Chief Executive"** means the Chief Officer of the Trust;

- **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources;

- **"Commissioning Plan"** means the Trust's plan for the provision of healthcare to its patients, from time to time, as agreed with commissioners;

- **"Committee"** means a committee or sub-committee created and appointed by the Board of Directors;

- **"Committee Members"** means persons formally appointed by the Board of Directors to sit on or to chair specific Committees;

- **"Contracting and Procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets;

- **"Council of Governors"** – is as defined by NHS England and NHS Improvement and is set out in the Trust's Constitution;

- **"Director of Finance"** means the Chief Financial Officer of the Trust;

- **"Executive Director"** means a member of the Board of Directors who is an officer of the Trust;

- **“Independent Regulator”** means the independent regulator of NHS Trusts, which at the time of adoption of these SFIs is NHS England & NHS Improvement

- **“In House Services”** means services that are provided by the Trust (or its wholly owned subsidiary company) to the Trust;

- **"Nominated Officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Financial Instructions;

- **"Non-Executive Director"** means a member of the Board of Directors who is not an officer of the Trust;

- **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust;

- **“Procurement Team”** means the procurement team within NTW Solutions Limited (the wholly owned subsidiary of the Trust), which is contracted to provide a procurement service to the Trust;

- **“Scheme of Reservation and Delegation”** means the document which sets out the decision making powers and duties that the Board of Directors have reserved to the Board and those decision making powers and duties that the Board of Directors has delegated to specific Directors, Officers or Committees, in the form set out at Appendix E to these SFIs;

- **"SFIs"** means Standing Financial Instructions;

- **"SOs"** means Standing Orders;

- **"Trust"** means the “Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust”;

1.2.2 Wherever the title Chief Executive, Director or other nominated officer is used in these Instructions, this will include other officers who have been duly authorised to represent them.

2 Duties, Accountabilities, Responsibilities and Delegation

2.1 Principles

2.1.1 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Scheme of Reservation and Delegation document. All other powers, decisions and responsibilities have been delegated to specific

Directors, Officers or Committees also in accordance with the Scheme of Reservation and Delegation.

2.1.2 The Board has delegated executive responsibility for the performance of its functions to the Chief Executive. All powers are invested in the Chief Executive, who in turn will provide delegated powers to relevant Officers.

2.2 Chief Executive

2.2.1 Within these Standing Financial Instructions it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources.

2.2.2 The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met. Further, the Chief Executive is recognised by Statute as the Accountable Officer of the Trust and as such is accountable to Parliament through the Independent Regulator, for all actions undertaken by the Trust.

2.2.3 The Chief Executive will delegate detailed responsibility for financial activities and controls to the Director of Finance but shall retain overall accountability. The extent of such delegation is set out in these SFIs. The extent of such delegation will be kept under review by the Board of Directors.

2.2.4 It is the responsibility of the Chief Executive, through the Director of Finance, to ensure that existing staff and all new staff are notified and made aware of their responsibilities within these SFIs.

2.3 Director of Finance

2.3.1 The Director of Finance is responsible for all financial matters, and is required to:

(i) Implement the Trust's Financial Policies and for coordinating any corrective action necessary to further these Policies;

(ii) Maintain an effective system of internal financial control including ensuring that detailed Financial Procedures and Systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(iii) Ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose the financial position of the Trust at any one time,

(iv) ensure the provision of financial advice to other members of the Board of Directors and employees;

(v) ensure the design, implementation and supervision of systems of internal financial control;

(vi) ensure the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.4 Board Secretary

2.4.1 The Board Secretary is responsible for ensuring that documents within the Corporate Governance Manual, which includes Standing Financial Instructions, are kept up-to-date and any changes are made through the correct governance processes.

2.5 Corporate Responsibilities of all members of the Board of Directors and all Officers of the Trust

2.5.1 All members of the Board of Directors and all Officers of the Trust are severally and collectively responsible for:

(i) The security of the property of the Trust;

(ii) Avoiding loss;

(iii) Exercising economy and efficiency in the use of resources; and

(iv) Conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation as well as all Trust Policies and Procedures.

2.6 Contractors and their Employees

2.6.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3 Audit

3.1 References

3.1.1 The Board of Directors shall establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's Auditors.

3.2 Audit Committee

3.2.1 In accordance with Standing Orders and the Regulator's Code of Governance, the Board of Directors shall formally establish an Audit Committee with clearly defined Terms of Reference, which will provide an independent and objective view of the adequacy and effective operation of the Trust's overall internal control system.

3.2.2 The Terms of Reference for the Audit Committee, as set out at Appendix F to these SFIs, shall be considered as forming part of these Standing Financial Instructions.

3.3 **Internal Audit**

3.3.1 Internal Audit is an independent assurance function. The work of Internal Audit embraces the risk management, control and governance processes of the Trust including all its operations, resources, services, and responsibilities for other bodies. This includes considering compliance with behavioural and ethical expectations as well as compliance with established Policies, Procedures, Laws and Regulations. The overall objective of Internal Audit is to enable the Head of Internal Audit to deliver an audit opinion as specified by the Department of Health and Social Care and the Accountable Officer, i.e. the annual Head of Internal Audit Opinion.

3.3.2 The Director of Finance is responsible for:

(i) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;

(ii) Ensuring that the internal audit is adequate and meets the mandatory audit standards;

(iii) Deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(iv) Ensuring that an Annual Audit Report is prepared for the consideration of the Audit Committee covering:

(a) Progress against Internal Audit Plan over the previous year;

(b) Major internal financial control weaknesses discovered;

(c) Progress on the implementation of management actions from Internal Audit findings;

(d) the Strategic Internal Audit Plan covering the next three years;

(e) A detailed Internal Audit Plan for the coming year.

3.3.3 The Director of Finance or designated Auditors are entitled without necessarily giving prior notice to require and receive:

(i) Access to all records, documents and correspondence relating to any financial or other relevant transaction, including documents of a confidential nature, e.g. work diaries;

(ii) Access at all reasonable times to any land, premises or officer of the Trust;

(iii) The production of any cash, stores or other property of the Trust under an Officer's control; and/or

(iv) Explanations concerning any matter under investigation.

3.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

3.3.5 An Internal Audit representative will normally attend Audit Committee Meetings and Internal Audit has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust.

3.3.6 The Head of Internal Audit is accountable for the delivery of an agreed programme of work to the Director of Finance. As such, the Head of Internal Audit and designated officers have a right of access to members of the Audit Committee, the Chair and Chief Executive of the Trust as part of the role to develop Internal Audit's contribution to the Internal Control Principles. The Head of Internal Audit and designated officers have an absolute right of access to all records, assets, personnel and premises, and authority to obtain such explanation and information as the Head of Internal Audit considers necessary to fulfil the assurance responsibilities of internal audit.

3.4 External Audit

3.4.1 The Trust is to have an External Auditor appointed (or removed) by the Council of Governors.

3.4.2 The External Auditor shall be provided every facility and all information which they may reasonably require for the purposes of their functions under Schedule 10 of the NHS Act 2006, and to comply with the FT Audit Code.

3.4.3 The External Auditor is to carry out his duties in accordance with any directions given by the Independent Regulator on Standards, Procedures and Techniques to be adopted.

3.4.4 An External Audit representative will normally attend the Audit Committee Meetings and External Audit has a right of access to all Audit Committee Members, the Chairman and the Chief Executive of the Trust

3.5 Fraud, Bribery and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and the Director of Finance shall monitor and ensure compliance with relevant Laws, guidance and directions on Fraud, Bribery and Corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist, as specified by Section 6 of the Health and Social Care Act 2012, who shall report to the Director of Finance.

3.5.3 The Local Counter Fraud Specialist has a right of access to the Director of Finance, the Audit Committee, the Chair and Chief Executive of the Trust, and has the same entitlement as a designated Auditor with regard to accessing records, premises, officers of the Trust, explanations, as set out at section 3.3.3 of these SFIs.

4 Annual Planning, Budgets, Budgetary Control and Monitoring

4.1 Annual Business Planning

4.1.1 The Chief Executive, with the assistance of the Director of Finance, shall compile and submit to the Board of Directors and the Independent Regulator, Strategic and Annual Operational Plans in accordance with the guidance issued about timing and the Trust's financial duties within the Regulator's Risk Assessment Framework.

4.1.2 The Annual Operational Plan shall be reconcilable to regular updates of the financial pro formas, which the Director of Finance will prepare and submit to the Board of Directors and the Regulator.

4.1.3 The Director of Finance will report to the Board of Directors any significant in-year variance from the Annual Operational Plan and to advise the Board of Directors on the action to be taken.

4.1.4 The Director of Finance will also be required to compile and submit to the Board of Directors such financial estimates and forecasts, both revenue and capital, as may be required from time to time.

4.1.5 Officers shall provide the Director of Finance with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.

4.2 Budgets, Budgetary Control and Monitoring

4.2.1 The Director of Finance shall, in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and in accordance with Trust Planning Policies to the Board of Directors for its approval.

4.2.2 Budgets will be in accordance with the aims and objectives set out in the Trust's Annual Plan.

4.2.3 The Director of Finance will devise and maintain systems of budgetary control incorporating the reporting of, and investigation into, financial, activity or workforce variances from budget. All Officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems.

4.2.4 The Director of Finance shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

4.2.5 The Chief Executive may delegate management of a budget or part of a budget to officers to permit the performance of defined activities. The Scheme of Reservation and Delegation shall include a clear definition of individual and group responsibilities for control of expenditure. In carrying out those duties, the Chief Executive shall not exceed the budgetary limits set by the Board of Directors, and officers shall not exceed the budgetary limits set them by the Chief Executive.

4.2.6 Any funds not required for their designated purpose shall revert to the immediate control of the Chief Executive.

4.2.7 Expenditure for which no provision has been made in an approved budget and which is not subject to funding under the delegated powers of virement, shall only be incurred after authorisation by the Chief Executive or the Board of Directors as appropriate.

4.2.8 The Director of Finance shall keep the Chief Executive and Board of Directors informed of the financial consequences of changes in Policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

5 Annual Accounts and Reports

5.1 The Director of Finance will prepare financial returns in accordance with the guidance given by the Independent Regulator, the Treasury Financial Reporting Manual (FReM) and the Government Accounting manual (GAM), the Trust's Accounting Policies and International Financial Reporting Standards.

5.2 The Director of Finance will prepare Annual Accounts which must be certified in accordance with current guidelines. The Director of Finance will submit them along with, any reports issued by the Trust's Auditor, to the Regulator and arrange for them to be laid before Parliament.

5.3 The Trust's Annual Accounts must be audited by an Auditor appointed by the Council of Governors in accordance with the appointment process set

out in the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the Regulator.

5.4 The Trust will publish an Annual Report, in accordance with guidelines on local accountability and present it at a public meeting of the Council of Governors.

5.5 The Annual Report will be laid before Parliament, with the annual accounts.

6 Bank and Government Banking Services (GBS) Accounts

6.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

This advice will take into account guidance and directions issued from time to time by the Independent Regulator. The Board of Directors shall approve the banking arrangements.

6.2 The Director of Finance is responsible for all banking accounts and Government Banking Services (GBS) accounts and for establishing separate bank accounts for the Trust's non-Government funds, where applicable.

6.3 The Director of Finance is responsible for ensuring payments from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made. Further they must report to the Board of Directors all arrangements with the Trust's bankers for accounts to be overdrawn.

6.4 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include the conditions under which each bank and GBS account is to be operated, the limit to be applied to any overdraft and those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.5 The Director of Finance must advise the Trust's bankers in writing of the condition under which each account will be operated.

6.6 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7 Income, Fees, Security of Cash and Cheques,

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection, and coding of all monies due, including income from other NHS bodies. The Director of Finance is also responsible for the prompt banking of all monies received.

7.1.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.1.3 All officers must inform the Director of Finance promptly (or their delegate as set out in the Scheme of Reservation and Delegation) of money due arising from transactions and the Director of Finance must have access to all supporting documentation.

7.1.4 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with Losses Procedures.

7.1.5 The Director of Finance is responsible for approving the form of all receipt records, agreement forms, or other means of officially acknowledging or recording monies received or receivable. This includes the ordering and securely controlling any such stationery.

7.1.6 The Director of Finance is responsible for the provision of adequate facilities and systems for officers, whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the Procedures for keys and for coin operated machines.

7.1.7 The Director of Finance is responsible for prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.1.8 Official money shall not under any circumstances be used for the encashment of private cheques or I.O.U.s.

7.1.9 All cheques, postal orders and cash, shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.1.10 The holders of safe keys shall not accept unofficial funds for depositing in their safe unless such deposits are in sealed envelopes (signed and dated across the seal) or lockable containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.2 Money Laundering

7.2.1 The Trust has a responsibility to report any suspicions of money laundering to the appropriate authorities. Any significant payments made in the form of cash which appear unusual in their nature should be reported to the Director of Finance for further review.

7.3 Contracts for the Provision of Healthcare Services

7.3.1 The Executive Director of Commissioning & Quality Assurance is responsible for ensuring that the Trust enters into suitable service contracts with commissioners for the provision of the Trust's healthcare services, in line with guidance from NHS England and NHS Improvement. Such contracts will be approved and executed in accordance with the Scheme of Reservation and Delegation.

7.3.2 The Executive Director of Commissioning & Quality Assurance is responsible for reporting performance to the Board of Directors against the contracts entered into in accordance with clause 7.3.1 above. Contracts should be drafted so as to minimise risk whilst maximising the Trust's opportunity to generate income.

7.3.3 The Executive Director of Commissioning & Quality Assurance shall produce regular reports for relevant stakeholders.

8 Buying Goods, Works and Services

8.1 Principles

8.1.1 As a Public Sector Body, the Trust must ensure that all procurement and related contracting activity meets the requirements of relevant legislation, most notably the Public Contract Regulations 2015 (PCRs), the Utilities Regulations 2015, Policy and DHSC guidance.

8.1.2 Officers of the Trust must follow the instructions in these SFIs in relation to procurement activity

8.1.3 The Director of Finance shall advise the Board of Directors regarding the setting of thresholds above which Quotations or formal Tenders must be obtained. This will take into account legal requirements to comply with applicable Laws and Government guidance on procurement.

8.1.4 The Director of Finance shall be responsible for establishing procedures to ensure that competitive Quotations and Tenders are invited for the supply of goods, works and services under contractual arrangements wherever possible.

8.1.5 The Trust will give first consideration to the utilisation of any National Frameworks, Dynamic Purchasing Systems (DPS) or contracts which are in place as a first course of action before exploring open market Tendering and Quotations options.

8.1.6 The Trust will commit to ensuring that its procurement processes will:

(i) Be fair, open and transparent;

(ii) Encourage providers from all sectors to participate in tendering opportunities;

(i) Deliver safe, high quality services which offer value for money and are fit for purpose; and

(ii) Promote competition wherever possible.

8.1.7 A Trust contract opportunity shall not be divided into smaller contracts to avoid the provisions of these SFIs, the PCRs or any other relevant policy. However, Officers should consider Regulation 46 of the PCRs that requires contracting authorities to divide contracts into lots, where possible.

8.2 Quotations

8.2.1 In respect of contract opportunities for goods, works and services up to a value of £10,000 (excluding VAT), Officers may use their discretion to achieve value for money, it is best practice to obtain more than one (1) quote, whatever the value. These contract opportunities may be audited from time to time by the Director of Finance or their nominated representative.

8.2.2 In respect of contract opportunities for goods, works and services for a value between £10,000 and £25,000 (excluding VAT), Officers must seek a minimum of three written quotations from potential suppliers. Officers may consult with the Procurement Team for advice. These contract opportunities may be audited from time to time by the Director of Finance or their nominated representative.

8.2.3 Officers must maintain confidentiality of quotations pending their evaluation. Following evaluation of quotations, confidentiality shall be maintained subject to the Freedom of Information Act 2000 and the Environmental information Regulations.

8.2.4 Officers should evaluate the Quotation and select the quote which gives the best value for money. If this is not the lowest Quotation if payment is to be made by the Trust, or the highest if payment is be made to the Trust, then the choice made and the reasons why should be recorded in a permanent record

8.2.5 The relevant Officer should maintain a record of Quotations.

8.2.6 Contract opportunities for utilities, goods, works and/or services which relate to the Trust's estate/property, of any value, must be referred to the Director of Estates & Facilities at NTW Solutions Limited (or their delegate). Officers are not permitted to conduct quotation processes or tenders, or award contracts in relation to estates, utilities and/or property requirements.

8.3 Formal Competitive Tendering

8.3.1 For contract opportunities for goods, works and/or services of a value between £25,000 and the relevant OJEU threshold, Officers shall conduct competitive procurements processes through Contracts Finder. Officers shall publish evaluation and award criteria to such contract opportunities and apply these to tenders received. Officers should consult with the

Procurement Team for guidance on conducting a tender process within this value range.

8.3.2 For contract opportunities for goods, works and/or services of a value above the relevant OJEU level Officers must agree an appropriate tender/quotation process and effective evaluation criteria with the Head of Procurement, NTW Solutions Limited, or their nominated representative (usually a member of the Procurement Team). This process will be established and conducted in accordance with the PCRs and other applicable guidance.

8.4 Health Care Services – Contracts with other Providers

8.4.1 Contracts with other providers for the supply of healthcare services, shall be drafted, negotiated and entered into by the Executive Director of Commissioning and Quality Assurance (or their delegate) in accordance with the current national NHS guidance that is applicable to the Trust.This includes circumstances where the Trust enters into a lead provider or provider collaborative contract to sub-contract the delivery of healthcare services to another party. Such contracts will be approved and executed in accordance with the Scheme of Reservation and Delegation.

8.4.2 The Chief Executive shall nominate officers to commission Contracts and Service Agreements with other providers of healthcare services in line with the Commissioning Plan approved by the Board of Directors. This responsibility is delegated by the Chief Executive to the Executive Director of Commissioning & Quality Assurance.

8.5 Contracting / Tendering Procedure

8.5.1 Invitation to Tender

This section applies to quotations and tenders as described in sections 8.2 and 8.3 of these SFIs:-

(i) All Invitations to Tender shall state the date and time as being the latest time for the receipt of Tenders;

(ii) All Invitations to Tender shall be electronic;

(iii) All Tenders are returned to the Trust's eTendering System and held until the specified completion date and time of Tender Submission;

(iv) Every Tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable or on such terms and conditions as may otherwise be advised by the Head of Procurement, NTW Solutions Limited or their nominated representative;

(v) Every Tender for building, maintenance, construction or engineering works shall be in the form of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of Environment (GC / Wks) standard forms of contract or, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers, or the NEC suite of contracts published by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and / or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

8.5.2 Receipt and Safe Custody of Tenders

(i) The Head of Procurement, NTW Solutions Limited or their nominated representative will be responsible for the receipt, endorsement and safe custody of electronic Tenders received until the time appointed for their opening.

(ii) The date and time of the receipt of each Tender shall be endorsed electronically.

8.5.3 Opening Tenders and Register of Tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of Tenders, they shall be opened by the Head of Procurement, NTW Solutions Limited, or their nominated representative.

(vi) Electronic Register shall be maintained by the Procurement Team, to show for each set of Competitive Tender Invitations despatched:

(a) The name of all firms / individuals invited;

(b) The names of firms / individuals from which Tenders have been received;

(c) The date the Tenders were received;

(d) The Procurement Staff Member who opened the Tender.

(e) Procurement Staff will process the Tenders once opened as governed by OJEU legislation and Trust Procedures.

(vi) A full audit trail shall be maintained electronically.

8.5.4 Admissibility

(i) If for any reason the designated officers are of the opinion that the Tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no Contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one Tender is sought and / or received the Chief Executive and Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.5.5 Late Tenders

(i) Tenders received after the due time and date, but prior to the opening of the other Tenders, may be considered only if the Chief Executive or his / her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a Tender be considered which is received after the opening of the other tenders and only then if the Tenders that have been duly opened have not left the custody of the Chief Executive or his / her nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the Tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

8.5.6 Acceptance of Formal Tenders

(i) Any written clarifications with a tenderer which are deemed necessary to clarify technical aspects of the Tender before the award of a contract will not disqualify the Tender, verbal discussions to clarify tenders are not permitted;

(ii) Tender documentation will clearly set out the evaluation criteria and methodology to be applied, including price and quality factors, in accordance with the PCRs;

(iii) No Tender or Quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive;

(iv) The use of these procedures must demonstrate that the award of the Contract was:

(a) Not in excess of the going market rate / price current at the time the contract was awarded;

(b) That best value for money was achieved;

All Tenders should be treated as confidential and should be retained for inspection.

8.6 Tender Reports to the Board of Directors

8.6.1 Reports on contracts and procurement activity will be submitted to the Board of Directors or the relevant Committee and/or Officer, in accordance with the Scheme of Reservation and Delegation

8.7 Authorisation of Tenders and Competitive Quotations

8.7.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract will be decided according to the levels of authorisation set out in the Scheme of Reservation and Delegation

8.7.2 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors and CDT-B this shall be recorded in the minutes.

8.7.3 All contracts that are awarded by the Trust must have an identified contract owner, who is responsible for the management of the supplier and the contract.

8.8 Instances where Formal Competitive Tendering or Competitive Quotation are not required

8.8.1 Formal Tendering and/or Quotation Procedures **may be waived by the Chief Executive or the Director of Finance** in the following circumstances, although approval is not to be regarded as automatic and each case shall be treated on its own merit:

(i) In very exceptional circumstances where the Chief Executive or the Director of Finance decides that formal Tendering Procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(iii) Where the requirement is covered by an existing contract and this can be extended in the circumstances prescribed by Regulation 72 of the PCRs (where this applies) and provided that the Procurement Team are consulted with and the extension is agreed by the Director of Finance;

(iv) Where National agreed Contracts, including NHS Supply Chain, are in place;

(iv) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of consortium members, as permitted by the PCRs;

(v) In an emergency situation, where the timescale genuinely precludes competitive tendering. Failure to plan the work properly would not be regarded as a justification for a single Tender;

(vi) Where specialist expertise is required and is available from only one source, provided that this has been established through genuine market analysis**;**

(vii) Subject to Regulation 72 of the PCRs (where this applies), when the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(viii) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by Competitive Tendering and provided that Regulation 72 of the PCRs is followed (where this applies);

(ix) The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

8.8.2 The waiving of Competitive Tendering/Quotation Procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a Competitive Procedure. Approval of the Chief Executive or the Director of Finance is required prior to the award of contracts under sub-clauses 8.10.1 (i), (ii), (v), (vi) and (vii).

8.8.3 Where the Chief Executive or the Director of Finance agree that Competitive Tendering/Quotation is not applicable and should be waived, the fact of the waiver and the reasons should be documented in an appropriate Trust record held by the Head of Procurement, NTW Solutions Limited. A bi-annual summary of such waivers shall be reported to the Audit Committee. However, an individual waiver shall be reported to the next Audit Committee where in the opinion of the Chief Executive or Director of Finance the circumstances of the waiver could be regarded as contentious or unique.

8.9 Compliance Requirements for all Contracts

8.9.1 The Board of Directors may only approve the entering into of Contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with the following:

(i) The Trust's Standing Orders and Standing Financial Instructions;

(i) EU directives and other Statutory provisions;

(iii) Contracts with NHS Foundation Trusts must be in a form compliant with appropriate NHS Guidance;

(iv) Contracts shall be in the same form of Terms and Conditions of Contract as was included in the documents under which Tenders or Quotations were invited;

(v) In all Contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money by use of all systems in place.

8.10 Personnel and Agency or Temporary Staff Contracts

8.10.1 The Chief Executive shall nominate officers in accordance with the Scheme of Reservation and Delegation to enter into Contracts of Employment, regarding Staff, Agency Staff or Temporary Staff Service Contracts.

8.11 Disposals of Trust assets

8.11.1 Competitive Tendering or Quotations Procedures shall not apply to the disposal of:

(i) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined, or pre-determined in a reserve, by the Chief Executive or their nominated officer;

(ii) Obsolete or condemned articles, which may be disposed of in accordance with the Supplies Policy of the Trust;

(iii) Items to be disposed of with an estimated sale value of less than £10,000 exclusive of VAT this figure to be reviewed on a periodic basis;

(iv) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

(v) Land or buildings concerning which DH Guidance has been issued but subject to compliance with such Guidance.

In all other instances competitive written quotes shall be sought from potential buyers for Trust assets.

8.12 Applicability of Standing Financial Instructions on Tendering and Contracting for Funds held on Trust including Charitable Funds

8.12.1 These Instructions shall not only apply to expenditure of revenue funds but also to works, services and goods purchased from the Charitable Funds or any funds held on Trust.

9 Terms of Service and Payment of Directors and Employees

9.1 Remuneration Committee

9.1.1 In accordance with Standing Orders and the Independent Regulator's Code of Governance, the Board of Directors shall establish a Remuneration Committee, with clearly defined Terms of Reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting.

9.1.2 The Terms of Reference shall be considered as forming part of these Standing Financial Instructions.

9.2 Contracts of Employment

9.2.1 The Board of Directors shall delegate responsibility to the Director of Workforce and Organisational Development for:

(i) Ensuring that all officers are issued with a Contract for Employment in a form approved by the Board of Directors and which complies with employment legislation;

(ii) Dealing with variations to, or termination of, Contracts of Employment.

9.3 Payroll

9.3.1 The Director of Finance in conjunction with the Director of Workforce and Organisational Development shall make arrangements for the provision of Payroll Services to the Trust to ensure the accurate determination of any entitlement and to enable prompt and accurate payment to officers.

9.3.2 The Director of Finance in conjunction with the Director of Workforce and Organisational Development shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submissions of payroll data to support the determination of pay including where appropriate, timetables and specifications for submission of properly authorised notification of new officers, leavers and amendments to standing pay data and terminations.

9.3.3 The Director of Finance in conjunction with the Director of Workforce and Organisational Development is responsible for ensuring that instructions for the following exist, whether the payroll is provided in-house or externally:

(i) Specifying timetables for submission of properly authorised time records and other notifications;

(ii) The final determination of pay and allowances;

(iii) Making payment on agreed dates;

(iv) Agreeing method of payment.

9.3.4 The Director of Finance in conjunction with the Director of Workforce and Organisational Development will issue instructions regarding:

(i) Verification and documentation of data;

(ii) The timetable for payment of officers and allowances;

(iii) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(iv) Security and confidentiality of payroll information;

(v) Checks to be applied to the completed payroll before and after payment;

(vi) Authority to release payroll data under the provisions of the Data Protection Act 2018;

(vii) Procedures for payment by bank credit or cheque to officers. It is expected that all staff will be paid by bank credit;

(viii) Procedures for the recall of cheques and bank credits;

(ix) Pay advances and their recovery;

(x) Maintenance of regular and independent reconciliation of payroll control accounts;

(xi) Separation of duties for preparing records and handling payments;

(xii) A system to ensure the recovery of sums of money and property from those leaving the employment of the Trust.

9.3.5 Appropriately nominated managers must have delegated responsibility for:

(i) Submitting correctly completed and authorised time records and other notifications in accordance with agreed timetables;

(ii) Completing time records and other notifications in accordance with the instructions of the Director of Finance and the Director

of Workforce and Organisational Development and in the form prescribed by the Director of Finance in conjunction with the Director of Workforce and Organisational Development;

(iii) Submitting Termination Forms in the prescribed form immediately upon knowing the effective date of an officer's resignation, termination or retirement. Where an officer fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance and Director of Workforce and Organisational Development or nominated officer must be informed immediately.

9.3.6 Regardless of the arrangements for providing the Payroll Service the Director of Finance in conjunction with the Director of Workforce and Organisational Development shall ensure that the chosen method is supported by appropriate (Contracted) Terms and Conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.4 Advances of Pay

9.5.1 Advances of pay will only be made in exceptional circumstances. The Director of Finance in conjunction with the Director of Workforce and Organisational Development will prepare detailed procedural instructions.

9.5 Loans

9.5.1 The Trust will only extend loans towards approved schemes agreed by the Trust, e.g. Salary Sacrifice Schemes.

9.5.2 The Director of Finance in conjunction with the Director of Workforce and Organisational Development will prepare detailed procedural instructions.

9.5.3 The Director of Finance in conjunction with the Director of Workforce and Organisational Development will issue detailed procedures covering payments to staff.

9.6 Staff Appointments

9.6.1 No member of the Board of Directors or officer may engage, re-engage or re-grade officers, either on a permanent or temporary nature or hire agency staff, or agree to changes in any aspect of remuneration:

(i) Unless authorised to do so by the Chief Executive;

(ii) Within the limit of their approved budget and funded establishment.

9.6.2 The Board of Directors will approve procedures presented by the Chief Executive or nominated officer for the determination of commencing pay rates, conditions of service, etc., for officers.

9.7 Staff Expenses

9.7.1 The Director of Finance in conjunction with the Director of Workforce and Organisational Development shall be responsible for establishing procedures for the management of expense claims submitted by Trust officers on forms approved by the Director of Finance in conjunction with the Director of Workforce and Organisational Development. The Director of Finance in conjunction with the Director of Workforce and Organisational Development shall arrange in most cases for duly approved expense claims to be processed locally or via the Trust Payroll provider.

9.7.2 Expenses should be claimed monthly. Any claims older than three months will not be paid unless approval is obtained from the appropriate director.

10 Non-Pay Expenditure

10.1 Delegation of Authority

10.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Council of Governors is responsible for approving "significant transactions" as defined in the Trust Constitution.

10.1.3 The Chief Executive will set out:

(i) The list of managers who are authorised to place requisitions for the supply of goods and services;

(ii) The financial limits for requisitions and the system for authorisation above that level.

10.1.4 The Director of Finance shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied or the service to be performed, shall always obtain best value for money for the Trust. The advice of the Procurement Team may be sought.

10.2.2 Payment of contract invoices shall be in accordance with contract terms. The Director of Finance (or their delegate) must be provided with a copy of all contracts involving payment.

10.2.3 The Director of Finance will:

(i) Advise the Board of Directors regarding the setting of thresholds above which Quotations (competitive or otherwise) or formal Tenders must be obtained. Once approved, the thresholds should be reviewed annually;

(ii) Prepare detailed procedures for requisitioning, ordering, receipt and payment of goods, works and services;

(iii) Be responsible for the prompt payment of all properly authorised accounts and claims;

(v) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;

(vi) The system shall provide for:

(a) Certification that:

- Goods / services have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expense, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, price and the charges for the use of vehicles, plant and machinery have been examined;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

(b) A system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

(c) A list of officers authorised to certify any type of payment. It is the responsibility of budget holders to inform the Director of Finance of changes to authorised officers;

(d) Instructions to officers regarding the handling and payment of accounts within the Finance Department;

(e) The delegation of responsibility for ensuring that payment for goods and services is only made once the goods / services are received, except where 10.2.4 below applies;

(f) All invoices must be addressed to the Accounts Payable Department and not to individual officers, wards or departments. Under no circumstances will invoices be paid on behalf of third parties.

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(i) The financial advantages must outweigh the disadvantages i.e. cash flows must be discounted to Net Present Value (NPV);

(ii) The appropriate director must provide in the form of a written report, a case setting out all the relevant circumstances of the purchase. The Report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement, unable to meet their commitments;

(iii) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed;

(iv) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the Director of Finance if problems are encountered.

10.2.5 Official orders must:

(i) Be consecutively numbered;

(ii) Be in a form approved by the Director of Finance;

(iii) State the Trust's Terms and Conditions of trade;

(iv) Only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 Officers must comply fully with the procedures and limits specified by the Director of Finance, ensuring that:

(i) All, leases, tenancy agreements and any other commitments which may result in a liability are notified and a copy sent to the Director of Finance (or their delegate) in advance of any commitment being made;

(ii) Contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(iii) No order shall be issued for any item or items to any firm that has made an offer of gifts, reward or benefit to Directors or officers, other than exceptions detailed in the Trust's Standards for Business Conduct and Conflicts of Interest Policy;

(iv) No requisition / order (including the use of purchasing cards) is placed for any item / service for which there is no budget provision unless authorised by the Director of Finance;

(v) The Director of Finance shall ensure that a process for reporting on compliance the Trust's "No PO no Pay" Policy is followed which provides that all goods, works and services require a purchase order to ensure payment of suppliers;

(vi) Orders are not split or otherwise placed in a manner devised so as to circumvent the financial thresholds;

(vii) Purchases from Petty Cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance. Petty Cash Records are to be maintained in a form as determined by the Director of Finance.

10.2.7 Goods and services for which Trust or National Contracts are in place should be purchased within those Contracts. Any purchasing request made outside such Contracts must be referred, in the first instance, to the responsible officer for approval.

10.2.8 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of Building and Engineering Contracts and property transactions comply with the Guidance contained within Concode and Estatecode. The technical audit of these Contracts shall be the responsibility of the Director responsible for the Estates function.

10.3 The Trust Seal

10.3.1 The seal is a corporate signature and may be interchangeable with the words "for and on behalf of the Trust" and its use indicates that the document is important and / or valuable.

10.3.2 A seal must be used in the conveyancing of land and may be used in Legal Agreements, Deeds, and Licences or when a seal is requested by the other party.

10.3.3 The Trust shall apply the following arrangements:

(i) The seal of the Trust shall be kept by the Board Secretary in a secure place;

(ii) Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Executive Directors duly authorised by the Chief Executive, and not also from the originating Department, and shall be attested by them;

(iii) The Board Secretary shall maintain a Register to record of the sealing of every document.

11 Investments, External Borrowing and Public Dividend Capital

11.1 Investments

11.1.1 The Director of Finance will produce an Investment Policy in accordance with any guidance received from the Independent Regulator, for approval by the Board of Directors. Investment may include investment made by forming or participating in forming, bodies corporate and / or otherwise acquiring membership of bodies corporate.

11.1.2 The Policy will set out the Director of Finance's responsibilities for advising the Board of Directors concerning the performance of investments held.

11.1.3 In addition, the Director of Finance will prepare a Treasury Management Policy, i.e. procedural instructions for investing cash and the records to be maintained.

11.2 External Borrowing and Public Dividend Capital

11.2.1 The Director of Finance will advise the Board of Directors concerning the Trust's ability to pay interest on any proposed borrowings. The Director of Finance is also responsible for reporting periodically to the Board of Directors all borrowings and overdrafts.

11.2.2 Any application for a loan or overdraft will only be made by the Director of Finance or by an officer acting on their behalf and in accordance with the Scheme of Reservation and Delegation, as appropriate.

11.2.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.2.4 All short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance.

11.2.5 All long term borrowing must be consistent with the plans outlined in the current Annual Operational Plan.

12 Capital Expenditure and Investment, Fixed Asset Registers and Security of Assets

12.1 Capital Expenditure and Investment

12.1.1 The Chief Executive is ultimately responsible for all capital expenditure of the Trust, including expenditure on assets under construction. To discharge this duty, the Chief Executive will include entries in the Scheme of Reservation and Delegation for approval of capital commitments and will arrange for the development of detailed Policies and Procedures covering all aspects of capital investment management, including scheme appraisals, contract awarding, contract management and financial control.

12.1.2 The Council of Governors is responsible for approving “significant transactions” as defined in the Trust Constitution and the Trust may only apply for a merger, acquisition, separation or dissolution with the approval of the Council of Governors as per the Trust Constitution.

12.1.3 The Chief Executive shall provide executive delegation to the Director of Finance to manage the contracts and programmes for capital works expenditure with NTW Solutions, including assets under construction, within the restrictions of the Scheme of Reservation and Delegation which will include:

(i) Specific authority to commit expenditure;

(ii) Authority to proceed to Tender;

(iii) Authority to accept a successful Tender.

12.1.4 The Chief Executive therefore shall:

(i) Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(ii) Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to planned cost;

(iii) Ensure that the investment is not undertaken without confirmation, where appropriate, of purchaser's support and the availability of resources to finance all revenue consequences, including capital charges;

(iv) Ensure a business case is produced in line with the Trust's Investment Policy setting out:

(a) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs and

(b) Appropriate project management and control arrangements and

(c) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.5 The approval of a Capital Programme shall not constitute approval for expenditure on any scheme.

12.1.6 The Director of Finance shall be responsible for preparing detailed Procedural Guides for the financial management and control of expenditure on capital assets.

12.1.7 At all times, the Board of Directors and officers of the Trust will work in accordance with the Trust's Standing Orders and be mindful of the recommendations within HBN 00-08 Part 2 (for Estates).

12.2 The Regulator and Council of Governors

12.2.1 The Board of Directors must notify the Regulator and the Council of Governors without delay, and should consider whether it is in the public interest to bring to the public attention, any major new developments in the Trust's sphere of activity which are not public knowledge and which may lead, by virtue of their effect on its assets and liabilities or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the Trust.

12.3 Asset Registers

12.3.1 The Trust shall maintain an Asset Register recording fixed assets.

12.3.2 The Director of Finance shall:

(i) Be responsible for the maintenance of the Asset Register, approving the form of the Register and the method of updating and arranging a physical check of assets against the Register once a year;

(ii) Implement Procedures to comply with guidance on valuation in accordance with current accounting standards as applicable to NHS Foundation Trusts;

(iii) Establish Procedures covering the identification and recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified and validated by reference to appropriate supporting documentation;

(iv) Develop Policies and Procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence of disposal and supporting documentation, the application of sales proceeds and the amendment of financial records including the Asset Register.

12.3.3 Additions to the Asset Register must be clearly identified to a Trust property asset or to an appropriate budget holder for a non-property asset and be validated by reference to:

(i) Properly authorised and approved agreements, architect's/quantity surveyor's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(ii) Stores, requisitions and wage records for own materials and labour including appropriate;

(iii) Lease agreements in respect of assets held under lease commitments.

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset Control Procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance.

These procedures shall make provision for:

(i) Recording managerial responsibility for each asset;

(ii) Identification of additions and disposals;

(iii) Recording of all repairs and maintenance expenses;

(iv) Physical security of assets;

(v) Periodic verification of existence of, condition of, and title to, assets;

(vi) Reporting, recording and safekeeping of cash cheques and negotiable instruments.

12.4.3 All discrepancies from the fixed Assets Register revealed by verification of physical assets must be notified to the Director of Finance.

12.4.4 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported to the Director of Finance by all officers in accordance with the procedure for reporting losses.

12.4.5 Where practical, assets should be marked as Trust property.

13 Stores

13.1 Overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers, subject to such delegation being within the Scheme of Reservation and Delegation. The Director of Finance has responsibility for the systems of control.

13.2 Stores should be:

13.2.1 Kept to a minimum;

13.2.2 Subject to an annual stocktake; and

13.2.3 Valued at the lower of cost and net realisable value.

13.3 The control of any pharmaceutical stocks shall be the responsibility of the Designated Pharmaceutical Officer.

13.4 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager or pharmaceutical officer. Wherever practical, stocks should be marked Trust property.

13.5 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues and returns to stores, and losses.

13.6 Stocktaking arrangements shall be agreed with the Director of Finance.

13.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14 Disposals and Condemnations, Losses and Special Payments

14.1 Procedures

14.1.1 The Director of Finance is responsible for ensuring that the Trust has procedures for the disposal of assets including condemnations, and ensure that these are notified to managers whilst taking into account the recommendations within the NHS Estatecode.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking into account professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(i) Condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance;

(ii) Recorded by the condemning officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

14.1.4 The Condemning Officer shall satisfy himself / herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take appropriate action.

14.2 Losses and Special Payments

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

14.2.2 Any officer discovering or suspecting a loss of any kind must immediately inform their manager, who must inform the Chief Executive and Director of Finance. This should be done immediately if the loss is significant.

14.2.3 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.

14.2.4 In cases of fraud or corruption, the Director of Finance must inform the Trust's Local Counter Fraud Specialist (LCFS) and NHS Protect.

14.2.5 The Director of Finance must notify the Audit Committee, LCFS and the External Auditor of all frauds.

14.2.6 For losses apparently caused by theft, arson, or neglect of duty, except if trivial, the Director of Finance must immediately notify:

(i) The Board of Directors;

(ii) The External Auditor;

(iii) and the Audit Committee at the earliest opportunity.

14.2.7 The Director of Finance shall approve the writing off of losses according to the limits set in the Scheme of Reservation and Delegation.

14.2.8 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interest in bankruptcies and company liquidations.

14.2.9 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.10 No special payments exceeding delegated limits shall be made without prior approval of the Director of Finance and Chief Executive.

14.2.11 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. The Director of Finance shall report losses and special payments to the Audit Committee on a regular basis.

15 Information Technology

15.1 Executive Director of Commissioning and Quality Assurance Responsibilities

15.1.1 The Executive Director of Commissioning and Quality Assurance, who is responsible for the accuracy and security of the computerised data of the Trust, shall:

(i) Devise and implement any necessary procedures to ensure adequate and reasonable protection of the Trust's data, programmes and computer hardware for which the Director is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and the Freedom of Information Act;

(ii) Ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(iii) Ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment;

(iv) Ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as the Director of Finance may consider necessary, are being carried out.

15.1.2 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

15.1.3 The Executive Director of Commissioning and Quality Assurance shall publish and maintain a Freedom of Information (FOI) Publication Scheme, which is a complete guide to the information routinely published and describes the classes or types of information about the Trust which are publicly available.

15.2 Contracts for Computer Services with Other Health Bodies or Outside Agencies

15.2.1 The Executive Director of Commissioning and Quality Assurance shall ensure that Contracts for Computer Services for financial applications with another health organisation or any other agency, shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The Contract should also ensure rights of access for audit purposes.

15.2.2 The Executive Director of Commissioning and Quality Assurance shall periodically seek assurances that adequate controls are in operation.

15.3 Risk Assessments

15.3.1 The Executive Director of Commissioning and Quality Assurance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk.

15.3.2 This shall include the preparation of and testing of, appropriate disaster recovery plans.

15.4 Requirements for Computer Systems which have an impact on Corporate Financial Systems

15.4.1 Where Computer Systems have an impact on Corporate Financial Systems, the Director of Finance shall need to be satisfied that:

(i) Systems acquisition, development and maintenance are in line with Corporate Policies such as an Informatics Strategy;

(ii) Data produced for use with Financial Systems is adequate, accurate, complete and timely and that an audit trail exists;

(iii) Finance staff have access to such data; and

(iv) Such computer audit reviews as are necessary, are carried out.

16 Patients' Property

16.1 The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(i) Notices and information booklets;

(ii) Hospital admission documentation and property records;

(iii) The oral advice of administrative and nursing staff responsible for admissions.

That the Trust will not accept responsibility or liability for patients' property brought into the Trust's premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 In all cases where property of a deceased patient is of total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.5 Staff should be informed on appointment by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.6 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17 Retention of Records

17.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in The Records Management Code of Practice for Health and Social Care 2016.

17.1.1 The documents held in archives shall be capable of retrieval by authorised persons.

17.2 Documents held under the latest Department of Health & Social Care Guidance shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

18 Risk Management and Insurance

18.1 The Chief Executive shall ensure that the Trust has a programme of risk management which shall be approved and monitored by the Board of Directors.

18.2 The programme of risk management shall include:

(i) A process for identifying and quantifying risks and potential liabilities;

(ii) Engendering amongst all levels of staff a positive attitude towards the control and management of risk;

(iii) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

(iv) Contingency plans to offset the impact of adverse events;

(v) Audit arrangements including: internal audit; clinical audit; health and safety review;

(vi) Arrangements to review the risk management programme.

18.3 The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the Annual Report and Accounts.

18.4 The Director of Finance shall ensure that insurance arrangements exist in accordance with the risk management programme.

19 Funds held on Trust

19.1 Corporate trustee

19.1.1 The Standing Orders for the Board of Directors outline the Trust's responsibilities as a corporate trustee for the management of funds received in trust and Funds held on Trust.

19.1.2 The discharge of the Trust's corporate trustee responsibilities are exercised separately and distinctly from its powers exercised as the Trust, and therefore these powers may not necessarily be discharged in the same manner. The Board of Directors has devolved responsibility for the on-going management of the Funds to the Charitable Funds Committee, which is a sub-committee of the Board of Directors. Nevertheless, there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

19.1.3 The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements. The Director of Finance shall, in exercising his responsibilities set out in this SFI 19, have regard to appropriate and independent legal advice, as and when required.

19.2 Accountability to Charity Commission and the Independent Regulator

19.2.1 Accountability for charitable Funds held on Trust is to the Charity Commission.

19.2.2 Accountability for non-charitable Funds held on Trust is to the Independent Regulator.

19.2.3 The Scheme of Reservation and Delegation makes clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and Officers must take account of the provisions of the Scheme of Reservation and Delegation before taking action.

19.3 Applicability of SFIs to Funds Held on Trust

19.3.1 So far as it is possible to do so, and subject to SFIs 19.5 to 19.11 below, these SFIs will also apply to the management of Funds held on Trust.

19.3.2 The overriding principle in managing Funds held on Trust is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

19.4 Existing donated funds

19.4.1 The Director of Finance shall arrange for the administration of all existing donated funds. The Director of Finance shall also ensure that governing

instrument exists for all funds and shall produce detailed codes of procedure covering every aspect of the financial management of donated funds, for the guidance of all Officers. Such guidelines shall identify the restricted nature of certain funds.

19.4.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Board of Directors regarding the potential for rationalisation of such funds within guidelines issued by the Charity Commission, the Independent Regulator and under statute.

19.4.3 The Director of Finance may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, (e.g. designation for specific purposes).

19.5 **New donated funds**

19.5.1 The Director of Finance shall arrange for the creation of a new donated fund where funds and/or other assets, received in accordance with the Trust's policies, cannot adequately be managed as part of an existing fund.

19.5.2 The Director of Finance shall present the governing document to the Board of Directors for each new donated fund. Such a document shall clearly identify the objects of the new donated fund, the capacity of the Trust to delegate powers to manage the fund and the power to assign the residue of the donated fund to another fund contingent upon certain conditions, (e.g. discharge of original objects).

19.6 **Sources of new funds**

19.6.1 **In respect of donations, the Director of Finance shall provide:**

(i) guidelines to Officers as to how to proceed when offered funds. These are to include:

a. the identification of the donors intentions;

b. where possible, the avoidance of new trusts;

c. the avoidance of impossible, undesirable or administratively difficult objects;

d. sources of immediate further advice; and

e. treatment of offers for personal gifts;

(ii) secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's donated funds and that the donor's intentions have been noted and accepted.

19.6.2 **In respect of legacies and bequests, the Director of Finance shall:**

(i) provide guidelines to Officers covering any approach regarding:

a) the wording of wills; and

b) the receipt of funds and/or other assets from executors;

c) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Trust is the beneficiary;

(ii) be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;

(iii) be directly responsible for the appropriate treatment of all legacies and bequests; and

(iv) keep a register of all enquiries regarding legacies.

19.6.3 **In respect of fund-raising, the Director of Finance shall:**

(i) deal with all arrangements for fund-raising by and/or on behalf of the Trust and ensure compliance with all relevant statutes and regulations;

(ii) be empowered to liaise with other organisations and/or persons raising funds for the Trust. The Director of Finance shall be the only Officer empowered to give approval for such fund-raising subject to the overriding direction of the Board of Directors;

(iii) be responsible for alerting the Board of Directors to any irregularities regarding the use of this Trust's name or its registration numbers; and

(iv) be responsible for the appropriate treatment of all funds received from such sources.

19.6.4 **In respect of trading income, the Director of Finance shall:**

(i) be responsible for any trading undertaken by the Trust as corporate trustee; and

(ii) be responsible for the appropriate treatment of all trading income received by the Trust as corporate trustee.

19.7 **Investment management**

19.7.1 The Director of Finance shall be responsible for all aspects of the management of the investment of Funds held on Trust. The issues on which shall be required to provide advice to the Board of Directors shall include:

(i) the formulation of investment policy within the powers of the Trust under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(ii) the appointment and agreement of the terms of appointment of advisers, brokers, and, where appropriate, fund managers, written agreements to be signed by the Chief Executive;

(iii) the pooling of investment resources in accordance with a scheme approved by the Charity Commission, where the Funds held on Trust are charitable;

(iv) the participation by the trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(v) the use of trust assets;

(vi) the review of the performance of brokers and fund managers; and

(vii) the reporting of investment performance.

19.7.2 The Director of Finance shall be responsible for the appropriate treatment of all investment income including all dividends, interest and other receipts.

19.8 Expenditure management

19.8.1 The exercise of expenditure discretion (including dispositions) shall be managed by the Director of Finance in conjunction with the Charitable Funds Committee. In so doing the Director of Finance shall be aware of the following:

(i) the objects of various funds and the designated objectives;

(ii) the availability of liquid funds within each trust;

(iii) the powers of delegation available to commit resources;

(iv) the avoidance of the use of Exchequer funds to discharge trust fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(v) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and

(vi) the definitions of 'charitable purposes' as agreed by the Charity Commission.

(vii) Expenditure of any donated Funds held on Trust shall be conditional upon the item being within the terms of the appropriate fund and the procedures approved by the Trust.

19.9 **Banking services**

19.9.1 The Director of Finance shall advise the Board of Directors and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by either the Independent Regulator or the Charity Commission.

19.10 **Asset management**

19.10.1 Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance shall ensure that:

(i) appropriate records of all assets owned by the Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(ii) appropriate measures are taken to protect and/or to replace such assets.

These to include decisions regarding insurance, inventory control, and the reporting of losses;

(iii) donated assets received on trust shall be accounted for appropriately; and

(iv) all assets acquired from Funds held on Trust which are intended to be retained within the trust funds are appropriately accounted for.

19.11 **Reporting and accounting, and Audit**

19.11.1 The Director of Finance shall ensure that regular reports are made to the Board of Directors (or to a committee of the Board of Directors) with regard to the receipt of funds to be held on trust, investments of these funds, and the disposition of resources.

19.11.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Board of Directors within agreed timescales.

19.11.3 The Director of Finance shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the

required returns to the Independent Regulator and to the Charity Commission for adoption by the Board of Directors as required.

19.11.4 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

19.11.5 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by Internal Audit during the year. The Director of Finance will liaise with external Auditors and provide them with all necessary information.

19.11.6 The Board of Directors shall be advised by the Director of Finance on the outcome of the annual audit.

19.12 **Administration Costs**

19.12.1 The Director of Finance shall identify all costs directly incurred in the administration of all Funds held on Trust, and subject to any legal restrictions, and with the agreement of the Board of Directors, shall charge such costs to the appropriate trust accounts.

19.13 **Taxation and Excise Duty**

19.13.1 The Director of Finance shall ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of all required returns, and the recovery of deductions at source.

20 Standards of Business Conduct and Conflicts of Interest Policy

20.1 The Chief Executive in conjunction with the Board Secretary shall ensure that all staff are made aware of the contents of the Trust's Standards of Business Conduct and Conflicts of Interest Policy, which provides guidance on:

(i) The acceptance of gifts;

(ii) The acceptance of hospitality;

(iii) The acceptance of sponsorship;

(iv) Declarations of interest;

(v) Outside employment;

(iii) Rewards for initiative.

End of Standard Financial Instructions

The following Sections continue with standard / mandated paragraphs as outlined in the Trust's Policy - CNTW(O)01 – Development and Management of Procedural Documents

21 Identification of Stakeholders

21.1 The Board Secretary and Director of Finance seek the views of key staff in determining the continuing suitability of the entries within Standing Financial Instructions, prior to sign off by the Director of Finance and scrutiny by the Audit Committee. The Audit Committee's role is to consider the appropriateness of the contents and the process for developing proposed changes with a view to recommending approval by the Board of Directors.

- North Locality Care Group
- Central Locality Care Group
- South Locality Care Group
- Cumbria Locality Care Group
- Corporate Decision Team (and each of the Sub-Groups)
- Business Delivery Group
- Safer Care Group
- Communications, Finance, IM&T
- Commissioning and Quality Assurance
- Workforce and Organisational Development
- NTW Solutions Limited
- Local Negotiating Committee
- Medical Directorate
- Staff Side
- Internal Audit (including local Counter Fraud)

22 Training – See Appendix B

22.1 A Training Needs Assessment is shown at Appendix B. Standing Financial Instructions will be circulated to all staff.

23 Implementation

23.1 All staff should be currently complying with Standing Financial Instructions. The changes in this version of the SFIs constitute an extensive review and update. Relevant staff have been consulted with and involved in the review. This version is to be considered by the Trust Board of Directors in February 2021 and, if agreed, adopted from that date.

24 Fair Blame

24.1 The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse

incidents, although there may be clearly defined occasions where disciplinary action will be taken.

25 Fraud, Bribery and Corruption

25.1 In accordance with the Trust's Policy, CNTW(O)23 Fraud, Bribery and Corruption Policy, all suspected cases of fraud and corruption should be reported immediately to the Trust's Local Counter Fraud Specialist or the Director of Finance or the NHS Fraud, and Corruption Reporting Line on 0800 028 40 60 or online at www.reportnhsfraud.nhs.uk.

26 Monitoring – See Appendix C

26.1 Reference to Internal Audit Reports is to those reports relevant to Standing Financial Instructions, i.e. finance, procurement, workforce, etc.

26.2 Each assignment audit states the relevant Guidance and this always includes Standing Financial Instructions.

26.3 The combination of the five factors listed within Appendix C, is to ensure that Standing Financial Instructions are kept up-to-date and that any non-compliance with Standing Financial Instructions will be highlighted to the Audit Committee.

27 Associated Documents

27.1 Standing Financial Instructions have effect as if incorporated into the Trust's Standing Orders (SOs) and they should be used in conjunction with the Scheme of Reservation and Delegation.

27.2 Standing Financial Instructions are part of the Corporate Governance Manual and they are therefore linked to the following documents:

- Trust constitution (which includes Standing Orders);
- Scheme of Reservation and Delegation;
- Standards of Business Conduct and Conflicts of Interest Policy – CNTW(O)61;
- Board of Directors' Terms of Reference;
- Board Committees' Terms of Reference;
- NHS Foundation Trust Accounting Officer Memorandum;
- Code of Conduct: Code of Accountability in the NHS;
- Code of Practice on Openness in the NHS;
- Code of Conduct for NHS Managers;
- Council of Governors' Terms of Reference;

- Council of Governors' Nominations Committee Terms of Reference

28 References

- International Financial Reporting Standards;
- NHS England and NHS Improvement's foundation Trust Annual Reporting Manual;
- NHS Act 2006 as amended by the Health and Social Care Act 2012;
- Code of Governance (July 2014);
- Your statutory duties: A Reference Guide for NHS foundation trust governors (October 2013);
- Audit Code for NHS Foundation Trusts (March 2011);
- HSG (93) 5 - Standards of Business Conduct for NHS employees issued in 1993;
- Commercial Sponsorship - Ethical Standards for the NHS issued in 2000;
- NHS Foundation Trust Accounting Officer Memorandum – Monitor (April 2008);
- Code of Conduct: Code of Accountability in the NHS – Department of Health (September 2013);
- Code of Practice on Openness in the NHS – Department of Health;
- Code of Conduct for NHS Managers – Department of Health (October 2002)

In general, any reference relevant to ensure that financial transactions are carried out in accordance with the Law, Government Policy, the Department of Health Guidelines and Policies laid down by the Independent Regulator of Foundation Trusts and Best Practice.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Appendix A

Equality Analysis Screening Toolkit			
Names of Individuals involved in Review	**Date of Initial Screening**	**Review Date**	**Service Area / Locality**
Debbie Henderson	XX 20	XX 22	Trust-wide
Policy to be analysed		**Is this policy new or existing?**	
CNTW(O)51 Standing Financial Instructions – V04		Existing – (previously within Corporate Governance Manual)	
What are the intended outcomes of this work? Include outline of objectives and function aims			
The purpose of Standing Financial Instructions (SFIs) is to regulate the conduct of the Trust, its Directors, officers and agents in relation to all financial matters. They explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy, the Department of Health guidelines and policies laid down by the Independent Regulator of foundation trusts and best practice. This is in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the Trust. They identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with any detailed department or financial procedure notes.			
Who will be affected? e.g. staff, service users, carers, wider public etc.			
The Trust, its directors, all staff and agents			
Protected Characteristics under the Equality Act 2010. The following characteristics have protection under the Act and therefore require further analysis of the potential impact that the policy may have upon them			
Disability			
Sex			
Race			
Age			
Gender reassignment (including transgender)			
Sexual orientation.			
Religion or belief			
Marriage and Civil Partnership			
Pregnancy and maternity			
Carers			
Other identified groups			

How have you engaged stakeholders in gathering evidence or testing the evidence available?
How have you engaged stakeholders in testing the policy or programme proposals?
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Summary of Analysis Considering the evidence and engagement activity you listed above please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic

Eliminate discrimination, harassment and victimisation	
Advance equality of opportunity	
Promote good relations between groups	
What is the overall impact?	
Addressing the impact on equalities	

From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010? No

If yes, has a Full Impact Assessment been recommended? If not, why not?

This Policy has been reformatted to meet with the Trust Standard for Policy documents.

Manager's signature: **Date: XX**

Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Appendix B

Communication and Training Check List for Policies

Key Questions for the accountable committees designing, reviewing or agreeing a new Trust Policy

Is this a new policy with new training requirements or a change to an existing policy?	Yes Change to existing Policy with new reference in line with Trust Policy on Procedural Documents - CNTW(O)01
If it is a change to an existing policy are there changes to the existing model of training delivery? If yes specify below.	Yes – there isn't any training currently available
Are the awareness/training needs required to deliver the changes by law, national or local standards or best practice? Please give specific evidence that identifies the training need, e.g. National Guidance, CQC, NHS Solutions etc. Please identify the risks if training does not occur.	It is necessary that all staff are aware of the SFIs because of the nature of this document and the instructions contained in it. The risk if training does not occur is that there is a breach of SFIs
Please specify which staff groups need to undertake this awareness/training. Please be specific. It may well be the case that certain groups will require different levels e.g. staff group A requires awareness and staff group B requires training.	Policy is applicable to all staff
Is there a staff group that should be prioritised for this training / awareness?	Any decision making members of staff
Please outline how the training will be delivered. Include who will deliver it and by what method. The following may be useful to consider: Team brief/e bulletin of summary Management cascade Newsletter/leaflets/payslip attachment Focus groups for those concerned Local Induction Training Awareness sessions for those affected by the new policy Local demonstrations of techniques/equipment with reference documentation Staff Handbook Summary for easy reference Taught Session E Learning	To be determined
Please identify a link person who will liaise with the training department to arrange details for the Trust Training Prospectus, Administration needs etc.	Debbie Henderson

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Appendix B – continued

Training Needs Analysis

Staff/Professional Group	Type of Training	Duration of Training	Frequency of Training
Budget Holders	on line module	15 mins	once every 3 years

Should any advice be required, please contact:- 0191 2456777 (option 1)

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Appendix C

Monitoring Tool

Statement

The Trust is working towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators will be undertaken using this framework.

CNTW(O)51 Standing Financial Instructions Policy - Monitoring Framework			
Auditable Standard / Key Performance Indicators		**Frequency / Method / Person Responsible**	**Where results and any associate Action Plan will be reported to Implemented and Monitored;** (this will usually be via the relevant Governance Group)
1.	Standing Financial Instructions (Policy)	Preferably on an annual basis but as a minimum every 3 yearly Review of Policy by Policy Author unless earlier review appropriate for emerging issues	Audit Committee and Trust Board
2.	Head of Internal Audit Opinion on the effectiveness of the system of Internal Control at 31st March	Annual Report from the Head of Internal Audit to the Audit Committee	Audit Committee
3.	Individual Internal Audit and Counter Fraud Reports	Individual Reports with less than significant assurance – full report considered by Corporate Decisions Team and the Audit Committee Individual Reports with significant assurance – summary included in the Internal Audit Progress Report considered by the Audit Committee	Audit Committee and Corporate Decisions Team Audit Committee

CNTW(O)51 Standing Financial Instructions Policy - Monitoring Framework			
Auditable Standard / Key Performance Indicators		**Frequency / Method / Person Responsible**	**Where results and any associate Action Plan will be reported to Implemented and Monitored;** (this will usually be via the relevant Governance Group)
4.	Report on the progress of management actions from Internal Audit and Counter Fraud Reports	Individual Reports with less than significant assurance – report from Board Secretary Issues from Reports with significant assurance – Report from Internal Audit	Audit Committee and Corporate Decisions Team Audit Committee
5.	Re-audits and follow up Internal Audit Reports	Individual Reports to the Audit Committee	Audit Committee

The Author(s) of each Policy is required to complete this monitoring template and ensure that these results are taken to the appropriate Quality and Performance Governance Group in line with the frequency set out.

Appendix D – Policy Notification Record Sheet

Link to be inserted

Appendix E – Scheme of Reservation and Delegation

[to be inserted when update completed]

Appendix F – Audit Committee Terms of Reference

[to be inserted]

NHS
Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Finance for a purpose
A framework for managing our resources

James Duncan
Deputy Chief Executive / Director of Finance

Caring | Discovering | Growing | **Together**

- The aim of our approach is to enable learning, improvement and devolved decision making.

- This means making things simple and transparent and putting you in control.

- We are paid to deliver services. We want to enable you to understand the income you get for delivering your service, the resources you have available to spend, and most importantly what you need to deliver with those resources.

- For clinical teams, the resources you have available come from the income you receive, less the contribution you make for corporate support, and the use of buildings IT and equipment. We want you to understand all of these elements, but most of all what this means for the resources available to you.

- For corporate services, we agree a financial envelope based on the needs of the Trust and clinical services

- Once we have agreed your contribution or financial envelope, you have the freedom to make best use of the resources available to you. We will produce an information sheet which makes clear what decisions you can make and when you need to seek support or help. Our aim is that most decisions are made as close to care as possible

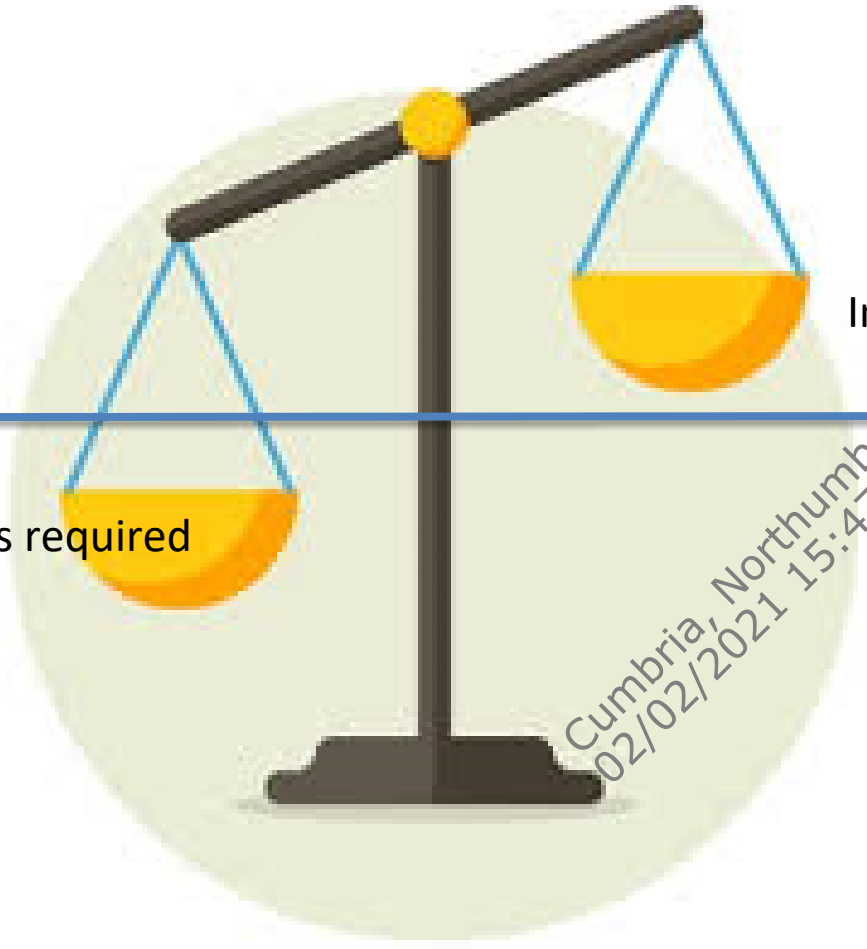
- This will include enabling you to determine the staffing and skills you need, now and in the future, to provide services to the agreed standards and quality, **within the resources you have available**

- You will have resources to invest if you have committed less than you need to deliver your contributions – you can think of this as being in credit (having money in the bank)

- You will need to think about how to reduce costs or increase income if you are spending more than the resource envelope available to you – you can think of this as being overdrawn at the bank

- We want to help you to think about how you can always stretch the resources available to you to deliver better care and support, bit by bit, day by day

Groups / CBU
financial decisions / responsibilities



In Credit – Group can invest

CONTRIBUTION

Overdrawn – Savings required

EXAMPLES OF CBU POSITIONS

Income and expenditure managed in CBU at Cost Centre level

The CBU position is managed and delivered based on the resource on each Cost Centre

The contribution is the total income less the total expenditure managed within the CBU

Agreed Contribution

In Credit / Overdraft is the amount the CBU are above (can invest) or below (overdrawn) their required contribution.

CBU 'overdrawn'

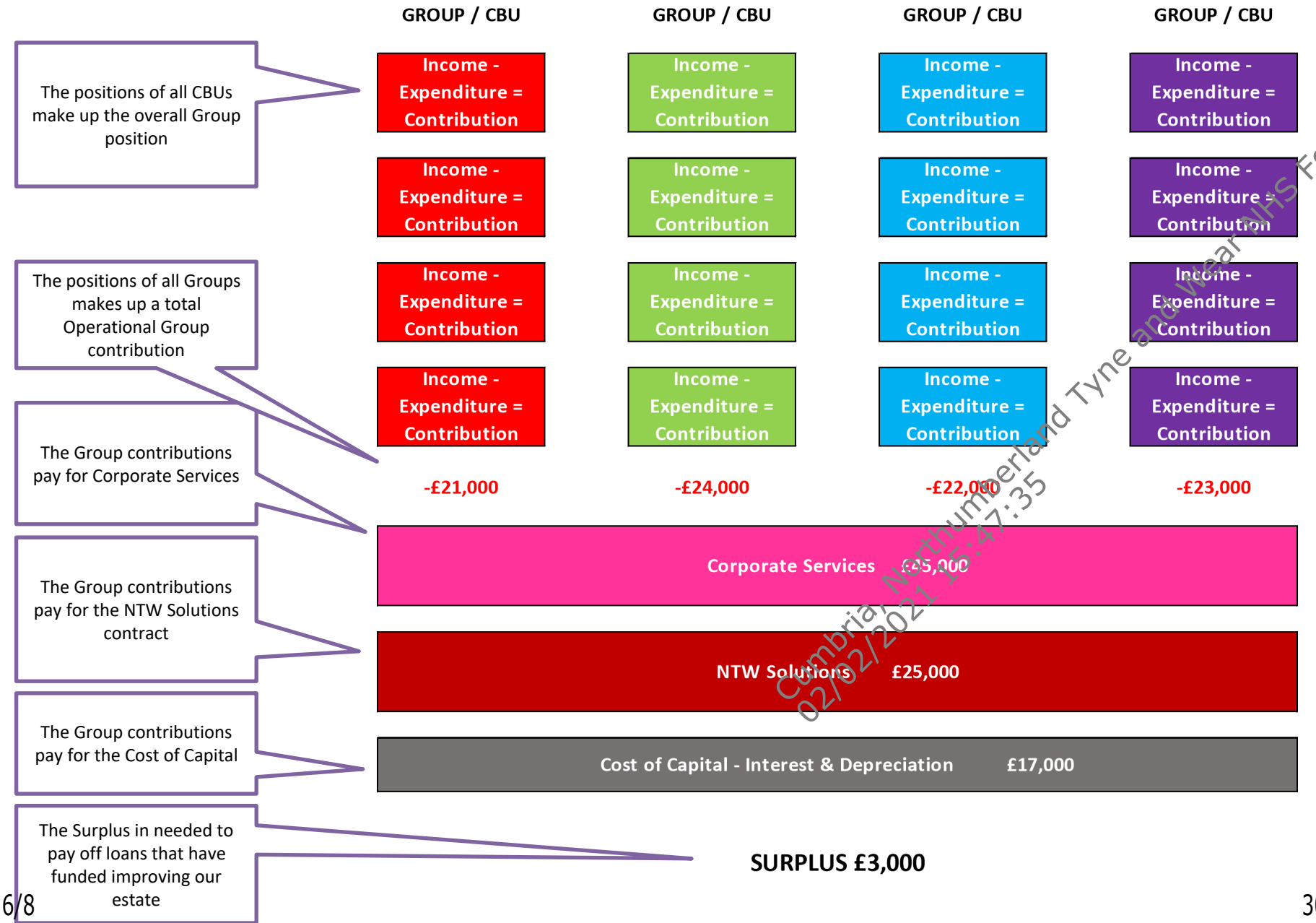
CBU			
Cost Centre Budgets	Income	Expenditure	
	£'000	WTE	£'000
Community Team West	-3,500	55.00	4,000
Community Team East	-4,250	45.00	3,500
Management	0	10.00	400
CYPS Team	-2,500	15.00	1,000
OPS Team	-1,000	7.00	500
Crisis Team	-450	5.00	300
OPS	-3,000	25.00	1,500
TOTAL	-14,700	162.00	11,200
Contribution			-3,500
Expected Contribution			-5,000
OVERDRAFT		-25.00	-1,500

CBU 'in credit'

CBU			
Cost Centre Budgets	Income	Expenditure	
	£'000	WTE	£'000
Community Team West	-4,000	35.00	2,750
Community Team East	-3,750	38.00	3,000
Management	0	10.00	400
CYPS Team	-1,850	11.00	750
OPS Team	-750	7.00	500
Crisis Team	-650	5.50	350
OPS	-3,500	20.00	1,250
TOTAL	-14,500	126.50	9,000
Contribution			-5,500
Expected Contribution			-5,000
IN CREDIT		8.00	500

DECISIONS AT COST CENTRE LEVEL DETERMINE THE CBU OVERALL POSITION

EXAMPLE OF TRUST FINANCIAL ARCHITECTURE



What is different?

- We are moving away completely from historical budgets
- Our resource planning is based on the income we receive, what we are delivering for that income, and the resources we are using
- We want to be clear with you about the resources you have available to you now and going forward-and how these are driven by the income you receive.
- Our historical way of budgeting has led to false expectations of recruitment and cost, over-estimating the gap between income and cost, and in turn this has led to big Cost Improvement Programmes
- Resource planning will be based on what you spend now.
- Vacancies will not be budgeted for but that does not mean you can't recruit. You need to ask yourselves the questions
  - Are we in credit or overdrawn?
  - Are we getting income to cover the new posts?
  - If we recruit will we be avoiding existing costs (eg, bank, agency, overtime)?
  - Do we want to change our skill mix as people leave or move on?
  - Can we avoid other costs to afford this post?
- Your budget will change according to your decisions, as long as you are living within your agreed financial envelope

Your position

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors
3rd February 2020

Title of report	Resource Planning 2021/22
Report author(s)	James Duncan, Deputy Chief Executive / Executive Director of Finance Chris Cressey, Associate Director of Finance and Business Development
Executive Lead (if different from above)	James Duncan, Deputy Chief Executive / Executive Director of Finance Lynne Shaw, Executive Director of Workforce & Organisational Development

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	x
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	27/1/21
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	

Management Group meetings where this item has been considered (specify date)	
Executive Team	11/1/21
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	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	

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

Resource Planning 2021/22

1. Executive Summary:

- The Trust is undertaking a Resource Planning exercise that will form the basis of the financial and workforce plans for 2021/22.
- In 2020/21, in line with national planning guidance the Trust is planning to breakeven. Over the years the Trust has invested significantly in its estate, partly funded by loans, including PFI. Each year the Trust needs to repay around £5m on these loans, and in order to maintain these payments, and sustain the Trust cash position, a surplus of £5m is therefore required. Over the coming years, and excluding any future change in the cash management regime, the Trust will need to recover this underlying surplus. Our current proposal is to generate a surplus of £3m in 2021/22.
- During 2020/21 there have been significant interim changes to the commissioning and contracting regime as we manage COVID 19. While planning guidance is not expected until later this quarter, it is expected that 2021/22 will be a year of consolidation, laying the ground for more fundamental reforms and longer term planning from 2022/23.
- During the year we have focused our resource planning on actual and forecast expenditure run rates month by month compared with income. This has allowed us to further explore opportunities for real zero basing of resource plans, and to explore how we can develop further transparency and ability for devolved decision making across the organisation.
- To support this we have also started looking at how we truly integrate our planning around quality goals, activity planning, workforce and financial management. We propose using 2021/22 as the next stepping stone in this journey.
- For 2021/22 we propose to entirely re-think our resource planning - starting with re-aligning our financial plans and workforce plans to our current income, spend and staffing numbers. To do this we propose utilising baseline contracts as the starting point for income arrangements, to build up a picture of expected income at Trust, Group, Clinical Business Unit (CBU) and cost centre level. Income guidance and income blocks are expected from NHSEI in March.
- We propose using current expenditure and workforce wte worked as our baseline for resource use, using our monthly run rate analysis down to cost centre level
- Over the next two months we will agree with each group a planned contribution to cover corporate costs, the costs of NTW Solutions Ltd and capital costs, as well as delivering the Trust surplus. At the same time we will agree an envelope for corporate costs and our contract with Solutions.
- Our intention is that Groups/Departments determine how they want to allocate resources within their areas, but this must deliver the agreed level of contribution.
- Under this proposal, expenditure budgets will reflect current spending levels and workforce running into 2021/22, adjusted only for unavoidable costs. Vacancies would not be budgeted for and instead recruitment and additional expenditure would require management teams to ask the questions:

    - Will this replace or reduce an existing cost (eg temporary staffing costs?)
    - Is there a source of income to cover this expenditure?
    - Have we headroom to commit additional expenditure and still meet our contribution?
    - Do we need support or help to deliver this?

- Our intention is to increase simplicity, transparency and enable resource decisions to be made and accountability to be held at a local level, unless there is a specific request for support passed upward.

2. Resource Planning 2021/22

Before COVID-19 CNTW had planned to deliver a £2m surplus in 2020/21 as part of financial trajectories agreed with the Integrated Care System (ICS). The table below shows the financial trajectories agreed with the ICS.

	2020/21	2021/22	2022/23	2023/24
Surplus	£2m	£3m	£4m	£5m

The CNTW trajectories reflect the Trust's financial needs as simply breaking even would result in reductions in the Trust's cash balances. The Trust needs to generate a surplus to fund the repayment of loans and support the Trust's capital programme. Generating an increasing surplus through the period will lessen the reduction of the Trusts cash balance throughout the plan. The Trust must agree a plan to deliver the required trajectories.

The Trust is undertaking a Resource Planning exercise that will form the basis of the financial and workforce plans for 2021/22. This will replace the previously described, 'budget setting' exercise. In the last 2 years the Trust has evolved the old budgeting practice of rolling forward recurrent baselines to an exercise of Groups/Departments identifying the income and expenditure required to deliver their services. This has been done through reviewing the finances of the previous year, and making adjustments to reflect changes in year and changes expected in the coming year. Each group has been required to make a contribution to fund corporate costs, including our contract with NTW Solutions Ltd, capital costs (paying interest and dividends on investment finance) and delivering the surplus required to pay off the capital element of our loans. Any shortfall between the agreed contribution required and the position identified by the Group has been recognised as the financial gap that has needed to be closed that year.

Each year the process of budgeting has led to a significant gap between planned use of resources and available resources, which has generated what we have previously referred to as our Cost Improvement Programme (CIP) or Financial Delivery Plan (FDP), which has then led to a separate process by which we identify schemes to close the gap. The gap has always been inflated because we recognise pressures on budgets but continue to assume that we will fill historical vacancies. This results in a number of issues

- Inflating the gap creates a sense of fear and uncertainty
- Significant work is put into develop Cost Reduction Schemes, which are often not owned or realistic, and which consume much management resource
- Failure to recruit in line with the plan leaves much of this work redundant-we have delivered our financial position year on year, but failed in each year to deliver more than 50% of our planned schemes
- Ineffective and unrealistic workforce planning, which is not aligned to the activity we need to deliver to achieve quality standards
- Schemes are often undertaken on a trust wide basis distorting further the relationship we have between the income we get in and the services that we deliver

As part of the Trust Long Term Planning work that was commenced before COVID, work was undertaken to review our approach to resource planning. One of the underlying

principles of the planning work is to agree the correlation between the quality standards we seek to attain, activities undertaken to deliver these standards, and the workforce delivering those activities, which generates the cost of the Team/Service provided. With that in mind it is proposed to move the financial planning to a more proactive methodology for 2021/22 focusing on actual staff numbers for the year. This will identify the expected staffing levels during 2021/22 to deliver agreed services safely.

The results of the exercise are intended to provide management across the organisation with a transparent and clear understanding of sources of income for our services, resources (particularly staffing) currently utilised to deliver those services, and the resulting underlying position in terms of financial sustainability. This will be considered alongside quality and activity planning as we look to develop a more in depth integrated approach through 2021/22. This will also give the Trust an understanding of where to focus to deliver sustainable services for the long term, informing our discussions around attainable quality standards, and enabling discussions on workforce planning to be properly developed across the organisation

This approach is designed to support the CNTW devolved management ethos. This process will enable groups to understand at a group, CBU and cost centre level, income for services, resources utilised in delivering those services and resultant contribution to corporate and capital costs. An expected level of contribution will be agreed with each group, alongside an agreed financial envelope for corporate services. Groups and corporate services will be tasked with delivering against these agreed positions.

How the resources are allocated to deliver services will be able to be fully determined by the Group/CBU/Department management team. Where a management team are over-committed against resources available they are effectively, 'overdrawn' and have to reduce costs/increase income to deliver their contribution. Where a management team are under-committed against their available resources, they are 'in credit' against their contribution and can utilise those resources to invest in services. Whenever a management team are looking to increase expenditure through recruitment or other areas of spend they should consider:

- Will this replace or reduce an existing cost (eg temporary staffing costs?)
- Is there a source of income to cover this expenditure?
- Have we headroom to commit additional expenditure and still meet our contribution?
- Can we divert resources from another area?
- Are we taking an opportunity to review our skill mix to meet service needs as people leave or move on?
- Do we need support or help to deliver this?

For example if a ward team requires help or support, this would be considered at CBU level, and if support agreed, the CBU would look to manage resources across its teams accordingly. If the CBU could not manage this within its resources it would pass for consideration by the group and so on. The expectation would be that each management team would look to develop its own solutions without referring the issue upwards. The Trust's scheme of delegation will clarify decision making at each level in support of this and each level of management will be issued with its own guide to decision making

A set of slides has been developed to help discuss this proposal and its implications with budget managers across the organisation. It is proposed this is cascaded through the

Trust management meeting hierarchy through January and February. The slides are included as Appendix A.

2.1 Identify Income & Expenditure for 2021/22

Patient Care Income

Alternative arrangements have been in place through 2020/21 for income from Commissioners in response to the COVID-19 pandemic. The Trust have received block income payments from local CCGs based on allocated income levels calculated nationally. The Trust now understand that this approach is to be extended into the first quarter of 2021/22, but that details of resource allocations will not be available until March. Guidance will also be issued on the allocation of Mental Health Investment Standard, Transformational Funding and the £500m non-recurring funding announced by the Chancellor in November to support Mental Health Covid Recovery.

In the meantime it is proposed that the Resource Planning exercise uses the contracts that were in place for 2019/20 as a starting point. The financial uplift for 2020/21 was revised to a 2.8% uplift, therefore that will be applied to the 2019/20 contracts. The Income Team are working closely with CCGs to agree the key elements of what a baseline contract for 2020/21 would look like. This will include how additional resources expected for 21/22 would be applied to contracts. This will be refined as guidance and allocations become clearer.

The Trust have had sight of a proposal for changes to the arrangements for non-contracted income and have fed back comments. In the meantime the Trust will plan on the basis of the setting income targets for non-contracted activity for English and non-English CCGs. All non-contracted income targets will include an activity target.

The Patient Care income plan for 2021/22 will be signed off by Group Triumvirates following final allocations.

Non Patient Care Income & Non Pay

To identify the resource levels for Non-Patient Care income and Non-Pay, Groups and Departments have been asked to provide a profile of the income / expenditure through 2021/22. Previous year run rates, together with the M1-6 actual and M7-12 forecast runs rates will provide both a support and a challenge to the amounts included.

Staffing

Resource planning for staffing will firstly consider staffing levels through 20/21 and the run rate into 21/22. This has been the subject of close co-operation within group support teams. This will represent the first cut of information to understand where each group and corporate department stands now against its planned contribution or financial envelope, considering income against committed expenditure. Separately we will identify the impact of new funded developments, proposals for increasing spend that are unfunded and aspirations for further recruitment both of which have been identified. Groups and Departments have worked with their subject experts for Business Development and Workforce to consider the staffing numbers by WTE. This information will be brought together to develop resource, workforce and where possible at this stage, activity plans, in line with delivery of the Trust overall plan.

The cost of the staff will be provided through a central costing exercise of the staff numbers included undertaken in Central Finance.

2.2 Apply the national and local uplifts

Funding uplifts were provided pre-COVID for 2019-20 up to 2023/24. The 2021/22 uplift will be applied to income as agreed with CCGs. The uplift needs to be broken down into the element for inflation, the element for growth and any offsetting annual efficiency factor. Once the detail is published this will clarify the level of efficiency required and the Mental Health Investment Standard funding to be agreed as part of the contracting exercise for 2021/22.

2020/21 was the final year of the three year pay deal agreed by the NHS. The Chancellor advised in the October statement that there is to be a pay freeze for public sector staff, although the NHS will be exempt. At this stage there are no further details. Once the detail is provided the resource planning exercise will reflect the pay arrangements for 2021/22. Groups and Departments will need to manage the costs of inflationary increases within the annual NHS uplift applied to their contributions / resource allocations.

2.3 Consider the implications of Planning Guidance

Planning guidance for 2021/22 was expected in February but this is now delayed till April due to the ongoing COVID crisis. It was already expected that this would be for an interim plan in this year to support stabilisation and recovery post Covid, and pending wider legislative changes, particularly to support system working. This has now been confirmed, and existing arrangements will continue in quarter 1, with planning guidance issued in April. Within this guidance we will get an understanding of resources available and expectations for delivery for the full year, to supplement information provided for quarter 1 in March. We know that there will be clear expectations set around recovering service quality and in mental health particularly around community transformation. We will need to consider these above and beyond the baseline assumptions that we have included in our planning to date.

2.4 Developing the resource plan and budget for 2021/22

Based on the work above a resource and workforce plan for 2021/22 will be generated, which will be based on the level of income and expenditure expected through the year. As we consider each of the elements we will agree contributions or financial envelopes for each area of the Trust, matching financial, workforce, delivery and quality considerations. This will effectively determine the requirements for financial delivery across each area of the Trust. We will aim to make this fair, equitable and deliverable. Teams will be encouraged to work with their support groups to consider monthly run rates going forward, along with quality deliverables to determine actions required to meet competing demands. We will aim to provide information that makes this clear and transparent and promotes timely decision making. It is recognised that this will be a year of transition and we will look to learn from the process on an ongoing basis. It's is intended that we will present the resource and workforce plan to the Board in April.

The Trust have a run-rate forecast for the remainder of the year (October 20 – March 21). The Resource Planning exercise will deliver a planned run rate from April 21 – March 22. The target is to then maintain an 18 month forecast run rate going forward. It may be practical that this is updated quarterly

2.5 Support the Long Term Plan objective for financially sustainable services

As part of the Trust's Next Phase planning work the Trust are striving for services to move towards becoming financial sustainable in their own right with contractual arrangements reflecting this. Income should cover the fully absorbed costs of the service commissioned, based on the agreed levels of activity. As part of the work identifying resource needs for 2021/22 the full cost of individual services will be identified. This will form the basis of an update to the financial toolkits that are supporting the planning work.

The Resource Plans will identify surpluses/deficits at service level and contract level based on the underlying resource commitment. This will help determine the contributions expected from Groups in the coming years. A key objective of planning over the next 5 years is to focus on aligning income and expenditure across services so they are financially sustainable in their own right. Services can move to making plans over several years to re-align their income/expenditure. This will need to be done in conjunction with all stakeholders.

More fundamentally work through 2021/22 will focus on understanding our quality deliverables and the activities required to deliver them. This will enable the development of an aligned workforce plan, considering workforce numbers, skills and roles needed. This in turn will enable us to understand and correlate quality, activity, Workforce and financial information in our future planning

3. Next Steps

The results of the resource planning discussions are being costed and the outputs are being shared with the Groups/CBUs/Departments to identify their positions against the expected contributions. Where there are differences, work will be required to understand how Groups/CBUs/Departments plans to deliver their contributions in 2021/22 and beyond. A summary of the position will be produced in February with a draft final version of the resource plan for 2021/22 produced in March.

The work to support the long term financial sustainability service will form part of the Trust's Next Phase planning work once it is stood back up.

4. Recommendation

The Board are asked to support the Resource Planning process for 2021/22 and its use as the basis of planning for delivery of financially sustainable services beyond 2021/22.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
3rd February 2021

Title of report	Quality Account update
Report author(s)	Allan Fairlamb, Head of Commissioning & Quality Assurance
Executive Lead (if different from above)	Lisa Quinn, Executive Director of 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

1. Executive Summary

The Department of Health and Social Care (DHSC) is currently reviewing whether regulations should be amended to revise the 30 June quality accounts deadline for 2020/21.

Out of area bed days have increased by one on the previous quarter.

There has been a continued focus upon waiting times within the period, with ongoing enhanced monitoring of over 18-week waiters. This has reduced by 0.83% on the quarter 2 possition.

2. Update on national timescales:

NHS England/Improvement provided an update regarding the process for the end of year timetable on the 15th January 2021.

In this letter they outline that the requirements and deadlines for quality accounts are prescribed in regulations and are not controlled by NHS England and NHS Improvement. DHSC is currently reviewing whether regulations should be amended to revise the 30 June quality accounts deadline for 2020/21.

3. Suggested engagement process:

It is suggested that the following engagement process is undertaken for 2021-22 (working towards a November 2021 submission).

4. Quality Account 2020-21 & Quality Priorities 2021-22 Timetable

Month	Action
February BoD: 3rd Feb	Quality Account Quarter 3 update on priorities Proposed process for 2020-21 Quality Account
March BDG: 19th March CDTQ: 22nd March Q&P: 24th March CoG Quality Group: 25th March	Stakeholder event (Confirm date) Develop Online Survey Share potential area of focus for 2021-22 Quality Priorities Update on development of Quality Account
April BoD: 7th April	Update on development of Quality Account
May BDG: 7th May CoG Quality Group: 13th May CDTQ: 24th May BoD: 26th May	Consider suggested quality priority area Agree Quality Priority Areas – **no board meeting in June**
July BDG: 16th July CDTQ: 26th July CoG Quality Group: 27th July Q&P: 28th July	Further development of draft quality priorities

Audit Committee: 28th July CoG: 13th July	
August 2021 BoD: 4th August	Further development of draft quality priorities Update on development on of proposed Quality Account
September 2021 BDG: 3rd Sept CDTQ: 27th Sept	Draft 1 of Quality Account to be developed and shared Stakeholder event (Date TBC) & launch of 30 day consultation Draft 1 of Quality Account to be circulated Presentation of draft 1 to Local Authority Overview and Scrutiny Committee's
October 2021 BDG: 16th Oct CDTQ: 25th Oct Audit: 27th Q&P: 27th	Review of Quality Account final draft
November 2021 BoD: 3rd Nov	Final draft approved by Trust Board
December 2021	Submission to centre

5. Update on current Quality Prioirties (Q3 2020/21):

Progress for quarter 3 requirements for each of the 2020-21 quality priorities is summarised below.

Quality Goal:	2020-21 Quality Priority:		Quarterly Achievement:				
			Q1	Q2	Q3	Q4	Comments
Keeping you safe	1	Improving the inpatient experience					Work is developing to allow the clinical system to capture and flow out of area placement bed usage via MHSDS
Working with you, your carers and your family to support your journey	2	Improve waiting times for referrals to multidisciplinary teams.					There continues to be patients waiting more than 18 weeks
Clinical Effectiveness	3	Equality, Diversity & Inclusion and Human Rights (in relation to the core values of fairness, respect, equality, dignity and autonomy (FREDA))					

Out of Area Bed Days

During Quarter 3, there has been 79 inappropriate out of area bed days. The out of area bed days which occurred in Quarter 3 were within the acute pathway, relating mainly to male beds. Quarter 3 is a slight rise on quarter 2.

Number of inappropriate out of area bed days	Q1 Actual	Q2 Actual	Q3 Actual
Trustwide	58	78	79

Waiting Times

There has been a continued focus upon waiting times within the period, with ongoing enhanced monitoring of over 18-week waiters.

The number of people waiting more than 18 weeks for their first contact with services has decreased in the quarter from 66 as at 30 September 2020, to 38 as at 31 December 2020. The number of people waiting overall has decreased (by 0.82%) from 3546 as at 30 September 2020 to 3517 as at 31 December 2020.

6. Summary of Quality Priorities from other Trusts:

TEWV: has 4 agreed priorities for 2020/21

Northumbria: has 8 agreed priorities for 2020/21

Newcastle Hospitals: has 7 agreed priorities for 2020/21

Sunderland and South Tyneside: has 14 agreed priorities for 2020/21

North Cumbria: has agreed 3 priorities for 2020/21

Examples of quality priorities include:

- Improve the clinical effectiveness and patient experience in times of transition from Child to Adult Services
- Reduce the number of Preventable Deaths
- Making Care Plans more personal
- Management of acutely unwell patients
- Children and young peoples emotional well-being and mental health
- End of Life care and Bereavement
- Make sure things get better and better – Quality improvement
- Improve the service for people who need mental health care – Treat as one
- Improve the service for people who might or do have a learning disability – reasonable adjustments.
- Improve the recognition and management of deteriorating patients
- Learn from patient feedback
- Ensure patients are involved in decisions about their care
- Ensure that patients receive adequate information and support for safe discharge from hospital
- Improve quality, efficiency and reduce variations in service by implementing recommendations from GIRFT

More detail and a full list of priorites by Trust is included in Appendix 1.

7. Actions:

- Provide future updates regarding Quality Account 2021-22 to the board on a bi monthly basis.

8. Recommendations

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

Appendix 1: Summary of Quality Priorities from other Trusts:

***TEWV*:**

There are 4 agreed priorities for 2020/21 which are –

Priority 1: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult Services
Priority 2: Reduce the number of Preventable Deaths
Priority 3: Making Care Plans more personal
Priority 4: Increase the percentage of inpatients feeling safe on the ward
Priorities 1-3 were priorities in 2019/20

Northumbria:

There are 8 agreed priorities for 2020/21 which are –

Priority 1: Flow and discharge – reducing number of days a patients stays on a ward from being declared medically fit, maintain 92% bed occupancy.
Priority 2: Staff experience – continue to implement and embed measuring and improving staff experience with the aim to evidence improvements in all domains of staff experience witin their 'Joy at work' framework
Priority 3: Management of acutely unwell patients - Increase feedback to teams on how well they are keeping to individual patient observation schedules and use this information to help teams improve as well as identify issues.
Priority 4: Supply and administration of medicines – Complete a thorough review of the use of patient group directions. Support staff training im related areas such asnone medical prescribers in community settings.
Priority 5: Children and young peoples emotional well-being and mental health – improve timilness of initial assessment referred to the service in North Tyneside. Agreeing a new pathway with commissioners and monitor the impact of these changes.
Priority 6: End of Life care and Bereavement – Undertake in depth clinically led analysis of reviews that provide opportunities for learning and share learning across the Truts. Review the volume and nature of workload.

***Newcastle Hospitals*:**

There are 7 agreed priorities for 2020/21 which are –

Priority 1: Reduce infections
Priority 2: Reduce pressure ulcers
Priority 3: Make sure we act when someone's test results are not what they should be
Priority 4: Bring together all the information we get from reviews and audits – closing the loop
Priority 5: Make sure things get better and better – Quality improvement
Priority 6: Improve the service for people who need mental health care – Treat as one
Priority 7: Improve the service for people who might or do have a learning disability – reasonable adjustments.

Sunderland and South Tyneside:

There are 14 agreed priorities for 2020/21 which are –

Priority 1: Reduce incidence if severe harm from patient falls
Priority 2: Reduce hospital acquired pressure ulcers
Priority 3: Improve the recognistion and management of deteriorating patients
Priority 4: Improve the standards of clinical documentation
Priority 5: Improve medication management
Priority 6: Learn from patient feedback
Priority 7:Ensure patients are involved in decisions about their care
Priority 8: Provide a safe, secure, clean and comfortable environment for patients and their carers/families
Priority 9: Ensure that patients receive adequate information and support for safe discharge from hospital
Priority 10: All patients and specifically those with physical, mental health and learning disabilities received person-centred care
Priority 11: Implement recommendations from the national maternity safety strategy
Priority 12: Improve outcomes for patients with serious infection by timely identofcation and treatment of sepsis
Priority 13: Improve quality, efficiency and reduce variations in service by implementing recommendations from GIRFT
Priority 14: Learn and act on the results from reviews of patients deaths
Priority 15:Integrate the four priority standards for seven day working

North Cumbria Integrated Care

Priority 1: We will improve the health and care outcomes of our local communities and support people of all ages to be in control of their own health
Priority 2: We will build health and care services around our local communities
Priority 3: We will provide safe an sustainable high quality services

Version Control: 2019/20 Year End (at Aug 20)	HEE North East & North Cumbria Current View of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust					
GMC TRAINEE NTS 2019	**GMC TRAINER NTS 2019**	**CQC Rating**	**NHSI Segment Rating**	**CNE QSG Monitoring**	**Initial LDA HEE NE Funding provided to Trust for 2019/20**	
9/206 HEE 9/233 UK	**9/206 HEE 9/233 UK**	**OUTSTANDING G, O, O, O, O July 2018**	**1**	**ROUTINE**	**£ 7,447,710**	

	Current HEE Intensive Support Framework Escalation Levels							
	HEE Overall ISF escalation	**Domain 1 Learning Environment & Culture**	**Domain 2 Educational Governance & Leadership**	**Domain 3 Supporting & Empowering Learners**	**Domain 4 Supporting & Empowering Educators**	**Domain 5 Delivering Curricula & Assessments**	**Domain 6 Developing a Sustainable Workforce**	**Comments/Concerns**
HEE view of LEP at organisational level	**0**	**0**	**1**	**0***	**0***	**0**	**0**	**Overall:** **1:** **2: Governance of system & post changes** **3: Year on year ranking in trainee NTS** **4: Year on year ranking in trainer NTS** **5:** **6:**

System view of Service Groups	**CQC ratings of Service Groups**	**HEE ISF Escalation Levels of Training Posts & Programmes by Domain**						**Negative**	**Positive**
Adults of Working Age	**G**	**0**	**0**	**0**	**0***	**0**	**0**		
Child & Adolescent	**O**	**0**	**0**	**0**	**0***	**0**	**0**		
Community	**O**	**0**	**0**	**0**	**0***	**0**	**0**		
Older People	**G**	**0**	**0**	**0**	**0***	**0**	**0**		
Forensic	**G**	**0**	**0**	**0**	**0***	**0**	**0**		
Rehabilitation	**O**	**0**	**0**	**0**	**0***	**0**	**0**		
Learning Disability	**O**	**0**	**0**	**0**	**0***	**0**	**0**		

Summary of current and recent issues being monitored by HEE NE&C	**Supportive Learning Environment**		**GMC Assurance Activity**
Issues being actively monitored • Governance of system & post changes with recent trust reconfiguration **Recently resolved issues** • Core Psychiatry: St Georges Morpeth • Old Age Psychiatry: St Georges Morpeth	**POSITIVE** Foundation Psychiatry Old Age Psychiatry – incl Trainers Rehabilitation Learning Disability - Trainers	**NEGATIVE**	**Themes arising from GMC Regional review** • Identification of leaners • Process for raising concerns *N.b: New GMC quality assurance cycle starting with HEE NE&C in 2021. This may involve active GMC participation in routine HEENE&C/ LEP quality management processes this year.*

2020 Education Self-Assessment Report
Executive Summary for CNTW Board
February 2021

1. Introduction

This executive summary is provided as an accompaniment to the main Self-Assessment Report (SAR) which is submitted by CNTW to Health Education England North East and North Cumbria (HEE NE&NC). The main report is attached as Appendix 1.

The paper is being presented at the board for information, to allow discussion and to seek approval of the report, a HEE requirement.

2. Background

CNTW is contracted to provide education to three broad groups of people; multi-professional staff, postgraduate medical staff and undergraduate medical staff. This training is not only essential for our ongoing recruitment but also brings a range of benefits in relation to patient safety and care, staff recruitment, innovation, research and financial resource (current contact £7.5 million).
The quality management of the education provided is done within the trust, as part of the quality governance this is reported to HEE and finally up to the GMC. The SAR is part of the mechanism for this reporting within the quality cycle, in addition to this HEE triangulate our date with external measures and also visit the trust annually.

3. HEE 2020 quality dashboard for CNTW

The HEE quality dashboard for CNTW uses RAG rating to show how the trust performs in education based on a range of external measures. For this year highlights include good GMC trainee and trainer feedback (9th out of 233 trusts), and outstanding CQC rating. There is one issue highlighted from previous years, that of governance. This was raised due to the changes in trust structure with the joining of North Cumbria with the North East and reflecting the need to align governance structures across the trust to reflect this.

Version Control: 2019/20 Year End (at Aug 20)	HEE North East & North Cumbria Current View of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust							
GMC TRAINEE NTS 2019	GMC TRAINER NTS 2019	CQC Rating	NHSI Segment Rating	CNE QSG Monitoring	Initial LDA HEE NE Funding provided to Trust for 2019/20			
9/206 HEE 9/233 UK	9/206 HEE 9/233 UK	OUTSTANDING G, O, O, O, O July 2018	1	ROUTINE	£ 7,447,710			
	Current HEE Intensive Support Framework Escalation Levels							
	HEE Overall ISF escalation	Domain 1 Learning Environment & Culture	Domain 2 Educational Governance & Leadership	Domain 3 Supporting & Empowering Learners	Domain 4 Supporting & Empowering Educators	Domain 5 Delivering Curricula & Assessments	Domain 6 Developing a Sustainable Workforce	Comments/Concerns
HEE view of LEP at organisational level	0	0	1	0*	0*	0	0	Overall: 1: 2: Governance of system & post changes 3: Year on year ranking in trainee NTS 4: Year on year ranking in trainer NTS 5: 6:
System view of Service Groups	CQC ratings of Service Groups	HEE ISF Escalation Levels of Training Posts & Programmes by Domain						Negative / Positive
Adults of Working Age	G	0	0	0	0*	0	0	
Child & Adolescent	O	0	0	0	0*	0	0	
Community	O	0	0	0	0*	0	0	
Older People	G	0	0	0	0*	0	0	
Forensic	G	0	0	0	0*	0	0	
Rehabilitation	O	0	0	0	0*	0	0	
Learning Disability	O	0	0	0	0*	0	0	

Summary of current and recent issues being monitored by HEE NE&C	Supportive Learning Environment		GMC Assurance Activity
Issues being actively monitored • Governance of system & post changes with recent trust reconfiguration **Recently resolved issues** • Core Psychiatry: St Georges Morpeth • Old Age Psychiatry: St Georges Morpeth	**POSITIVE** Foundation Psychiatry Old Age Psychiatry – Incl Trainers Rehabilitation Learning Disability - Trainers	**NEGATIVE**	**Themes arising from GMC Regional review** • Identification of leaners • Process for raising concerns *N.b: New GMC quality assurance cycle starting with HEE NE&C in 2021. This may involve active GMC participation. In routine HEENE&C LEP quality*

4. SAR summary

The 2020 SAR is divided into the following sections:

1. A front-sheet tracking quality reporting to the trust Board level

2. Section 1 - An Executive Summary including top 3 successes and challenges

We have identified our main successes being our response to supporting education through the covid-19 pandemic, adjusting to organisational change and improvements in recruitment. The response to the covid-19 pandemic is also one of our highlighted challenges, as is delivering a new undergraduate medical curriculum and the recruitment challenge within learning disability services. Each challenge has plans identified to address the risk and challenge

3. Section 2 Assurance and Exception Reporting against standards for:

4.

- Multi-Professional against HEE Domains
- Postgraduate Medical against promoting excellence
- Undergraduate Medical against HEE domains

Within this section we have measured our educational performance for each group of learners against the quality standards relevant to their training. Where there are areas that standards are not being fully met actions have been identified within an educational quality improvement plan to address these. Areas of good practice and challenge are also highlighted within this section.

5. Section 3 Organisational policies and processes in support of delivery of the HEE Quality Framework.

Within section 3 there is reference made and listing of local trust polices in support of delivery of the HEE Quality Framework. Policies that have changed over the reporting year are highlighted.

6. Section 4 19/20 Financial accountability

Section 5 allows us to provide a high level overview of how the monies provided for training is used within the trust. Our system of having separate educational budget lines is one HEE is highly supportive of. This allows us to demonstrate accountability more easily than other trusts, and we can demonstrate clear alignment of resource with educational activity.

Appendix 1 – CNTW SAR
Appendix 2 – 2019-20 CNTW HEE assessment grid

Dr Bruce Owen
Director of Medical Education

Report to the Board of Directors
February 3rd 2021

Title of report	**CNTW Self-Assessment Report (SAR) 2020**
Report author(s)	**Drs Bruce Owen, Prathibha Rao, Frauke Boddy and Sam Dearman, Emma Paisley, Anne Moore and Michelle Hall**
Executive Lead (if different from above)	**Dr Rajesh Nadkarni, Medical Director**

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	25/01/21
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	x	Environmental	x
Financial/value for money	x	Estates and facilities	x
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

Health Education England

2020 Education & Training

Self-Assessment Report (SAR)

Reporting Period: 1 August 2019 to 31 July 2020

Deadline for submission to HEE NE: 29 January 2021

Trust's name:	**Cumbria, Northumberland Tyne and Wear**
Trust Chief Executive's name:	**Mr John Lawlor**
Value of contract / funding with HEE:	Total initial 20/21 LDA (education contract) value Q2 Indicative: **£7,447,710**
Director(s) / those responsible for Education (name and role):	**Dr Bruce Owen Director of Medical Education** **Anne Moore, Group Nurse Director**
Name and Title of author(s):	**Drs Bruce Owen, Prathibha Rao, Frauke Boddy and Sam Dearman, Emma Paisley, Anne Moore and Michelle Hall**
Report signed off by:	**John Lawlor, Dr Rajesh Nadkarni and Gary O'Hare**
Name of Board Level Exec/Non-exec Director responsible for Education and Training: **Board Approval Status and Date:**	**Dr Rajesh Nadkarni** **Due at Feb Board**

The SAR is aligned to the GMC Standards for medical education: Promoting excellence, and the HEE standards which includes a sixth theme, developing a Sustainable Workforce. The SAR should be read alongside the relevant Quality Improvement Plan (QIP).

Contents

Section 1: Executive Summary

1.1 Organisation's governance for education and training

To help outline your organisation and team, please briefly describe current structures. Please share visuals.to demonstrate multi-professional education structures, reporting to the Trust Board. This will also help ensure we have up to date key contacts.

Within CNTW there are established educational teams leading on the delivery and quality management of both medical and multi-professional training. Within the medical education team the team manager and quality lead work alongside the DME and AMDs within medical education to review quality metrics and priorities. These are then shared with both the executive team and trust board. Over the last year there has been work completed to review the governance structures and policies relating to governance in education to align practice across the NE part of the trust and N Cumbria.

Within the multi-professional education structure, there are similar structures with dedicated teams planning education and placements and linking into the executive team and trust board.

Attached are organisational diagrams outlining these structures and links.

1.2. Top three education and training successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period.

Description of success	Domain(s)	Standard(s)
The covid19 pandemic has resulted in significant challenge for the trust, impacting all aspects of trust service and business. The rapid establishment of a Gold Command Centre with a broad membership, including Directors leading on education and training ensured that as the response to the pandemic developed the educational impact could be considered and kept high on the agenda. In addition to having education considered at this high level there were a number of effective initiative established to both support learners and trainers, this included: • establishing weekly meetings open to all trainees with the DME and members of the medical education faculty • production of an online, live, workbook providing all staff with the latest clinical and ICP guidance regarding managing patients during the pandemic. • Working with trainees to respond to workforce pressures due to the pandemic, establishing additional resources out of hours to reflect the increased intensity of work	All	All

• Working with learners and trainers to establish remotely accessible CPD both targeted at managing the pandemic and wider learning needs.		
During the period of reporting there has been significant organisational change with mental health services for North Cumbria now being delivered alongside those within the Northumberland, Tyne and Wear region and the formation of CNTW trust. From an educational and training perspective this has significant implications; we have however been able to prepare for this change well and the change has, we believe, allowed us opportunities to share good practice across the organisation and use the increased size of the organisation to the advantage of both learners, trainers and patient care. Evidence of this is through the GMC trainer and trainee survey where we continue to perform well. Examples of actions include: • Combining training opportunities for trainees and trainers across the trust • Reviewing and enhancing governance and quality control systems across the trust through sharing of good practice • Being able to establish a 24 hr first on call cover for inpatient services at the Carleton clinic, enhancing patient care and training experience	All	All
Focus on the development of our future workforce remains a key component of both Trust, medical and Nursing strategy. Throughout the current national Covid19 crisis we have continued to ensure we are recruiting and retaining staff. We are pleased with the success we have had in medical recruitment, both in relation to medical trainees, (both on training programmes and trust initiatives) consultant trainers and the development of innovative roles. The Trust Academy has continued to build and expand career pathways through the implementation of our Grow our Own strategy, ensuring delivery and recruitment to Degree Nursing Apprenticeships and Advanced Clinical Practitioner programmes, as well as continued investment and expansion of vocational programmes. The Trust was able to deploy over 170 Nursing and AHP undergraduates into paid placements within clinical services from April to September. This enabled undergraduates to continue to meet the clinical components of their programmes and for final year students complete on time, enabling the Trust to maintain recruitment to our workforce. This initiative was a welcomed component in our ability to continue to deliver high quality services to those we serve.	3,5,6	3.1, 3.4, 3.6, 3.8, 5.9, 5.10. 6.3, 6.4

1.3. Top three education and training challenges or prominent issues

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
While we have identified our response to the covid19 pandemic as one of our main achievements this has also been a significant challenge. While our familiarity with managing clinical, staffing and training issues relating to the pandemic has increased this remains a significant challenge, and is likely to over the coming year. In relation to training we remain aware of the need to continue with the adaptations that have been made to a range of training opportunities, from CPD events, clinical training and psychotherapy. We are aware that the degree of uncertainty that has been a feature of the pandemic is likely to lead to further unexpected challenges however by ensuring good links with the trust gold command centre and partners in education (HEE and Universities) we are well placed to be able to adapt to these. The established focus on delivery of clinical placements based on academic calendars means deployment of significant numbers of nursing students at specified times throughout the academic year. In the current climate this can be very challenging in meeting HEI timescales for allocation of placements and means that large numbers are focused on delivery at the same time which creates a pressure on clinical services.	All	All
CNTW delivered Newcastle University's new 2017 Curriculum for the first time for the third year medical students in January 2020. Particular challenges included - upskilling clinical teachers to deliver formal teaching using a flipped classroom approach and delivering more small-group teaching, whilst student numbers in each cohort of students had doubled from previous years, which significantly affected demand on resources both for formal teaching and clinical placements. - The rotation was cancelled mid-way due to COVID-19, and we had to produce remote teaching materials at short notice. - We had to deliver a catch-up rotation before Christmas for those student who had completely missed out when the rotations were cancelled. - It has been a particular challenge to accommodate a larger number of students in view of COVID and social distancing requirements and organising patient contact has been a challenge, particularly where community services have been working more remotely.	3, 5	All within 3 and 5

Learning Disability workforce We have seen a gradual increase in the numbers accessing local undergraduate learning disability programmes and this is welcomed. However there remains a significant challenge around the learning disability workforce and ensuring this continues to exist. This requires greater access to Learning Disability nursing by having adequate Learning Disability nurses trained to support the workforce need across mental health, primary care and acute services across the region. This challenge nursing recruitment is mirrored in medical recruitment where higher training posts remain difficult to fill in LD.	6	

1.4. HEE priority themes for 2020-21 quality cycle

HEE has identified priority themes from issues arising over the previous Quality Cycle(s) and is keen to identify how your organisation is adapting and planning to address these, with a view to ensuring the continued delivery of high quality education and training across all programmes and placements within your organisation.

HEE's priorities are identified for each domain of the HEE Quality Framework. Please complete each section identifying how your organisation is addressing each theme across all programmes and placements, which areas and issues are proving to be the greatest challenge, and what additional support would be helpful in addressing these.

Mindful of time and in a bid to ensure proportionality, responses should be an overall summary and we suggest are limited to 250 words.

HEE priority themes for 2020-21 quality cycle
Domain 1 Learning environment and culture Provision of a **safe clinical learning environment** for all trainees, students and staff has been a challenge in 2020 and has resulted in the suspension of some education and training programmes and/or the movement of staff to unfamiliar clinical areas. How did you ensure induction occurred for all learners – did any not receive one? Did any learner not attend a placement because a lack of PPE? What escalation processes did you use for learners to raise safety concerns?
All trainees and students had access to PPE, as any other member of staff did. At no point was lack of PPE a factor inhibiting student or trainee placements. At the start of the pandemic the trust had limited access to FFP3 masks, these being necessary during any aerosol generating procedure. While these procedures are relatively infrequent within mental health services, they do occur, both in a planned way (e.g. ECT) and emergency situations (e.g. arrest situation). Junior doctors were prioritised within the trust for fitting and allocation of FFP3 masks due to the nature of their work. For all students and trainees across disciplines there has a reporting process established for possible C19 infections and students and trainees have had access to Lateral Flow Testing In addition to the above information regarding induction we introduced a number of additional measures to maintain a safe clinical learning environment: • Weekly online forum – a weekly online forum chaired by the DME and open to all trainees across the trust. • Covid19 workbook – the rapidly change nature of the pandemic in relation to guidance and management made it difficult for trainees and indeed clinicians to keep abreast of best practice.

This has become a key reference document for the trust and more widely, indeed on request it has been shared with the Royal College of Psychiatrists who have linked it with their own guidance.

- Gold command links – Members of both the medical education and multi-professional training teams having close links with, and regular attendance at the trust Gold Command centre has allowed training needs to be considered at all times and a rapid flow of information.
- To provide additional support to Newcastle Medical students we introduced a mentor scheme, whereby small groups of students are linked up with a clinical mentor who meets with them once a week
- Induction for trainees was mostly held with MS Teams, with only a half day of face to face sessions in Covid secure trust approved rooms/buildings to: answer induction/clinical queries, sign essential paperwork and receive fit testing for FFP3 masks.
- Additional support and training for educators, with AHPs, nurses and medical staff
- To work with educators to adapt placements across all disciplines
- Laptops were bought to allow AHP and medical students to access placements remotely
- Psychology students within community services were largely having training delivered remotely, with psychological assessments and interventions provided by video consultation (using OneConsultation) or by telephone

Domain 2 Educational governance and leadership

With rapidly changing clinical environments, the **governance of both clinical and educational supervision** has been challenging both at organisation and departmental levels. How did you ensure learners and supervisors were aware of new arrangements if redeployed to another area? Did all learners receive appropriate supervision? Did you receive any complaints? What escalation processes did you use for learners to raise educational concerns?

Medical Trainees:

- Minimal re-deployment within trust – We ensured that any decision to re-deploy trainees was carefully considered and communicated to all relevant schools. The overall rate of these was low, with the majority of those being led by training needs, as reflected with the reduced community service provision in the immediate aftermath of the pandemic, and the bulk of the work intensity being within inpatient work environments at the time. We ensured that we reverted back to pre-COVID arrangements at the earliest opportunity. The rest of the re-deployments were led by Occupational health advice and individual risk assessments of trainees. All trainees thus affected by this were individually consulted and their clinical supervision arrangements were left intact.
- Foundation trainee changes – As recommended by the HENE and the Northern Foundation School, all Foundation Year 1 trainees were re-deployed back into acute trusts. There were a few other instances where the Foundation year 2 trainees themselves initiated re-deployment processes back to their acute trusts for individual reasons. All of these were managed on a case by case basis, and with good communication with the Foundation tutors of the respective acute trusts and the Foundation school.

Nursing:

- The Trust PET converted the annual update programme to an e learning format and have continued to provide updates via e learning during this period. In addition we have ;
- during deployment phase all placements were provided with an pack detailing changes under the emergency standards
- utilised Trust communication systems to continue to update and inform
- The team have provided additional support to placement supervisors and students via Microsoft teams. Throughout we have maintained robust communication and worked in partnership with our HEI colleagues. All learners continued to receive supervision. Preparatory work has been

undertaken with Practice Assessors and Supervisors (PA/PS) for students moving into year 2 in recognition of the deficit in year 1 clinical placement.

AHPS and Psychology:

- Students all had access to supervision, at times this was face to face on other occasions MS Teams was utilised to provide this.

Domain 3 Supporting and empowering learners

The changed clinical environment has been challenging to all staff. Have you found learners had additional health and well-being needs and if so how did you address them?

- All trainees and students had individual risk assessments completed with their clinical supervisors with additional occupational health advice where appropriate. Based on recommendations we employed a number of supportive actions, such as arrangements to work remotely during the day with IT support for those who needed shielding and in the case of medical trainees releasing them from OOH work.
- Some trainees moved to settings that were deemed to be of lower risk of transmission of COVID. All trainees continued to have regular weekly supervisions with their supervisors to monitor their well-being. Mid placement reviews also provided the additional pastoral support.
- We recognise that this has been an anxiety provoking time and to provide reassurance in addition to access to supervision and support for nursing students we have developed a resilience training module. We are currently piloting this module with our current preceptee's and will deliver to all students per locality commencing in March. This programme will be evaluated and outcome shared with HEI.
- In light of the necessary changes to delivery of community services we have utilised placement capacity funding and in addition invested significant Trust financial resources to funding provision of over 200 dedicated laptops for students (nursing and medical) use during placement. This provides greater access to students whilst on placement.
- Work intensity – The pandemic highlighted pockets of intense Out of Hours work activity in three of our medical rota areas. Following consultation with trainees in the trainee forum, we initiated additional weekend 6 hour shifts for these rotas with trainees volunteering to work into this. The trainees unanimously agreed as this being very helpful; this improved patient care and speed of response and reduced burn outs. We have continued to keep up with these extra shifts for 2 of these sites.

Domain 4 Supporting and empowering educators

Please describe how you have continued to support educators and trainers in their roles to ensure that they have had sufficient time and resources to provide supervision, support and educational delivery to their students and trainees. What additional support has been identified and what have you provided to address these needs?

For all staff with educator roles the support in place in relation to job plans and resource has been maintained throughout the pandemic.

Medical:

- Educators and trainers have continued to be supported throughout the pandemic. All of the Faculty Development Programme courses, which are aimed at both undergraduate and postgraduate trainers of medical students and trainee doctors, were moved online via MS Teams and went ahead as planned. The Medical Education Conference was also moved onto MS Teams and shortened to a half day programme of updates, keynote speaker and educating during Covid related workshops. Attendance at all online courses and events has been at the levels it would normally have been, with good feedback and an appreciation that training and support were still being provided.

- The Medical Education team updated and developed central teaching resources for medical student teaching, so they could be delivered online, mostly via MS Teams. In addition we provided educators with guidance on facilitating clinical placements during the pandemic- both in form of educational videos and in writing.
- Balint group – Following suspension of all training activities, Balint groups were also suspended initially for a couple of months. With online support and access, and with guidance from the Royal College and the School of Psychiatry, we have been able to resume these groups on an online format, and now run regularly.

Nursing:

- Implementation of a Team approach to create additional capacity through a more productive student to PA/PS ratio. Additionally, it advocates the use of qualified NA for year 1 student support, and AHPs to provide practice supervision to any professional learners.
- review of PET structure and the addition of new roles whilst continuing to deliver existing roles in particular Education Support Nurses
- delivery of e learning packages for PA/PS to inform of changes and have supported delivery including additional information packs
- development of an internally facilitated PA /PS module which will see an increase across all services as part of our expansion programme
- working in partnership with Northumbria University developed a virtual programme for 1st year students delivered by experienced clinicians which includes , preparation for practice, resilience training and simulation of handover and MDT for those undertaking a “staggered” placement

AHPs:

- Additional educator training slots with UNN were offered as were on line training sessions.
- Open question and answer sessions were run for educators with PPF, deputy director and university
- Educators were linked/buddied up with one another to offer support and develop creative ways of managing the placements within the limitations at the time.
- A group has been established for clinicians and the HEIs (Northumberland, Cumbria and Sunderland) to share good practice, develop innovative new ways of delivering placements, creating new placement opportunities etc.
- Students, educators, PPF and lecturers ran a workshop for clinicians at the annual AHP conference to showcase their work to date and encourage other to join the group mentioned above.

Domain 5 Developing and implementing curricula and assessments

So far in 2020, many programmes and placements, have struggled to deliver the full range of educational and training opportunities required by all curricula. Assessment processes have been adapted to support progression to the next training level where appropriate, but with the view to ensuring any shortfall in experience is made up over the next training year where possible. Please describe how you are ensuring that all students and trainees within your organisation will receive the appropriate opportunities for both educational and practical experience required by their curriculum. How were any concerns escalated in real time? Did you have areas where learners could not complete their objectives/had more adverse ARCP outcomes than usual?

Medical Trainees:

- Access to educational CPD – After a gap of a few months initially during the pandemic, both local and trust wide postgraduate teaching sessions were commenced. We have ensured that since August all core trainees have been provided the opportunity for case presentation and participation in journal club, thus fulfilling their curriculum requirements for the ARCP year. Balint teaching also resumed after a short break, and therefore did not unduly affect ARCP outcomes.

Trainees commenced teaching sessions with external speakers to help support their learning needs

- CASC - The usual opportunities provided by the trust to help core trainees prepare for MRC Psych CASC exam in September were offered. A mock CASC exam was held in July via MS Teams as this reflected the format of the actual exam and helped trainees to undergo this experience beforehand. In addition to this, the CASC Club ran and was moved onto MS Teams. This comprised four evenings per week over two weeks. Overall feedback for both events was good and in line with the face to face events delivered.
- Psychotherapy – Provision of Psychotherapy training experiences suffered during the pandemic. The Psychotherapy tutor has worked hard to 'catch-up' with this shortfall and simultaneously accommodate the large number of core trainees who joined the scheme in Aug 20. The Balint groups have resumed on an online format with bringing in additional Balint facilitators external to the organisation to support this. Access to short case is now smoother with some practical changes to the introductory training sessions (which can now also be delivered in an online format) and with additional funding support for supervision. Initial difficulties with access to long case is now made easier with the Psychotherapy department now resuming assessments after a break during the pandemic. A few trainees received ARCP COVID outcomes due to the delay, but have now resumed their training requirements.

Medical students:

- we adapted undergraduate teaching with the introduction of technology to support remote teaching while maintaining clinical face to face (with PPE) contacts as much as possible
- we supported Newcastle University by transferring all of the Integrated Clinical Placements formal teaching content to remotely delivered content, which students were able to access in their own time prior to attending for a clinical catch-up rotation which we delivered in December 2020 in addition to our usual commitments.

Nursing students:

- The challenges faced in delivering nursing undergraduate programmes during this unprecedented time are detailed in the domains above. We have had no areas in which students have not been able to complete objectives or had adverse ARCP outcomes reported. We have worked collaboratively with HEI at all times to adjust to changes required by necessity and continued to build on our existing robust relationships.

AHPs:

- HEI utilised role play type assessments to ensure students reached required competencies
- Some professions e.g. Physiotherapy struggled a little as much of their work is "hands on" and clinics were not running making it difficult to assess levels of expertise/competency
- Not aware of any areas where AHP students were unable to meet competencies in fact some stayed on longer and rolled onto their second placement over the summer to assist with workforce/capacity issues, managing to meet the competencies required for this too.

Domain 6 Developing a sustainable workforce

We are the NHS: People Plan for 2020/21 – action for us all was published at the end of July 2020. Please detail how your organisation intends to address the work set out in the plan with particular regard to education and training, and identify which areas of your workforce are particularly vulnerable in terms of delivering the needs of **both** current clinical services and the training/education of the future workforce. Please provide details of how the educational team is working within the North East & North Cumbria Integrated Care System. Please identify any barriers you are encountering to the delivery of collective ICS approach to education, training and workforce across the whole of NENC.

The workforce expansion across professions to fulfil the NHS Long Term Plan and implement the Community Mental Health implementation framework is long overdue for mental health, learning disability and neuro disability services, and is very welcome.

In terms of ICS mental health workforce planning, this is coordinated through a Mental Health workforce subgroup of the ICS mental health work-stream. Workforce implications are also discussed in relation to each of the ICS MH work-stream priority areas. The MH workforce subgroup is chaired by CNTW's Medical Director, which has allowed good communication and alignment of trust and ICS priorities. CNTW's Director of AHPs and Psychological Services is also a member, ensuring that the professional and workforce issues for AHPs and the psychological professions are disused and considered.

The Trust Nursing strategy is intrinsically aligned with Trust strategic ambitions and workforce strategy. In line with the NHS People Plan and our work within the North East and Cumbria ICS our focus is on continuing our work to create a skilled and flexible workforce which provides opportunity to work in new ways , in innovative roles and provides career development for our existing and future workforce.

Section 2: Statements of assurance & exception reporting to standards

2.1 Multi-professional

2.1.1 Assurance statement & exception reporting against HEE quality domains & standards

a) Professional groups & assurance summary

Please check the box in column 1 for all multi-professional programmes within your organisation which you are reporting and declaring assurance for. Please select whether you are meeting all standards for these by checking the appropriate box in columns 3-5.

	Programme	Meeting ALL requirements	Some PARTIALLY [illegible]	Some NOT Met
Allied Health Professionals				
☐	Art Therapist	☐	☐	☐
☐	Dietician	☐	☐	☐
☐	Drama Therapist	☐	☐	☐
☐	Music Therapist	☐	☐	☐
☐	Occupational Therapist	☐	☐	☐
☐	Operating Department Practitioner	☐	☐	☐
☐	Orthoptist	☐	☐	☐
☐	Optometrist	☐	☐	☐
☐	Osteopath	☐	☐	☐
☐	Physiotherapist	☐	☐	☐
☐	Podiatrist	☐	☐	☐
☐	Prosthetist/Orthotist	☐	☐	☐
☐	Radiographer - Diagnostic	☐	☐	☐
☐	Radiographer - Therapeutic	☐	☐	☐
☐	Speech & Language Therapist	☐	☐	☐
Ambulance Service Team				
☐	Emergency Medical Technician	☐	☐	☐
☐	Paramedic	☐	☐	☐
Dental Team				
☐	Dental Hygienist	☐	☐	☐
☐	Dental Nurse	☐	☐	☐
☐	Dental Technician & Clinical Dental Technician	☐	☐	☐
☐	Dental Therapist	☐	☐	☐
☐	Orthodontic Therapist	☐	☐	☐
Health Informatics				
☐	Clinical Informatics	☐	☐	☐
☐	Libraries & Knowledge Management	☐	☐	☐
Healthcare Sciences				
☐	Clinical Bioinformatics Genomics	☐	☐	☐
☐	Health Informatics	☐	☐	☐
☐	Physical Sciences	☐	☐	☐
☐	Life Sciences Analytical Toxicology	☐	☐	☐
☐	Clinical Biochemistry	☐	☐	☐
☐	Clinical Immunogenetics	☐	☐	☐
☐	Genetics	☐	☐	☐
☐	Haematology	☐	☐	☐
☐	Histocompatibility & Immunogenetics	☐	☐	☐
☐	Microbiology	☐	☐	☐
☐	Molecular Pathology of Acquired Disease	☐	☐	☐
☐	Molecular Pathology of Infection	☐	☐	☐
☐	Reproductive Science	☐	☐	☐
☐	Virology	☐	☐	☐
☐	Physical Sciences Clinical Biomedical Engineering	☐	☐	☐
☐	Clinical Pharmaceutical Science	☐	☐	☐
☐	Medical Physics	☐	☐	☐
☐	Rehabilitation Engineering	☐	☐	☐
☐	Renal Technology	☐	☐	☐
☐	Physiological Sciences Audiology	☐	☐	☐
☐	Cardiac physiology	☐	☐	☐
☐	Critical Care Science	☐	☐	☐
☐	Gastrointestinal & Urological Sciences	☐	☐	☐
☐	Neurophysiology	☐	☐	☐
☐	Ophthalmic & Vision Sciences	☐	☐	☐
☐	Respiratory & Sleep Physiology	☐	☐	☐
☐	Vascular Science	☐	☐	☐
Medical Associate Professions				
☐	Advanced Critical Care Practitioner	☐	☐	☐
☐	Anaesthesia Associate	☐	☐	☐
☐	Physician Associate	☐	☐	☐
☐	Surgical Care Practitioner	☐	☐	☐
Nursing & Midwifery				
☐	Adult Nurse	☐	☐	☐
☐	Children's Nurse	☐	☐	☐
☐	District Nurse	☐	☐	☐
☐	General Practice Nurse	☐	☐	☐
☒	Learning Disability Nurse	☒	☐	☐
☒	Mental Health Nurse	☒	☐	☐
☐	Midwife	☐	☐	☐
☐	Neonatal Nurse	☐	☐	☐
☐	Nursing Associate	☐	☐	☐
☐	Theatre Nurse	☐	☐	☐
Pharmacy				
☒	Pharmacist			
☒	Pharmacy Technician	☒	☐	☐
Psychological professions				
☒	Clinical Psychologist	☒	☐	☐
☐	Counselling Psychologist	☐	☐	☐
☐	Counsellor	☐	☐	☐
☐	Education Mental Health Practitioner	☐	☐	☐
☐	High Intensity Therapist	☐	☒	☐
☐	Psychological Wellbeing Practitioner	☒	☐	☐
☐	Psychotherapist	☐	☐	☐

b) Programme declarations by requirement

Using the intelligence gained through your governance structures, please consider all themes, standards and requirements in the table below and declare all programmes and posts where standards and requirements are met, partially or not met. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Illustrative example of how to complete the declaration

Domain 1 Quality Standards	***Met***	***Partially met***	***Not met***
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	***All** Met*		
Domain 5 Quality Standards	***Met***	***Partially met***	***Not met***
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	*All Met, with the exception of those programme listed in partially met/not met*	***Adult Nursing** – some issues with curriculum coverage during C19. See QIP for plan.*	

Declaration for completion

Domain 1 Learning environment and culture			
Domain 1 Quality Standards	**Met** *If all professions in scope meet the standard, please state 'All'* *If not all professions meet the standard please state:* *'All professions meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list profession(s) partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list profession(s) not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	All		
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	All		
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	All		
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	All		
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space,	All professions meet the standard with exception of	Partially met AHPs PPs	

IT facilities and access to quality assured library and knowledge.	those listed in partially met and/or not met box	Increased number of students on placement and restrictions on office space and on clinical practice changes in response to Covid 19 has led to issues in relation to access to IT hardware and safe, appropriate spaces for students across the Trust. One significant and unresolved issue has been the ability to record clinical sessions delivered via OneConsultation which has impacted on the learning experience both in terms of inputs to clinical supervision but also in terms of submission of materials for assessment	
1.6 The learning environment promotes inter-professional learning opportunities.	All		

Domain 2 Educational governance and leadership

Domain 2 Quality Standards	**Met**	**Partially met**	**Not met**
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	All		
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	All		
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	All		
2.4 Education and training opportunities	All		

are based on principles of equality and diversity.			
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	All		
Domain 3 Supporting and empowering learners			
Domain 3 Quality Standards	**Met**	**Partially met**	**Not met**
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	All		
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	All professions meet the standard with exception of those listed in partially met and/or not met box	Largely but the lack of ability to record sessions delivered remotely has impacted substantially on staff in training who need to submit records for supervision and formal course assessment	
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	All		
3.4 Learners receive an appropriate and timely induction into the learning environment.	All		
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	All		
Domain 4 Supporting and empowering educators			
Domain 4 Quality Standards	**Met**	**Partially met**	**Not met**
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	All		
4.2 Educators are familiar with the curricula of the learners they are educating.	All		
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	All		
4.4 Formally recognised educators are	All		

appropriately supported to undertake their roles.			
Domain 5 Delivering curricula and assessments			
Domain 5 Quality Standards	**Met**	**Partially met**	**Not met**
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	All		
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	All		
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	All professions meet the standard with exception of those listed in partially met and/or not met box	Partially met AHPs In early discussions with Northumbria University to support service user/carers to engage in the selection /interview process for AHP students and to have service user/carers deliver some of the teaching programme	
Domain 6 Developing a sustainable workforce			
Domain 6 Quality Standards	**Met**	**Partially met**	**Not met**
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All professions meet the standard with exception of those listed in partially met and/or not met box	Don't routinely work with other organisations, introduction of ICS may enable this to develop further	
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	All		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		

6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	All		
Declaration of assurance (Multi-professional section approval) *Sign off from the nominated person, on behalf of the executive team.*			
Name and Role: **Date:**			

2.1.2 Multi-professional good practice items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1). Please explain what was implemented and why, the benefits or positive impacts, lessons learnt, and any difficulties encountered. Any items listed here will be uploaded to HEEs 'best practice app' and shared across the region.

Description of what was implemented and why, profession(s) it relates to and a named contact for further information	**Benefits/positive impacts, lessons learnt, and any difficulties encountered**	**HEE Domain(s)**	**HEE Standard(s)**
Development of resilience training John.salkeld@cntw.nhs.uk Marc.House@cntw.nhs.uk	We recognise that this can be an anxiety provoking time and to provide reassurance in addition to access to above communications and training we have developed a resilience training module. We are currently piloting this module with our current preceptee's and will deliver to all students per locality commencing in March. This programme will be evaluated and outcome shared with HEI	3	3.1, 3.3, 3.4, 3.5
Development and delivery of Practice Assessor and Supervisor training John.salkeld@cntw.nhs.uk Marc.House@cntw.nhs.uk	To support the Trust clinical placement expansion programme the Practice Education Team have worked in collaboration with the Trust Academy to develop an internally facilitated PA /PS module which will see an increase in numbers across all services and provide underpinning structure for expansion	4	4.1.- 4.4
Work with local acute trusts to provide a 4 month placement to work into mental	Increased exposure to mental health which may have positive benefits in terms of	6	6.3

health. This was expanded in 2020 to incorporate other local trusts	future workforce planning and systems working		
Shared learning events between our trust and local acute trust pharmacy teams	Help promote increased learning opportunities between trusts and improves communication in view of the "working as one" and also helping to endorse the mental health champion role	6	6.3
In house departmental development sessions are on-going in addition to clinical development sessions for our new members of staff. We also have competency frameworks for both our new members of staff and pharmacist independent prescribers	Clear, development goals and a structure framework in terms of developing and supporting the relevant staff members	6	6.3
All professional staff are encouraged to engage in a service development or other research activity and to present as posters at regional/national events	Shows the impact of our work being done and how it improves care delivered to our service users	1	1.3
Successfully managing deployment of students to creatively adapted placements across all AHP and Psychological professions to manage the pressure on staffing due to Covid 19 and to allow the continuation of training. Contact: Julie Morrow Julie.Morrow@cntw.nhs.uk		3	
Working collaboratively with HEIs to adapt placements to ensure competencies can be met while working practices adapted to manage the restrictions surrounding Covid 19. Contact: Julie Morrow Julie.Morrow@cntw.nhs.uk		1	

2.1.3 Multi-professional challenges / important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the profession / professions)	HEE Domain(s)	HEE Standard(s)
Provision of pharmacy services in the North Cumbria region and its associated workforce pressures and the difficulty in training a workforce over a large geographical area	6	6.3

Recruitment of pharmacy workforce due to the emergent roles in other sectors e.g. pharmacists in primary care network workforce	6	6.3
Due to Covid-19 pressures there have been challenges with certain aspects of education and training and the delivery of us	3	3.1
Capacity challenges: Increase of university places, expansion of placements, AHPs being able to supervise nursing students and apprenticeships for AHPs coming on line in 2021 will all put additional pressure on the system of available placements and educators	4	
Service redesign will be a major factor over the next 3-5 years particularly in relation to community mental health services. Pathways will be in a state of flux at times, as will the roles of staff supervising students	3	
Coordination challenges to match students / trainees to placements. Lack of sufficient dedicated PPF capacity and the withdrawal of the placement management role for clinical psychology coupled with expansion of placements needed and the adaptations required due to the pandemic	2	

2.2 Postgraduate medical

2.2.1 Organisation assurance statement and exception reporting against the GMC quality themes (GMC Promoting Excellence), standards and requirements and the HEE domain 6 standards

a) Programmes & assurance summary

Please check the box in column 1 for all programmes within your organisation which you are reporting and declaring assurance for. Please select whether you are meeting all requirements for the programmes you are reporting for by checking the appropriate box in columns 3-5.

Provided in organisation	Programme	Meeting ALL requirements	Some PARTIALLY met	Some NOT Met
School of Acute Specialties				
☐	Acute Care Common Stem	☐	☐	☐
☐	Emergency Medicine	☐	☐	☐
☐	Paediatric Emergency Medicine	☐	☐	☐
☐	Pre-Hospital Emergency Medicine	☐	☐	☐
Dental Programme				
☐	Orthodontics	☐	☐	☐
☐	Restorative Dentistry	☐	☐	☐
☐	Paediatric Dentistry	☐	☐	☐
☐	Oral Surgery	☐	☐	☐
☐	Special Care Dentistry	☐	☐	☐
☐	Dental Public Health	☐	☐	☐
Anaesthesia & ICM				
☐	Anaesthetics	☐	☐	☐
☐	Core Anaesthetics	☐	☐	☐
☐	Intensive Care Medicine	☐	☐	☐
Foundation Programme				
☐	Foundation Year 1 Medicine	☐	☐	☐
☐	O&G	☐	☐	☐
	Paediatrics			
☒	Psychiatry	☐	☐	☐
☐	Surgery	☐	☐	☐
☐	Foundation Year 2 Medicine	☐	☐	☐
☐	O&G	☐	☐	☐
	Paediatrics			
☒	Psychiatry	☐	☒	☐
☐	Surgery	☐	☐	☐
General Practice				
☐	General Practice Medicine	☐	☐	
	O&G			
	Paediatrics			
☒	Psychiatry			
	Surgery			
Laboratory Medicine				
☐	Chemical Pathology	☐	☐	☐
☐	Forensic Pathology	☐	☐	☐
☐	Histopathology	☐	☐	☐
☐	Immunology	☐	☐	☐
☐	Medical Microbiology	☐	☐	☐
☐	Neuropathology	☐	☐	☐
☐	Paediatric & Perinatal Pathology	☐	☐	☐
☐	Virology	☐	☐	☐
☐	Chemical Pathology	☐	☐	☐
Medicine				
☐	Acute Medicine	☐	☐	☐
	Stroke Medicine			

☐	Cardiology	☐	☐	☐
☐	Clinical Genetics	☐	☐	☐
☐	Clinical & Medical Oncology	☐	☐	☐
☐	Clinical Neurophysiology	☐	☐	☐
☐	Clinical Pharmacology	☐	☐	☐
	Core Medical Training			
☐	Dermatology	☐	☐	☐
☐	Elderly Care Medicine	☐	☐	☐
☐	Endocrinology & Diabetes Mellitus	☐	☐	☐
☐	Gastroenterology	☐	☐	☐
☐	Hepatology	☐	☐	☐
☐	General Internal Medicine	☐	☐	☐
☐	Genito-Urinary Medicine	☐	☐	☐
☐	Haematology	☐	☐	☐
☐	Infectious Diseases	☐	☐	☐
☐	Internal Medicine Training	☐	☐	☐
☐	Metabolic Medicine	☐	☐	☐
☐	Medical Oncology	☐	☐	☐
☐	Neurology	☐	☐	☐
☐	Occupational Medicine	☐	☐	☐
☐	Paediatric Cardiology	☐	☐	☐
☐	Palliative Medicine	☐	☐	☐
☐	Renal Medicine	☐	☐	☐
☐	Rehabilitation Medicine	☐	☐	☐
☐	Respiratory Medicine	☐	☐	☐
☐	Rheumatology	☐	☐	☐
Obstetrics & Gynaecology				
	Community Sexual & Reproductive Health			
☐	Obstetrics & Gynaecology	☐	☐	☐
☐	Gynaecological Oncology	☐	☐	☐
☐	Maternal & Fetal Medicine	☐	☐	☐
☐	Reproductive Medicine	☐	☐	☐
	Urogynaecology			
☐	Genitourinary Medicine	☐	☐	☐
Ophthalmology				
☐	Ophthalmology	☐	☐	☐
☐	Medical Ophthalmology	☐	☐	☐
Paediatrics				
☐	Paediatrics	☐	☐	☐
☐	Child Mental Health	☐	☐	☐
☐	Community Child Health	☐	☐	☐
☐	Neonatal Medicine	☐	☐	☐
☐	Paediatric Diabetes & Endocrinology	☐	☐	☐
☐	Paediatric Intensive Care Medicine	☐	☐	☐
☐	Paediatric Gastroenterology, Hepatology & Nutrition	☐	☐	☐
☐	Nephrology	☐	☐	☐
☐	Neurodisability	☐	☐	☐
☐	Neurology	☐	☐	☐
☐	Oncology	☐	☐	☐
☐	Respiratory Medicine	☐	☐	☐
☐	Rheumatology	☐	☐	☐
Psychiatry				
☒	Adult Mental Health	☐	☐	☐
☒	Child & Adolescent Mental Health	☐	☐	☐
☒	Forensic Psychiatry	☐	☐	☐
☒	General Psychiatry	☐	☐	☐
☒	Liaison Psychiatry	☐	☐	☐
☒	Rehabilitation Psychiatry	☐	☐	☐
☒	Substance Misuse Psychiatry	☐	☐	☐
☒	Learning Disability	☐	☐	☐
☒	Old Age Psychiatry	☐	☐	☐
Public Health				
☒	Public Health Medicine	☐	☐	☐
Radiology				
☐	Clinical Radiology	☐	☐	☐
☐	Interventional Radiology	☐	☐	☐
Surgery				
☐	Cardio-thoracic Surgery	☐	☐	☐
☐	Core Surgical Training	☐	☐	☐
☐	General Surgery	☐	☐	☐
☐	Neurosurgery	☐	☐	☐
☐	Oral & Maxillo-Facial Surgery	☐	☐	☐
☐	Otolaryngology	☐	☐	☐
☐	Paediatric Surgery	☐	☐	☐
☐	Plastic Surgery	☐	☐	☐
☐	Trauma & Orthopaedic Surgery	☐	☐	☐
☐	Urology	☐	☐	☐
☐	Vascular	☐	☐	☐

b) Programme declarations by requirement

Using the intelligence gained through your governance structures, please consider all of the themes requirements in the table below and declare all programmes and posts where requirements are met, partially or not met. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Illustrative example of how to complete the declaration

Domain 1 Quality Requirements	***Met***	***Partially met***	***Not met***
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	***All** Met*		
R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being	*All met, except for those programmes listed as partially / not met*	***Trauma and Orthopaedics, Urology***	***Core Surgical Training, General Surgery, ENT, Plastics,*** *(Significant challenges detailed within the QIP).*

able to justify their decision.			

Declaration for completion

Theme 1 Learning environment and culture **Standards** S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.			
Theme 1 Quality Requirements	**Met** *If all posts/programmes in scope meet the requirement, please state 'All'* *If not all posts/programmes meet the requirement, please state: 'All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list post(s)/ programme(s) partially meeting the requirement* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list post(s)/ programme(s) not meeting the requirement* *Please ensure all items declared as not met are added to the QIP*
R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences	All		
R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.	All		
R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.	All		
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	All		
R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.	All		
R1.6 Organisations must make sure that learners know about the local processes	All		

for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.			
R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.	All		
R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.	All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box	Foundation doctors North Cumbria - out of hours. During the year of reporting we have not had on site supervision for foundation doctors out of hours in North Cumbria. As a result of this these doctors have not done out of hours work, which impacts their training opportunities. Plans to address this are underway and is captured within our QIP	
R1.9 Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.	All		
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.	All		
R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent.5 Supervisors must assure	All		

themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.			
R1.12 Organisations must design rotas to: **a** make sure doctors in training have appropriate clinical supervision **b** support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK **c** provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme **d** give doctors in training access to educational supervisors **e** minimise the adverse effects of fatigue and workload.	All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box	In relation to point 'e' we are aware that first on call rotas had an increase in intensity during the early part of the pandemic. This was due to increased work and the impact of covid19 on staffing levels. As a result of this rotas were reviewed with additional resource built in and more robust contingencies for unexpected gaps in rotas	
R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out: **a** their duties and supervision arrangements **b** their role in the team **c** how to gain support from senior colleagues **d** the clinical or medical guidelines and workplace policies they must follow **e** how to access clinical and learning resources. As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.	All		
R1.14 Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.	All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box	We have identified an issue with the handover of clinical information at the point of admission within the North Cumbria service. Standards have been set and measure put in	

		place to address this	
R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.	All		
R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.	All		
R1.17 Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.	All		
R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.	All		
R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.	All		
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	All		
R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.	All		
R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.	All		
Theme 2 Educational governance and leadership **Standards**			

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Theme 2 Quality Requirements	**Met**	**Partially met**	**Not met**
R2.1 Organisations must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.	All		
R2.2 Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.	All		
R2.3 Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.	All		
R2.4 Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.	All		
R2.5 Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.	All		
R2.6 Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.	All		

R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.	All		
R2.8 Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.	All		
R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.	All		
R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.	All		
R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.	All		
R2.12 Organisations must have systems to manage learners' progression, with input from a range of people, to inform decisions about their progression.	All		
R2.13 (Not Applicable to Postgraduate Medical)			
R2.14 Organisations must make sure that each doctor in training has access to a named clinical supervisor who oversees the doctor's clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.	All		
R2.15 Organisations must make sure that each doctor in training has access to a named educational supervisor who is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training	All		

to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.			
R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.	All		
R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.	All		
R2.18 Medical schools (and the universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.	All		
R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.	All		
R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.	All		
Theme 3 Supporting learners **Standards** S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.			

Theme 3 Quality Requirements	Met	Partially met	Not met
R3.1 Learners must be supported to meet professional standards, as set out in *Good medical practice* and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.	All		
R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including: **a** confidential counselling services **b** careers advice and support **c** occupational health services. Learners must be encouraged to take responsibility for looking after their own health and wellbeing.	All		
R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.	All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box	Concerns raised following incident where trainee witnessed comments and perceived prejudice regarding attitudes towards LGBT community. Following formal Trust investigation by E&D Lead plan has been put in place around education for team	
R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010*.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.	All		
R3.5 Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.	All		
R3.6 When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This	All		

should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.			
R3.7 Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.	All		
R3.8 Doctors in training must have information about academic opportunities in their programme or specialty and be supported to pursue an academic career if they have the appropriate skills and aptitudes and are inclined to do so.	All		
R3.9 (Not Applicable to Postgraduate Medical)			
R3.10 Doctors in training must have access to systems and information to support less than full-time training.	All		
R3.11 Doctors in training must have appropriate support on returning to a programme following a career break.	All		
R3.12 Doctors in training must be able to take study leave appropriate to their curriculum or training programme, to the maximum time permitted in their terms and conditions of service.	All		
R3.13 Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.	All		
R3.14 Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.	All		
R3.15 Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.	All		
R3.16 Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given	All		

advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.			

Theme 4 Supporting educators

Standards

S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

Theme 4 Quality Requirements	Met	Partially met	Not met
R4.1 Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.	All		
R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.	All		
R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.	All		
R4.4 Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities.	All		
both locally and across specialties and professions.	All		
R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.	All		

Theme 5 Delivering and implementing curricula and assessments

Standards

S5.1 (Not Applicable to Postgraduate Medical)

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

Theme 5 Quality Requirements	Met	Partially met	Not met
R5.1 to R5.6 (Not Applicable to Postgraduate Medical)			

R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.	All		
R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.	All		
R5.9 Postgraduate training programmes must give doctors in training: **a** training posts that deliver the curriculum and assessment requirements set out in the approved curriculum **b** sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum **c** an educational induction to make sure they understand their curriculum and how their post or clinical placement fits within the programme **d** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation **e** the opportunity to work and learn with other members on the team to support interprofessional multidisciplinary working **f** regular, useful meetings with their clinical and educational supervisors **g** placements that are long enough to allow them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress **h** a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by doctors in training should support learning opportunities wherever possible. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.	All		
R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced	All		

to match doctors' progression through their education and training.			
R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.	All		
R5.12 Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the *Equality Act 2010*, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.	All		
HEE Domain 6 Developing a sustainable workforce (*HEE Quality Framework)*			
Domain 6 Quality Standards	**Met**	**Partially met**	**Not met**
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	All		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	All		
7. Providers must proactively develop and implement activities that will support individual learners to successfully transition from their education programme to employment. Feedback from learners needs to be utilised to develop activities	All		

and outcomes evaluated to assess the impact on retention levels and spread good practice.			
Declaration of assurance (Postgraduate medical section approval) *Sign off from the nominated person, on behalf of the executive team.*			
Name and role: **Date:**			

2.1.2 Postgraduate medical good practice items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1). Please explain what was implemented and why, the benefits or positive impacts, lessons learnt, and any difficulties encountered. Any items listed here will be uploaded to HEEs 'best practice app' and shared across the region.

Description of what was implemented and why, profession(s) it relates to and a named contact for further information	**Benefits/positive impacts, lessons learnt, and any difficulties encountered**	**HEE Domain(s)**	**HEE Standard(s)**
Serious Incident support programme for trainees Drs Prathibha Rao and Jennifer Harris	This trainee-led programme ensures multipronged approach which includes rolling programme of teaching the trainees, trainer support, informal peer support with systems to regularly evaluate the programme	1, 3	1.1, 1.2, 1.3, 1.4, 1.5, 1.17 3.1
Expansion of core posts and changes to GP posts Drs Prathibha Rao and Lisa Insole	3 new core posts were all allocated based on core training programme needs and to retain attractiveness of the training programme, whilst balancing the OOH service. Newly introduced Integrated GP posts from Feb 2020 has been a challenge to support and balance: training experience, service needs and ensure trainee welfare. This will need to be evaluated over the next year	5, 6	5.9
Trainee Led Teaching Dr Sadie Kitson	An online teaching programme has been established to supplement sessions provided by the medical education team. This is led by trainees, with some arms-length support from the	1, 3, 5	1.16, 3.8, 5.9

	trust. This has not only provided high quality teaching but also allowed trainees to drive this and develop through the process		
Central Postgraduate Teaching Drs Stuart Watson, Prathibha Rao and Curtis Osborne	The Covid19 pandemic was a catalyst for us to review how we deliver weekly PG teaching programmes. This has led to a review of the programme with alignment of teaching across the trust and the development of a monthly trustwide programme with a more academic focus to run alongside the weekly local programmes	1, 3, 5	1.16, 3.8, 5.9
Site videos MedEd Team & Trainees	We asked trainees to produce short videos to give an overview of each site. These have been used during local inductions and are available for trainees to view if they are doing on calls on a site they are not familiar with	1	1.13
Training rota to provide out of hours Mental Health Act training for first on call doctors Dr Bruce Owen	We have introduced a training rota that all first on call doctors across the NE of the trust will work into for either one weekend or block of night shifts. This rota has no service commitment but allows junior trainees to shadow second on call doctors doing MHA assessments in order to learn about the nature of these assessments. This rota also provides a back-up function to the other first on call rotas ensuring that unexpected gaps in rotas can be managed	1,5	1.16, 1.17, 1.22 5.9
Improved recruitment to North Cumbria site Drs Rajesh Nadkarni, Bruce Owen, Prathibha Rao, Sam Dearman, Roger Cable and Sarah Maddicott	Recruitment to North Cumbria has been a historical challenge, impacts both training and service in and out of hours. We have been able to create and recruit to (trainers and trainees) new	1, 5, 6	1.11, 1.12, 1.13, 1.14, 1.15, 5.9

	clinical and teaching fellow posts and core training posts. This has allowed us to introduce a 24 hour shift to cover the Carleton Clinic inpatient service.		
Improved recruitment and training opportunities through development of Research Fellow Posts Drs Bruce Owen, Prathibha Rao and Stuart Watson	We have developed two Research Fellow posts aimed at post foundation level doctors to allow the opportunity to get experience working in a role that involves clinical and research focussed work within the field of psychiatry. This has been useful to helping people explore academic opportunities and provide support for out of hours clinical rotas	3, 5, 6	3.8, 5.9, 5.10
Covid19 Inpatient Workbook Drs Joe Thorne and Bruce Owen	We developed a workbook that brought together guidance covering a full range of topics relevant to delivering care to inpatients during the pandemic. This document was live, being updated weekly as guidance and knowledge changed. This has become a key reference document for the trust and more widely, indeed on request it has been shared with the Royal College of Psychiatrists who have linked it with their own guidance. The work was led through the medical education team linking with IPC and Patient Safety	1	1.1, 1.5

2.2.3 Postgraduate medical challenges / important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Psychotherapy – Core psychiatry training programme. The pandemic has had an adverse impact on our ability to deliver psychotherapy training for core speciality trainees. In line with RCPsych guidance this form of therapy was initially suspended impacting trainees abilities to gain the necessary competencies. Although this has now resolved there is a backlog of demand and this is particularly an issue due to a bulge in the training scheme. We have secured funding for additional trainer time to help address this but are conscious it is a problem that requires close management.	5	5.9
Trainer capacity in N Cumbria – Core psychiatry training. There are current significant recruitment challenges for our services in N Cumbria. This impacts trainer availability which in turn impacts trainee capacity. We have successfully increased this in the last 12 months and have plans to further increase this but are conscious the situation remains fragile.	4, 6	
Junior on call room at Carleton is a challenge. Currently Juniors have an office in upper Rowanwood but this is not big enough to accommodate a bed to rest on for 24 hour on call shifts. MedEd have been working with estates to find a solution for all of 2020, but NCIC have various SLA's in place on rooms at Carleton site and so it's been difficult to establish a permanent option. Current situation for a temporary rest room is the use of a training room with a bed in lower Rowanwood and this is working fine. As of January 2021 estates have now identified a specific temporary room in the main Carleton building for Juniors to use as a rest room for on call, this needs small adaptions and furniture moved but should be available very soon. A permanent Junior on call room, Junior office and MedEd offices are planned for August 2021 in the main building. MedEd are also having weekly meetings with estates for updates.	1	1.19
Yewdale ward in West Cumberland Hospital due to geographical distance has not been able to be incorporated in to the 24 hour out of hours rota established in N Cumbria. This ward currently accesses medical cover out of hours through a dedicated GP service, supported by Consultant Psychiatrists. This creates a degree of inequity with other wards and is something we are looking to explore with the services.	1	

2.3. Undergraduate medical

2.3.1 Organisation assurance statement and exception reporting against the GMC quality themes, standards and requirements and the HEE domain 6 standards

Using the intelligence gained through your governance structures, please consider all themes, standards and requirements in the table below and declare all programmes and posts where standards and requirements are met, partially or not met. Please consider both placement and departments as well as trust wide policy, approach and ability to meet the standards and requirements in Promoting Excellence. Please ensure that any areas highlighted as partially or not met are listed in your organisation's Quality Improvement Plan (QIP).

Illustrative example of how to complete the declaration

Theme 1 Quality Requirements	***Met***	***Partially met***	***Not met***
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.		*All partially met – there is a Trust roll-out of lanyards, supported by posters and infographics.*	
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	*All met with the exception of those listed in partially met / not met*	*Acute Medicine (detail in QIP)*	*Paediatrics (detail in QIP)*

Declaration for Completion

Theme 1 Learning Environment and Culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Theme 1 Quality Requirements	**Met**	**Partially met**	**Not met**
R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences	All		
R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.	All		
R1.3 Organisations must demonstrate a culture that investigates and learns from	All		

mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.			
R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	All		
R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.	All		
R1.6 Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.	All		
R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.	All		
R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.	All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box	Partially met – Student feedback comments on lack of consultant contact, this might be an effect of the pandemic. Some students have not felt sufficiently supervised/ supported in clinical placements, resulting in a lack of patient contact, but not in any patient or student safety issues.	
R1.9 Learners' responsibilities for patient care must be appropriate for their stage of	All posts/programmes meet the requirement with	Partially met –	

education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.	exception of those listed in partially met and/or not met box	Linked to point point R1.8- resulting in reduced patient contact and opportunity to apply skills (for some students), mostly North of Tyne where we have higher student numbers; this does not impact on patient care.	
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.	All		
R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent.5 Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.	All		
R1.12 Organisations must design rotas to: **a** make sure doctors in training have appropriate clinical supervision **b** support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK **c** provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme **d** give doctors in training access to educational supervisors **e** minimise the adverse effects of fatigue and workload.	All		
R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out: **a** their duties and supervision arrangements **b** their role in the team **c** how to gain support from senior colleagues **d** the clinical or medical guidelines and workplace policies they must follow	All		

e how to access clinical and learning resources. As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.			
R1.14 Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.	All		
R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.	All		
R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.	All		
R1.17 Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.	All		
R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.	All		
R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.	All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box	Partial North of Tyne teaching spaces are not appropriate in relation to design capacity and standard; capacity issue will become critical in Sep 2021 as student numbers increase. Funding has been	

		agreed and work is due to start in February for new education centre in Newcastle which will be open in Aug 2021. Capacity will become an issue in Sunderland from 2022 when Sunderland medical students will also attend for teaching.	
R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.	All		
R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.	All		
R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.	All		

Theme 2 Educational governance and leadership

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Theme 2 Quality Requirements	Met	Partially met	Not met
R2.1 Organisations must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.	All		
R2.2 Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical	All		

education and training within their organisation and responding appropriately to concerns.			
R2.3 Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.	All		
R2.4 Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.	All		
R2.5 Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.	All		
R2.6 Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.	All		
R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.	All		
R2.8 Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.	All		
R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.	All		
R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.	All posts/programmes meet the requirement with exception of those listed in partially met and/or not met box	Partial Specified roles such as Base Unit Lead; SSC Lead have dedicated programmed	

		activities; clinical teachers have the role of teaching within their job plan but there is not an agreed tariff of time. There are ongoing discussions with trust finance team looking at aligning funds with quality of activity	
R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.	All		
R2.12 Organisations must have systems to manage learners' progression, with input from a range of people, to inform decisions about their progression.	All		
R2.13 Medical schools must have one or more doctors at the school who oversee medical students' educational progression. They must have one or more doctors at each LEP who coordinate training of medical students, supervise their activities, and make sure these activities are of educational value.	All		
R2.14 and R2.15	*(Not Applicable to Undergraduate Medical)*		
R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.	All		
R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.	All		
R2.18 Medical schools (and the universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who	All		

are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.			
R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.	All		
R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.	All		
Theme 3 Supporting learners **Standards** S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.			
Theme 3 Quality Requirements	**Met**	**Partially met**	**Not met**
R3.1 Learners must be supported to meet professional standards, as set out in *Good medical practice* and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.	All		
R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including: **a** confidential counselling services **b** careers advice and support **c** occupational health services. Learners must be encouraged to take responsibility for looking after their own health and wellbeing.	All		
R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.	All		
R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010*.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.	All		

R3.5 Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.	All		
R3.6 When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.	All		
R3.7 Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.	All		
R3.8	*(Not Applicable to Undergraduate Medical)*		
R3.9	*(Not Applicable for trust response)*		
R3.10 to R3.12	*(Not Applicable to Undergraduate Medical)*		
R3.13 Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.	All		
R3.14 Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.	All		
R3.15 Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.	All		
R3.16 Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification	All		

if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.			
Theme 4 Supporting educators **Standards** S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities. S4.2 Educators receive the support, resources and time to meet their education and training responsibilities			
Theme 4 Quality Requirements	**Met**	**Partially met**	**Not met**
R4.1 Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.	All		
R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.	All		
R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.	All		
R4.4 Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities.	All		
R4.5 Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.	All		
R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.	All		
Theme 5 Delivering and implementing curricula and assessments **Standards** S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates. *S5.2 (Not Applicable to Undergraduate Medical)*			
Theme 5 Quality Requirements	**Met**	**Partially met**	**Not met**
R5.1 Medical school curricula must be planned and show how students can meet the outcomes for graduates across the whole programme.	All		

R5.2 The development of medical school curricula must be informed by medical students, doctors in training, educators, employers, other health and social care professionals and patients, families and carers.	All		
R5.3 Medical school curricula must give medical students: **a** early contact with patients that increases in duration and responsibility as students progress through the programme **b** experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor **c** the opportunity to support and follow patients through their care pathway **d** the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics **e** learning opportunities that integrate basic and clinical science, enabling them to link theory and practice **f** the opportunity to choose areas they are interested in studying while demonstrating the learning outcomes required for graduates **g** learning opportunities enabling them to develop generic professional capabilities **h** at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work.	All		
R5.4 Medical school programmes must give medical students: **a** sufficient practical experience to achieve the learning outcomes required for graduates **b** an educational induction to make sure they understand the curriculum and how their placement fits within the programme **c** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of teachers, before using skills in a clinical situation	All		

d experiential learning in clinical settings, both real and simulated, that increases in complexity in line with the curriculum **e** the opportunity to work and learn with other health and social care professionals and students to support interprofessional multidisciplinary working **f** placements that enable them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress.			
R5.5 Medical schools must assess medical students against the learning outcomes required for graduates at appropriate points. Medical schools must be sure that medical students can meet all the outcomes before graduation. Medical schools must not grant dispensation to students from meeting the standards of competence required for graduates.	All		
R5.6 Medical schools must set fair, reliable and valid assessments that allow them to decide whether medical students have achieved the learning outcomes required for graduates.	All		
R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.	All		
R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.	All		
R5.9	*(Not Applicable to Undergraduate Medical)*		
R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through their education and training.	All		
R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.	All		
R5.12 Organisations must make reasonable adjustments to help disabled	All		

learners meet the standards of competence in line with the *Equality Act 2010*, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.			
HEE Domain 6 Developing a sustainable workforce *(HEE Quality Framework)*			
Domain 6 Quality Standards	**Met** *If all placements in scope meet the standard, please state 'All'* *If not all placements meet the standard please state: 'All placements meet the standard with exception of those listed in partially met and/or not met box'*	**Partially met** *Please list placements partially meeting the standard* *Please ensure all items declared as partially met are added to the QIP*	**Not met** *Please list placements not meeting the standard* *Please ensure all items declared as not met are added to the QIP*
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	All		
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	All		
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	All		
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	All		
Declaration of assurance (undergraduate medical section approval) *Sign off from the nominated person, on behalf of the executive team.*			
Name and role: **Date:**	Frauke Boddy, AMD Undergraduate Medical Education		

2.3.2 Undergraduate Medical Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1). Please explain what was implemented and why, the benefits or positive impacts, lessons learnt, and any difficulties encountered. Any items listed here will be uploaded to HEEs 'best practice app' and shared across the region.

Description of what was implemented and why, profession(s) it relates to and a named contact for further information	Benefits/positive impacts, lessons learnt, and any difficulties encountered	HEE Domain(s)	HEE Standard(s)
CNTW have ensured that there is well resourced undergraduate administrative support in Cumbria to support the final year medical student rotations there. By linking this in with the North East undergraduate team there is a greater support structure and the opportunity for sharing good practice Karen Peverell and Rachel Sercombe	The geographical distance to the main Medical Education hub was a challenge initially, the move to using MSTeams enhanced communication and helped to establish working relationships	R1	R1.19
Closer working between base units – including weekly undergraduate update meeting held via MSTeams and joint working groups to support the development and implementation of the new curriculum. Dr Frauke Boddy	This has facilitated closer working and sharing of good practice points and learning across base units, it has helped to address issues around standardisation of teaching experience and processed including assessments across the trust.	R4	R4.4 R4.5
Introduction of new flipped classroom teaching method to both the third and fifth year teaching, in order to develop students' critical thinking/ clinical decision making. Dr Frauke Boddy and Dr Martina Esisi	More interactive teaching/ learning. Difficulties were encountered with regard to student engagement with pre-loading requirements and the amount of pre-loading set for students in year 1. This has been adapted for 2021, both in terms of reducing the amount of pre-work and adapting the session for online delivery and we will review the feedback accordingly	R5	R 5.4c
CNTW faculty development session on "bedside teaching" was established and updated in view of COVID- related changes. Development also of a video faculty training resource illustrating good practice for bedside teaching in times of Covid for both in-patient and community settings. Dr Frauke Boddy and Dr Bruce Owen	The bedside teaching session has very positive feedback, The video is a very useful tool to highlight good practice to clinicians. Feedback was very positive, the plan is to share this more widely and build on it to improve clinical placements more widely across the trust.	R4	R4.6
A framework for base unit lead appraisal and development was established, which feeds into annual appraisal. Annual Base Unit lead	This has been very positively received and has helped to enhance the base unit leads' support from the medical	R4	R4.1

educational appraisal meetings with the AMD and DME to help review the BUL's performance and support their development. Dr Frauke Boddy and Dr Bruce Owen	Education department, by developing suitable personal development plans and supporting professional development more robustly.		
Undergraduate Medical Education Journal Club was established within the medical Education Department. Dr Frauke Boddy	The journal club runs supporting the development of scholarship among the teaching faculty. Currently only attended by core medical education staff, there is scope to widen participation and enhance scholarship more widely across the trust.	R4	R4.6

2.3.3 Undergraduate Medical Challenges / important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Facilities – North of Tyne teaching spaces are not appropriate in relation to design, capacity and standard; capacity issue will become critical in September 2021 with increasing Newcastle University student numbers and will in 2022 also include Sunderland University (when Sunderland students commence their mental health rotations in CNTW). Funding has been identified and plans are in place to address this with expected completion date Aug 2021	R1	R1.19
New curriculum – Newcastle medical School's 2017 curriculum still needs to be embedded for the year three teaching and needs to be developed and organised for the new 5th year assistantships commencing in September 2021.	R5	R5.3
The COVID pandemic is creating great challenge for the faculty to develop skills and resources for valuable and high quality remote teaching as well as putting extra strain on clinical placements who can accommodate less students to allow adhering to social distancing/ IPC guidelines, where the workforce is stretched due to absences/ home working and extra workload, and where many services are using remote consultations. This is not seen to be a challenge in terms of patient safety, but in terms of creating sufficient suitable clinical learning opportunities for students.	R1	R1.9

Section 3: Organisational policies and processes in support of delivery of the HEE/GMC Quality Standards and Requirements.

Please copy this section from your last year's SAR and highlight any changes and updates. *Please list policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required. Please advise which domains and standards are being supported by the policy. Please note, we do not require copies of documents. Please do not embed documents or insert links. If required, the quality team will request a copy by exception. Please advise if you have made a reference to a policy/process in other section(s) of the SAR.*

Description of supporting information	**HEE/GMC Domain(s)**	**HEE/GMC Standard(s)**	**Please advise if document referenced in the SAR e.g.** *SAR, section 1.4 and 2.1.1*
"Positive and Safe' Recognition, Prevention and Management of Violence and Aggression Policy CNTW(C)16	1	1.1	
Appraisal, Staff, Policy CNTW(HR)09	1 4	1.2 4.1/4.3./4.4	
Appraisal-Staff-Training-Develop Need Analysis Process PGN - SA-PGN-01 - CNTW(HR)09	1 4	1.2 4.1/4.3./4.4	
Research Governance Policy - CNTW(O)47	1	1.2	
Equality, Diversity and Human Rights Policy - CNTW(O)	1	1.2	
Revalidation, Nursing, Triennial review - Appraisal PGN - SA-PGN-03 - CNTW(HR)09	1 4	1.2 4.1/4.3./4.4	
Induction Policy - CNTW(HR)01	1	1.2	
Dignity and Respect at Work Policy - CNTW(HR)08	1	1.2	
Research Governance Policy - CNTW(O)47	1	1.3	
Learning Lessons - Incident PGN - IP-PGN-05 - CNTW(O)05	1	1.3/1.5	
Audit, Internal, Policy - CNTW(O)25	1	1.3/1.5	
After Action Review (AAR) - Incident PGN - IP-PGN-03 - CNTW(O)05	1	1.3/1.5	
Promoting Engagement with SU's Policy - V03.2 - Issued Dec 17 - CNTW(C)	1	1.4/1.5	
07Promoting Engagement-CYP-PGN-V02 - Issued Dec 17 - PE-PGN-01 - CNTW(C)07	1.	1.4/1.5	
Equality, Diversity and Human Rights Policy - CNTW(O)42	2	2.4	

Equality, Diversity and Human Rights- Impact Assessment PGN - EHDR-PGN-01 - CNTW(O)42	2	2.4	
Safeguarding CNTW(C)24 V04.1	2	2.5	
Adults at Risk and Raising Concerns Policy - CNTW(HR)06	2	2.5	
Safeguarding Children CNTW(C)04 V04.2	2	2.5	
Supporting Staff Involvement in an Incident PGN- IP-PGN-08 - CNTW(O)05	2	2.5	
Induction Policy - CNTW(HR)01	3	3.1/3.2/3.3./3.4/3.5	
Clinical Supervision and Peer Review Policy CNTW(C)31 V05	3	3.1/3.2/3.3./3.4/3.5	
Raising Concerns Policy - CNTW (HR) 06	3	3.1/3.2/3.3./3.4/3.5	
Induction Arrangements for Student Nurses - I-PGN-03 - CNTW(HR)01	3	3.1/3.2/3.3./3.4/3.5	
Study Leave Policy - CNTW(HR)23	4	4.1/4.3./4.4	
Whistleblowing policy (CNTW (HR) 06)	1	1.1	
Supervision of Medical Trainees (Appendix 8 Clinical Supervision Policy CNTW © 31 V05	1	1.10	
Continuing Professional Development, Study Leave PGN - SL-PGN-01 - CNTW (HR)23	4	4.1/4.3./4.4	
IP PGN - 08 (Incident policy) Supporting staff involved in an incident V04.			
IP-PGN-06 Part of CNTW(O)05 - Incident Policy			
Clinical Risk Strategy VO1.2 Positive and Safe	1	1.1	
Dignity in Care Policy CNTW(C)40	1	1.1	✓

Section 4: Financial Accountability Report

4.1. Details of LDA funding

In this section please describe how the trust is utilising HEE funding received to ensure spend on education and training activity. Please consider each contract heading.

Levy	Contract heading	Funding	Trust response
Postgraduate	Lead Employer	-72,693.00	
Postgraduate	Education Contract Posts	4,442,199.69	Within CNTW money provided to support medical training is ring-fenced and added to from the trust central funds to form a dedicated Doctors in Training budget. The budget holder for this is the DME which ensures these funds are used to support training and allows a trust-wide flexibility and has been critical in increasing recruitment. Over the reporting year costs in addition to trainee salaries include: Consultant time for leadership roles in PG education including DME, AMD and Tutors – 23 sessions - £280K Supervisor time – 140 x 0.5 sessions - £840K Non-medical clinical education salary - £45K Non pay teaching costs £190K Administrative costs: Pay - £170K Non-pay £44K Estates: Hopewood - £34K Jubilee Theatre - £130K Keswick House - £90K (50% as use also for UG) Total - £1,823,000.
Postgraduate	Foundation Activity Related	5,333.33	
Postgraduate Total		**4,374,840.02**	
Non Medical	Placement Fee	27,232.84	
Non Medical	IAPT	434,872.40	

Non Medical	Trainer Grant	117,500.00	
Non Medical	Trainer Grant	29,963.82	
Non Medical	Non-medical Tariff	639.72	
Non Medical	Non-medical Tariff	526,254.45	
Non Medical	Learning Development Fee	86,899.94	
Non Medical Total		**1,223,363.17**	
Workforce Development	SAS	26,831.24	As outlined in section below these funds are ring fenced for SAS development
Workforce Development Total		**26,831.24**	
Undergraduate Medical	Placement activity funding	1,708,252.40	Over the last 12 months we have been in discussions with the University around funding allocations due to some historical errors in this. As with postgraduate monies SIFT funding sits within a budget managed by the DME which allows a degree of flexibility. The money does follow the students, however there remains variation in how it is spent to support teaching and we are working with groups to explore this further
Undergraduate Medical Total		**1,708,252.40**	
Education Support Total		**93,723.42**	
Out of Region	National Activities	20,700.00	
Out of Region Total		**20,700.00**	
	Q2 LDA Value	**7,447,710.25**	

4.2. Additional in year funding already provided

In this section please list any additional funding received from HEE, for example any regional or national funding received outside of the LDA payments. Please state the amount received, provide a high-level description of what this additional funding is for and please describe how the trust has utilised this funding.

Funding Amount	High level description	Please describe how the trust has used this funding including any impact and considerations for future work

4.3. Use of funding to support Staff and Specialty Doctors (SAS) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required.

Questions	Trust's answer
Number of SAS doctors within the trust	**82**
Total SAS funding received	**£26,831**
Is the SAS funding ring-fenced to support SAS doctors only? (Y/N)	Yes
Please describe the process by which the development needs of SAS doctors within your organisation were individually and collectively identified. Using funding allocated for SAS development; How were priorities decided? Any plans or initiatives to respond to the GMC SAS/LED survey findings?	Several years ago, it was agreed by the SAS group that the money would be used to facilitate whole group SAS CPD sessions (our 4x yearly SAS Forum). We have a regular business meeting at each SAS Forum and discuss collectively the needs of the group and CPD topics we can include at future meetings that will benefit as many of the group as possible. For this reason, we tend to focus on generic topics rather than anything too specific to particular subspecialties. SAS Charter has been implemented in the trust. SAS/LED findings have been circulated, but no specific actions taken. Any local issues regarding SAS can be discussed in SAS Business meeting, SAS doctors are also represented at LNC.
SAS nominated lead within the trust	Dr Victoria Thomas

Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)

	Spending	Detail
1. Individual doctor's development (i.e. details of spending used to support the development of individual doctors including an anonymised list of amounts and what it was used for)		None
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered)	£1117.20 (Jan'20)	4 sessions per year (1 cancelled), 2 via Teams Average attendance 35/40

3. Payment for SAS tutors/leads sessions		1 PA
4. Administrative costs to support SAS tutors		0.5 of Band 3
5. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)		SAS doctors can free access to Faculty Development Programme, Med Ed conference, Trust CPD and weekly PG teaching. There is also funding for doctors on CESR Fellowship programme to support CESR application