Board of Directors Meeting (PUBLIC)

Wed 04 August 2021, 13:30 - 15:30

Microsoft Teams

Agenda

Please note this meeting will be Recorded

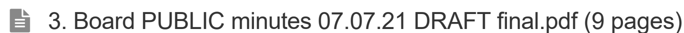
1. Welcome and apologies for absence

Ken Jarrold, Chairman

2. Service User / Carer Story

3. Minutes of the meeting held 7 July 2021

Ken Jarrold, Chairman


3. Board PUBLIC minutes 07.07.21 DRAFT final.pdf (9 pages)

4. Action Log and Matters Arising not included on the agenda

Ken Jarrold, Chairman

4. BoD Action Log PUBLIC as at 04.08.21.pdf (1 pages)

5. Chairman's Update

Ken Jarrold, Chairman

6. Chief Executive's Report

John Lawlor, Chief Executive

Quality, Clinical and Patient Issues

7. COVID-19 Response Update

Gary O'Hare, Chief Nurse

7. COVID Board Report - Aug 2021 FINAL.pdf (5 pages)

8. Commissioning and Quality Assurance Update

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Lisa Quinn, Executive Director of Commissioning and Quality Assurance

8. Monthly Commissioning Quality Assurance Report - Month 3.pdf (13 pages)

9. Service User and Carer Experience Report (Q1)

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

9. Service User and Carer Experience report Quarter 1 2021-22 V2.pdf (9 pages)

10. Quality Priorities 2021/22 (Q1) Report

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

10. Quality Priority Update Report - Q1 2021-22.pdf (13 pages)

11. Annual Infection and Prevention Report 2020-2021

Gary O'Hare, Chief Nurse

11. IPC Annual Report 20-21.pdf (26 pages)

11.1. Infection Prevention Bard Assurance Framework

Gary O'Hare, Chief Nurse

11. 1 IPC - Board Assurance Framework -Q1 2021 final August Board.pdf (24 pages)

12. Safer Staffing Levels Q1 including 6 monthly skill mix review

Gary O'Hare, Chief Nurse

12. Safer Staffing Monthly Report Including Six Month Skill Mix - May 2021 data.pdf (21 pages)

13. Safety and Security Management Annual Report 2020/21

Gary O'Hare, Chief Nurse

13.Safety and Security Management Annual Report - Board of Directors Final July 21.pdf (12 pages)

Strategy and Partnerships

14. Children, Adolescent Mental Health update

verbal update *Ramona Duguid, Chief Operating Officer*

Workforce Issues

15. Staff, Friends and Family Report (Q1)

Lynne Shaw, Executive Director Workforce and Organisational Development

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- 15. Staff Friends and Family Test Summary Qtr1 (2021-22) Front Sheet.pdf (2 pages)
- 15. Qtr1 (2021-22) Staff FFT Summary Report v1.0.pdf (3 pages)

Regulatory

16. CQC Action Plan update

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 16. CQC Must Do Action Plans Q1 Update v2 Final.pdf (37 pages)

17. Board Assurance Framework / Corporate Risk Register update

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 17. Trustwide Risk Management Report July 21.pdf (9 pages)
- 17. Trust-wide Risk Management Report - Appendix 1.pdf (1 pages)
- 17. BAF Risk Register Q1 - Appendix 2.pdf (28 pages)
- 17. Trust-Wide Risk Management Report - Appendix 3 July 21.pdf (24 pages)

18. NHSE/I Single Oversight Framework Compliance Report

Lisa Quinn, Executive Director of Commissioning and Quality Assurance

- 18. NHS Improvement Single Oversight Framework - Quarter 1 2021-22.pdf (5 pages)

Minutes / Papers For Information and Items

19. Committee Updates

Non-Executive Directors

19.1. Quality and Performance Committee

Alexis Cleveland, Chair

19.2. Audit Committee

David Arthur, Chair

19.3. Resource Business and Assurance Committee

Peter Studd, Chair

19.4. Mental Health Legislation Committee

Michael Robinson, Chair

19.5. Provider Collaborative Committee

Michael Robinson, Chair

19.6. CEDAR Programme Board

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Peter Studd, Chair

19.7. Charitable Funds Committee (as Corporate Trustees)

Paula Breen, Chair

20. Council of Governors' Issues

Ken Jarrold, Chairman

21. Any Other Business

Ken Jarrold, Chairman

22. Questions from the Public

Ken Jarrold, Chairman

23. Date and Time of Next Meeting

Wednesday 1st September 2021, 1.30pm – 3.30pm Via Microsoft Teams

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Minutes of the Board of Directors meeting held in Public
Held on 7 July 2021 1.30pm – 3.30pm
Via Microsoft Teams

Present:
Ken Jarrold, Chairman
David Arthur, Non-Executive Director
Darren Best, Non-Executive Director

Paula Breen, Non-Executive Director
Alexis Cleveland, Non-Executive Director
Michael Robinson, Non-Executive Director
Peter Studd, Non-Executive Director

John Lawlor, Chief Executive
James Duncan, Deputy Chief Executive/Executive Finance Director
Ramona Duguid, Chief Operating Officer
Rajesh Nadkarni, Executive Medical Director
Gary O'Hare, Chief Nurse
Lynne Shaw, Executive Director of Workforce and Organisational Development

In attendance:
Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary
Kirsty Allan, Acting Corporate Affairs Manager (Minute Taker)
Jayne Simpson, Corporate Affairs Officer
Fiona Grant, Lead Governor/Service User Governor for Adult Services
Anne Carlile, Carer Governor for Adult Services
Fiona Regan, Carer Governor for Learning Disabilities and Autism
Margaret Adams, Deputy Lead Governor/Public Governor for South Tyneside
Bob Waddell, Staff Governor – Non-clinical
Revell Cornell, Staff Governor – Non-clinical
Uma Geethanath, Staff Governor - Medical
Paul Richardson, Local Authority Governor, North Tyneside
Wilf Flynn, Local Authority Governor, South Tyneside Council
Tom Rebair, Service User Governor, Adult Services
Victoria Bullerwell, Staff Governor – Non-clinical
Allan Fairlamb, Acting Deputy Director of Commissioning and Quality Assurance
Chris Rowland, Equality and Diversity Lead
Lizzy Campbell, Service User
Beth Allan, Patient and Carer Involvement Facilitator (Central Locality)

Apologies:
Lisa Quinn, Executive Director of Commissioning and Quality Assurance
Tom Bentley, Public Governor for Gateshead
Raza Rahman, Staff Governor – Clinical
Kat Boulton, Service User Governor, Children and Young People's Service

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1. **Welcome and apologies for absence**

Ken Jarrold welcomed everyone to the meeting and apologies were noted as above.

2. Service User Story

Ken Jarrold extended a warm welcome and thanks to Lizzy Campbell who attended the Board to share her story, personal journey, achievements, and challenges on her journey to recovery.

3. Declarations of interest

There were no new conflicts of interest declared for the meeting.

4. Minutes of the meeting held 26 May 2021

The minutes of the meeting held on 26th May 2021 were considered and approved.

Approved:
- **The minutes of the meeting held 26 May 2021 were approved as an accurate record.**

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

None to note.

6. Chairman's Remarks

Ken Jarrold referred to the Board of Director's Development Session earlier today where discussions took place reviewing the considerable pressures facing the Trust.

Ken shared three conclusions from those discussions. The Board was determined to ensure that:

1. The focus of the Board and senior colleagues should resonate with the focus of front-line teams.
2. Staff should feel tangible support.
3. Service User, Carers and Partners should feel that things are being done differently.

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

7. Chief Executive's Report

John Lawlor referred to the Trust's Annual Staff Excellence Awards and the hope the Awards ceremony will be held face to face on 3rd September. John mentioned a fantastic level of interest with 868 nominations received within a shorter time frame than normal.

John mentioned the introduction of a quarterly staff survey is to be rolled out across the NHS from July 2021. The Quarterly staff survey will run alongside the annual NHS staff survey, providing a more regular insight into the working experience of our people.

An Armed Service Staff and Veterans Network has recently been formed and launched across the Trust. The Network aims to ensure the Trust provides sufficient support to staff who relate to the armed forces. The Network is co-chaired by Richard Lloyd and Dave Goldsmith (both ex armed forces) and is meeting quarterly. The first meeting took place on 7th June 021 which was well supported. The Network will also be key to helping the organisation fulfil its duties under the Armed Forces Covenant and the requirement of being a Veterans Aware organisation.

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Rajesh Nadkarni referred to an agreement between the Medical Directors of CNTW and NUTH to create a post within the Medical Leadership of NUTH for a psychiatrist to lead on mental and physical health interface issues. The post would be directly accountable to the Medical Director of NUFT and would improve services at NUFT from a mental health perspective. It is thought to be the first initiative of its kind.

John Lawlor mentioned NHS England and NHS Improvement has published a new integrated care system (ICS) design framework, to support progression and development. It sets out some of the ways NHS leaders and organisations will operate with their partners in ICSs from April 2022. It is subject to legislation, which is expected to begin the passage through Parliament before the end of the summer. This is an ambitious and significant change for the NHS, and one which will be challenging to deliver, given that the necessary legislation has not yet passed through Parliament and we have a new Secretary of State. The framework sets out a high degree of flexibility in design and implementation of the ICS and this is subject to significant discussion and debate across the North East and North Cumbria.

John mentioned that recent disparity ratios have been produced which highlight how staff with minority ethnic backgrounds are represented at different levels in each Trust in a bid to tackle 'racist practice' in the NHS. John referred to the data which has been submitted by organisations as part of the Workforce Race Equality Standard (WRES) and is presented at three tiers which is highlighted within the report.

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

Quality, Clinical and Patient Issues

8. COVID-19 Response update

Gary O'Hare provided an update on the current position as there has been a few changes since the report was produced. Gary mentioned there has been one patient COVID positive within acute services. Gary confirmed this was a community acquired infection and not a hospital acquired infection.

Staff numbers in relation to positive tests have accelerated over the last fortnight and the Trust is now in the position of 700 staff absences which is an increase of 200 absences within two weeks. Gary explained 194 of those absences are COVID related, with over 40 staff COVID positive. Gary mentioned the Trust has not had any outbreaks for 94 days across the organisation.

Gary mentioned vaccinations are very close to 90% in relation to staff receiving their first doses and 86% of staff receiving their second dose. Gary confirmed 10% of staff have not taken up the opportunity to receive the vaccine and mentioned managers are reminded to discuss vaccinations with staff.

The Trust continues to provide the vaccine to patients and confirmed over 70% of patients received their first dose, 55% receiving their second dose and the figure changes on a regular basis. Gary reminded the Board of any patients seeking their second dose would be

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followed up in the community if discharged from hospital, or alternatively, if the timing was appropriate patients would be vaccinated early before discharge to the community.

Gary explained the North East of England has the highest COVID-19 prevalence currently. Since the last report, North Tyneside and Cumbria local authorities commenced PCR Surge testing during June to target and prevent further spread. Newcastle is an area of concern and the potential for surge testing in this locality is highly likely.

Gary highlighted a Trust-wide Working Safely Group has been meeting fortnightly. Four workstreams have been established to develop 'new ways of working' models for Corporate and Operational / Clinical services. The group are exploring key enablers such as homeworking and Microsoft Teams to optimise benefits, including reduced travel and changes to accommodation requirements.

Darren Best thanked Gary O'Hare for the detailed update and referred to issues the Trust is facing around staffing levels and mentioned the fact that policy has not fully kept up with changes in circumstances locally. Darren queried whether discussions going forward around contingency planning will be more general.

Gary confirmed CNTW will continue to operate as previously after the 19th July 2021 when restrictions are to be lifted.

Paula Breen mentioned within Primary Care there are large increases in COVID cases within children as well as a significant increase of people who have already been double vaccinated, testing COVID positive. Paula asked what the Trust response is to IPC, to people who test positive and what that means for the Trust. Gary O'Hare mentioned the Trust is continuing to follow national guidance and will continue with IPC and PPE arrangements.

Resolved:
- **The Board received and noted the COVID-19 Response update**

9. Commissioning and Quality Assurance update Month 2

Allan Fairlamb spoke to the report and confirmed there have been three remote Mental Health Act Reviewer visits focussing on Wards 1 & 2 Walkergate Park and Aldervale ward and described the themes and actions from the visits highlighted within the report.

Allan mentioned the Trust met most local CCG contract requirements for Month 2 and Allan said the underperforming metrics relate to CPA metrics, delayed transfers of care and for Sunderland and North Cumbria IAPT, the numbers entering treatment (which is a national issue). Allan confirmed action plans are being formed with the relevant localities to track and improve on the areas that are underperforming.

Allan explained the number of follow up contacts conducted within 72 hours of discharge has decreased in the month and is reported trust wide at 91.4% which is above the 80% standard. During May 2021 the Trust received 269 Points of You survey returns, of which 64% were from service users, 12% from carers, 21% were completed on behalf of a service user and 3% did not state the person type. Of the 269 responses 261 answered the FFT question with 85% of service users and carers stating their overall experience with CNTW services was either good or very good.

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James Duncan mentioned the Trust has delivered a £0.6m surplus at Month 2. Income arrangements are a continuation of block contracts implemented in 2020/21 in response to COVID with the arrangements continuing for at least the first 6 months of the year. James mentioned the Trust has agreed to deliver break-even at the end of the first half of the year as part of the North ICP financial plan. James explained that the Trust is the Provider Collaborative lead for the North East and Cumbria for Specialist CYPS services and Adult Secure services and as a result, the Trust will manage an additional £53m income and expenditure in 2021/22.

Resolved:
- **The Board received and noted Commissioning and Quality Assurance update Month 2**

10. Non-Executive Director Service visits update

Nothing to note.

Strategy and Partnerships

11. ICS Design Framework

John Lawlor mentioned the Bill will be before Parliament soon with the expectation the ICS will be in shadow form by beginning of October 2021. CCGs will be abolished from 31st March 2022 with the ICS taking on their commissioning responsibilities from 1st April 2022.

Ken Jarrold referred to a good discussion within the Board Development Session where concerns have been raised regarding the rate of progress with the development of the ICS and Ken assured the Board the Trust is endeavouring to support the process as much as possible.

Resolved:
- **The Board received and noted ICS Design Framework update**

12. CNTW Annual Plan 2021/22.

James Duncan spoke to the report which sets out the plan for the current year. The transitional plan sets out how the organisation is intending to develop from a position of sustained COVID19 crisis management, learning from the pandemic and restabilising our core services, prioritising our workforce, quality standards and service delivery during 2021-22. It is also recognised the importance of looking beyond this year with the development of a refreshed strategy from 2022.

James mentioned three trust-wide priorities for the remainder of the financial year which are set out within the report. It is important to recognise that running across all our three priorities will be embedding and working with COVID19 as a constant feature whilst also identifying how we address service demand and delivery that support robust resource planning. The emerging development of the Integrated Care System will also be a constant feature during the year in terms of how we engage with our partners at place and influence the system to ensure mental health and disabilities have a strong voice and priority across the system.

As reported previously to Board, the Trust is in receipt of temporary system funding related to COVID-19 and current expenditure remains higher than previous income levels. Work is continuing to analyse this difference, considering agreed Long-Term Plan System Development Funding investment priorities.

Operational services will be supported where necessary to review and realign resources to deliver financially sustainable services in line with delivery of the Long-Term Planning ambitions, continuing a piece of work paused during the height of the pandemic to integrate planning around quality, activity, workforce, and financial management

James mentioned while the organisation recovers and restabilises this year, the Trust will be looking to support longer-term objectives by looking to the future in terms of working collaboratively across the North East and North Cumbria ICS and partners to deliver the regional strategy in particular the mental health system priorities. The Trust will be working closely with locality groups, as well as placed based systems, and leading on work to develop community-based services in line with the vision set out in the Community Mental Health Framework for Adults and Older Adults.

James Duncan requested the Board to consider and adopt the report noting the trust-wide priorities, risks and mitigations identified.

Peter Studd referred to the People Section within the report and asked if a trend graph of vacancy rates is available. Lynne Shaw mentioned that a future Board Development Session will provide a presentation reviewing recruitment and retention.

Peter Studd referred to the Trust Digital Strategy and as Chair of RBAC has requested to be involved in the review. James Duncan confirmed a CDT-Digital sub-group has recently been formed across the Trust to ensure a clear focus on the digital agenda and the digital strategy will be submitted through RABAC.

Resolved:
- **The Board received and noted the CNTW Annual Plan 2021/22.**

Approved:
- **The Board approved the plan and three priorities set out within the report.**

13. CQC Strategy from 2021

Allan Fairlamb spoke to the report and asked the Board to note the strategy. Allan mentioned within the document the CQC set out how it planned to develop its approach in line with a changing health and care landscape considering the context and learning from COVID-19, the development of system working and greater use of digital technologies to ensure its regulatory model is relevant and fit for purpose in an evolving system.

The CQC have now published their new strategy which lays out their intentions to take a more proportionate and risk-based approach to regulation and minimise burden where possible by using a more flexible and 'real time' approach.

Resolved:
- **The Board received and noted the CQC Strategy 2021**

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Workforce Issues

14. NHS People Plan update

Lynne Shaw spoke to the enclosed report which is a progress update on Trust level actions. Lynne confirmed the full paper and action plans have been discussed at CDT-Workforce and the Quality and Performance Committee. Lynne mentioned there are seven actions which are yet to be fully completed by the Trust which are outlined within the report.

Lynne confirmed the Respect campaign will commence next week and the first initiative under the Respect campaign will be centred around racism. Dr Carole Kaplan from Trust Innovations will Chair the task and finish group on the overhaul of recruitment and promotion practices, the first meeting was held in May and the work has been split into six work streams reviewing different elements of recruitment.

Lynne confirmed Roger Kline has agreed to work with the Trust in a support / advisory capacity on EDI issues for a six-month period. Lynne mentioned meeting with Roger Kline along with Rajesh Nadkarni in the coming days to discuss plans moving forward.

Ken Jarrold conveyed thanks to Lynne and everyone involved with the vast amount of work involving managers at all levels and mentioned it is pleasing to note Rodger Kline's involvement.

Resolved:
- **The Board received and noted the NHS People Plan update**

15. Equality, Diversity and Inclusion Plan update

Chris Rowlands presented the report which was taken as read.

Ken Jarrold referred to recent discussions and how committed the Trust is taking forward the actions set out within the report and mentioned a great deal is being done working closely with Staff Networks.

Resolved:
- **The Board received and noted the Equality, Diversity and Inclusion Plan update.**

16. Guardian of Safe Working Hours (Q4 and Annual Report)

Rajesh Nadkarni referred to the enclosed quarterly report on safe working hours which focusses on junior doctors. The report was accepted.

Resolved:
- **The Board received and noted Guardian of Safe Working Hours (Q4 and Annual Report)**

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Regulatory

17. Board and Sub-Committee Terms of Reference Review

Debbie Henderson presented the report which details the outcome of the Annual Review, Board and Board sub-committee Terms of Reference and confirmed the process is undertaken on an annual basis, however due to COVID pressures there was a deferral for one year. Debbie confirmed the only terms of reference which had not been deferred related to the Charitable Funds Committee as they were reviewed in 2020 and the newly established Provider Collaborative Committee which was approved April 2021.

Debbie confirmed every Committee has undertaken a self-assessment of the terms of reference with the proposed changes outlined within the report (pages 3-2) which largely relate to changes in memberships of the Committees

Resolved: • **Board received and approved the Board and Sub-Committee Terms of Reference Review**

18. Amendment of Scheme of Reservation and Delegation

James Duncan spoke to the enclosed report and mentioned following the approval of the Scheme of Reservation and Delegation in February 2021 it is noted the Director of Commissioning and Quality Assurance has been required to approve contracts between the Trust and other healthcare providers, and to authorise related payments that are in excess of the limits as currently set out in the Scheme of Reservation and Delegation. Proposed amendments are set out within the report which James Duncan requested for the Board to consider and approve the amendments to the Scheme of Reservation and Delegation.

Michael Robinson stated it was important to be clear that the amount has been increased in the context of Provider Collaboratives

Resolved: • **Board received and approved the Amendment of Scheme of Reservation and Delegation**

Minutes/papers for information and items
Committee updates

19. Committee updates

19.1 Quality and Performance Committee

Alexis Cleveland confirmed the Committee met on 23rd June 2021 where a large number of the reports that have been discussed at todays Closed and Open Boards were considered as well as a good presentation provided from North Locality touching on COVID lessons learnt and medical and nursing staffing levels. Case studies were reviewed on the use of MRE to understand where MRE had been used and highlighted it was good to see the use of MRE reducing. Alexis mentioned a deep-dive exercise looking at the positive and safe strategy was given.

19.2 Audit Committee

David Arthur mentioned the Audit Committee will soon be reviewing the risks within the digital area.

19.3 Resource and Business Assurance Committee

Nothing to report.

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19.4 Mental Health Legislation Committee

Nothing to report.

19.5 Provider Collaborative Committee and Terms of Reference

Michael Robinson informed the Committee met in June which was the second meeting of the Committee. Reports were reviewed on the lead provider arrangements that are in place as well as the three provider collaboratives the Trust Leads. Michael mentioned consideration was given to the risks assigned to the Provider Collaborative Committee and will provide some proposed changes at a future Board.

19.6 CEDAR Programme Board

Peter Studd provided progress against plan and referred to Northgate site timescales which are on programme. Peter mentioned Ferndene site is progressing but is 6 weeks behind schedule. Peter confirmed both main parts of the programme are currently forecast to come in on cost although there is significant risk given a considerable amount of contingency has been allocated and the unprecedented difficulties currently with supplies.

19.7 Charitable Funds Committee

Nothing to report.

20 Council of Governors issues

Ken Jarrold referred to the Nomination Committee and confirmed recruitment for three Non-Executive Director posts is underway with 99 candidates applied and 16 of those will be interviewed.

Ken Jarrold conveyed thanks to Tom Bentley who is working with Lynne Shaw and the Staff Networks providing support.

Ken confirmed our new Councillor for Newcastle City Council is Alex Hay and looks forward to meeting Alex soon.

Evelyn Bitcon requested an update on the Human Rights Research. Rajesh Nadkarni described the Human Rights work the Trust is undertaking and the links with Restricted Practices, Trauma Informed Care, reduced Seclusion and Long-Term Segregation. It was agreed that Rajesh Nadkarni would provide a brief update to the next Council of Governors General meeting and Board of Directors Public Board.

John Lawlor referred to the National Children, Young Person's Taskforce which is currently finalising the Human Rights training which all staff working into Children and Young People Inpatient facilities will need to undergo.

21 Any Other Business

None to note.

22 Questions from the public

None to note.

Date and time of next meeting

Wednesday, 4 August 2021, 1.30pm via Microsoft Teams

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Board of Directors Meeting held in public

Action Log as at 4 August 2021

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

Item No.	Subject	Action	By Whom	By When	Update/Comments
Actions outstanding					
26.05.21 (5)	Access to support and services by telephone	As part of the Community Transformation work, undertake a review of telephonic access points into the Trust to incorporate issues identified in complaints/feedback from service users	Ramona Duguid	September 2021	On track
Completed Actions					
		No completed actions to report since the previous meeting			

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Report to the Board of Directors
4th August 2021

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

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

Board Sub-committee meetings where this item has been considered (specify date)		**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

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Coronavirus (COVID-19)
Report for the Board of Directors meeting
4th August 2021

1. Executive Summary

This report provides an exception report in response to the COVID-19 pandemic since the last Trust Board. For this month the report includes 5 areas:

- COVID-19 Prevalence, Surge and Business Continuity
- Nosocomial and Outbreak Management
- Test and Release – Isolation Exceptions for staff
- Road Map Step 4
- CQC Care Home Deaths Report

2. Trust COVID-19 Prevalence

Since the last report to Board, the North East and Cumbria (NE&C) region has continued to see the highest case rates in England, across all localities. One in every 100 people in the region tested positive at the time of reporting, more than twice the national average. Local rates per 100,000 at the time of the report show the continued increase (data in brackets from 2 weeks previous) and rates exceeded those seen previously throughout the pandemic

- **Newcastle** 890.3 (664.1)
- **South Tyneside** 1.192 (604.1)
- **North Tyneside** 788.3 (547.3)
- **Cumbria** 663.8 (438.1)
- **Gateshead** 963.6 (565.2)
- **Sunderland** 1,117 (642)
- **Northumberland** 727.6 (693)

Whilst there has been some increase in cases of 60 plus years, predominately admissions and case rates have been in the unvaccinated 18 to 30 years and school children. It is hoped that as the local schools break for summer holidays this may ease pressure and outbreaks in this sector, but concern has been expressed regarding the September return. There are plans being developed for increased testing in schools in September and school 'bubbles' will be removed as isolation cohorts.

The region covered by the LA7 has been given Enhanced Response Status from government for a targeted approach over the next five weeks. Funding for increase in communications re: vaccinations and importance of social distancing, wearing masks, staying outdoors, washing hands etc. Also, some extra help with resource for door to door vaccination and testing capacity.

3. Surge and Business Continuity

NE&C hospitals have continued to see an increase in hospital admissions and some patients need for ventilation. Since the last report, the whole system e.g., Acute medical admissions, Emergency Departments, Primary Care, NEAS and Mental Health and Disability providers have come under immense pressure due to a combination of non-COVID presentations and demand on services, coupled with the impact of staff absence due to self-isolation following NHS App and Test and Trace notifications.

CNTW calls to the absence line hit a peak in early July with a combination of symptomatic, positive staff and staff needing to isolate due to close contacts. This was a compounded by a backdrop of vacancies in some services. To manage the surge in activity and

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business continuity, the Covid IMG was reinstated three times per week led by the Chief Nurse. The actions taken include:

- Assessment of all clinical and non-clinical services using OPEL Major Incident and Business Continuity framework. At the time of report, we were at Opel level 2.
- Decisions to redeploy corporate clinical staff to preserve frontline clinical services i.e., Inpatient and Crisis Teams.
- Targeted actions to assure increased qualified per shift and ensure Safe Staffing levels.
- Decision taken to stand down non-essential meetings.
- Specific areas of concern are Rowanwood, Ferndene, Alnmouth and Hauxley, each has a clear plan and mitigations for escalation
- Increased activity requiring resource increase to Absence line and Senior Nurse Test and Trace team to manage demand.
- Managers Meetings moved to weekly meetings to ensure timely communications and discussion feedback from managers.
- Communications to thank staff for their efforts during this challenging time and acknowledging need to focus on Inpatient and Crisis Teams and ensure staffing can be maintained.

4. <u>Support for Surge – Exception from contact isolation for fully vaccinated staff</u>

On the 2nd July 2021 the Trust introduced a process to robustly screen and risk assess staff who had received Proximity APP notifications. Following risk assessment by the DIPC and Test and Trace Team 102 returned staff to the workplace with negative PCR and daily LFD. This process has helped to establish an understanding of processes, skills and capacity required to support staff to return.

In response to the surge in staff absence the Government and Public Health England have updated their guidance **week commencing 19th July 2021** on self-isolation for health and care staff. CNTW IMG reviewed the Close Contact guidance issued 19th and 20th July from Public Health England (PHE) and the Chief Nursing Officer (CNO) / Chief Medical Officer (CMO), and carefully considered there is a need to balance the risk between staff absence and the potential impact on patient safety – it has been acknowledged that this needs to consider the risk to patients because of staff shortages versus risk associated with exposure to potential nosocomial or other transmission, which can affect patients and staff which could exacerbate staff shortages.

The work has been led by DIPC and Gold Command to swiftly but safely introduce a system to enable staff to be released back into the workplace. It sets out that

- If there is a risk that staff absence would lead to potential patient harm then **staff who are fully vaccinated (14 days post second dose)** may be brought back to work ahead of the self-isolation period following the completion of a local risk assessment on a **case by case basis**.
- Cases where the contact was a member of the staff member's household **will not be** eligible for this process.
- The staff member **should not work with clinically extremely vulnerable patients.**
- It is recommended that the staff member **should not take breaks or eat meals with other staff as per PHE guidance.**

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- Any staff who can return to work following these risk assessments **must adhere to legal isolation requirements at all other times i.e., when not at or travelling to work.**
- They can travel to work by their normal route but should wear a face covering for their journey if within an enclosed space with other individuals.
- **This is not a blanket approach to return all staff who are close contacts.**
- The guidelines give employers the 'right to allow' not to 'compel' staff to return to work.
- Processes have been agreed to introduce a process to be used on a case by case basis to potentially return, inpatient Medical staff including Junior Doctors and Registered Nursing staff only, to areas where there are significant patient safety concerns. On call medical support to inpatients being one of the critical areas. Approval following robust risk assessment will be signed off by the DIPC/Executive lead.

The process will immediately stop if there is a period of increase incidence or an outbreak associated with it. The Board will be updated on the impact of the new approach.

5. <u>Nosocomial Infections</u> <u>(Hospital Acquired)</u> **<u>and Outbreak Management</u>**

Since the last report to Board an outbreak has been declared on 20th July 2021 for Kinnersley. At the time of report, positive cohort included three staff and three patients.

- The root cause analysis is being undertaken, timeline suggests staff member may be the index case as patient is not a recent admission and had not had leave. Although no IPC breaches reported or indicated via Close Contact Risk Assessment, transmission is indicated to have been via touchpoints initially and aerosol transmission due to patient repeatedly coughing and unable to wear a mask.
- All IPC measures are in place and physical health monitoring supported by the CRIS team.

6. <u>Road Map Step 4 – Easing of Restrictions and Living with COVID</u>

On 19th July 2021 full easing of restrictions progressed throughout England. Emphasis on personal responsibility to wear a mask and socially distance / avoid crowded places.

- Importantly the IPC measures remain unchanged for Health Care Settings regarding PPE, social distancing, and covid secure spaces.
- Continued emphasis on staff considering risks outside of work and personal protective behaviours.
- Heat Wave – further exploration of what can be done to manage heat on wards – staff have been supported to wear scrubs as alternative to uniform as lighter fabric. Fan use only possible in single rooms due to increased risks. Further exploration of longer term solutions such as safe portable air conditioning units for clinical rooms and clinical settings.
- Outdoor seating expected delivery on 13th August 2021, and all should be secured in two weeks following around hospital sites and some community areas where requested.
- Signage – to update signage around sites to remind staff and visitors of need to wear masks and socially distance in hospital settings.

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7. CQC Care Home Deaths during Covid Report

Care Home Death Report received which will be reviewed for learning and brought back to a future report.

8. Recommendation

The Board are asked to receive this report, noting the increase in covid related activity and assurance on the measures taken to date.

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

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Report to the Board of Directors
4th August 2021

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

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

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	28.07.21
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	26.07.21
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	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

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CNTW Integrated Commissioning & Quality Assurance Report 2021-22 Month 3 (June 2021)

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 four Mental Health Act Reviewer visits – Fellside, Bluebell Court, Fraser and Redburn. Feedback from the visits that have taken place during Quarter 1 include; patient's rights not being read at appropriate times or on an individual basis, medication prescribed had not been authorised and internal audits had not recognised this and issues with care plans.

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

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

3. The Trust met all local CCG's contract requirements for month 3 and Quarter 1 with the exception of:

   - CPA metrics for all CCG's with the exception of Durham, Darlington and Tees and Sunderland.
   - Numbers entering treatment within Sunderland IAPT service (615 patients entered treatment against a target of 810) and North Cumbria (424 patients entered treatment against a target of 605).
   - Delayed Transfers of Care within South Tyneside, Durham, Darlington and Tees and North Cumbria.

4. The Trust met all the requirements for month 3 and Quarter 1 within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (98.3% against a 100% target).

5. All CQUIN schemes for 2021/22 have been suspended until Quarter 3 2021-22 due to the COVID-19 pandemic.

6. There are 19 people waiting more than 18 weeks to access services this month in non-specialised adult services (30 reported last month). Within children's community

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services there are currently 752 children and young people waiting more than 18 weeks to treatment (704 reported last month).

7 Training topics below the required trust trajectory as at Quarter 1 are listed below:

Training Topic	Quarter 1 position	Quarter 1 trajectory	Quarter 1 standard
Information Governance	93.2%	95%	
PMVA Breakaway training	74.5%	80%	
Mental Health Act combined	61.4%	79%	
Clinical Risk and Suicide Prevention training	82.6%	85%	
Clinical Supervision	80.2%	83%	
Seclusion training	70.1%	83%	
Rapid Tranquilisation	80.6%	85%	
Safeguarding Children Level 3	74.7%	82%	
PMVA Basic training	39.2%	Under review	
MHCT Clustering	59.1%		85%

8 Appraisal rates are reported at 77.1% in June 2021 (77.5% last month), therefore achieving the Quarter 1 trajectory of 77% Trust.

9 The percentage of staff with a completed clinical supervision record is reported at 52.0% as at 30th June 2021. At 30th June 2021 the proportion of staff with a management supervision recorded in the last 3 months is reported at 56.0% against a recovery trajectory of 71% for Quarter 1 2021.

10 The confirmed May 2021 sickness figure is 5.2%. This was provisionally reported as 5.35% in last month's report. The provisional June 2021 sickness figure is 5.87% which is above the 5% standard. The 12 month rolling average sickness rate has increased to 5.47% in the month.

11 At Month 3, the Trust has a surplus of £0.2m which is slightly below plan. Agency spend at month 3 is £4.5m of which £2.6m (59%) relates to nursing support staff.

Other issues to note:

- There are currently 17 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 94.0% which is above the 80% standard. (was 91.4% last month).
- There were no inappropriate adult out of area bed days reported in June 2021 which meets the trajectory from March 2021.
- During June 2021 the Trust received 400 Points of You survey returns, of which 71% were from service users, 18% from carers, 6% were completed on behalf of a service user and 5% did not state the person type. Of the 400 responses 385

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answered the FFT question with 83% of service users and carers stating their overall experience with CNTW services was either good or very good.

2021-22 Reporting of Quality Standards, Training & Appraisals during pandemic

During April, each of the locality groups and corporate services have been setting out their recovery trajectories for none compliance against standards. These trajectories show how the groups will progress towards meeting and maintaining each of the standards which will be monitored on a quarterly basis through the Accountability Framework and through to the Board in this report.

Training trajectories have been set whilst taking a number of considerations into account such as

- Availability of face to face training e.g. PMVA
- Ability for teams to release staff to take part in or deliver training e.g. PMVA
- Staff leave – taking carried forward annual leave as covid restrictions ease
- Trainee rotations – drop in LET doctor and doctors in training training standards when new rotations are taken on

Please see Appendix 1 for Training and Quality Trajectories for 2021 – 2022.

From Month 01 the Board report will monitor against the agreed trajectories rather than the overall standard. Please note, however the Trust moved to OPEL Level 2 on the 14th July which led to the suspension of al training and non-essential meetings due to staff shortages.

Please see Appendix 2 for progress by locality for the Quality Trajectories as at Quarter 1 2021-2022

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Regulatory	Single Oversight Framework			
	1	The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy).	Use of Resources Score:	2

CQC		
Overall Rating	Number of "Must Dos"	There have been four Mental Health Act reviewer visit reports received since the last report. The visits continue both virtually and online 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%	90%	70%	90%	80%	86%	87%	50%

Percentage of Quality Standards achieved in the month:

94%	90%	70%	90%	80%	86%	87%	50%

Contract Summary: Percentage of Quality Standards achieved in the month:

Cirrhosis & fibrosis tests for alcohol dependant patients	Staff Flu Vaccinations	Use of specific Anxiety Disorder measures within IAPT	Routine outcome monitoring in CYPS & Perinatal MH Services	Routine outcome monitoring in Community Mental Health Services	Biopsychosocial assessment by Mental Health Liaison Services	Healthy Weight in Adult Secure Services	Achieving high quality 'formulations' for CAMHS inpatients	Mental Health for Deaf	Routine outcome monitoring in perinatal inpatient services

All CQUIN schemes are currently suspended for 2021/22 until Quarter 3

Internal

Accountability Framework

North Locality Care Group Score: June 2021		Central Locality Care Group Score: June 2021		South Locality Care Group Score: June 2021		North Cumbria Locality Care Group Score: June 2021	
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	Increasing time staff are able to spend with service users and carers	Equality, Diversity & Inclusion and Human Rights

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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 3. There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group have developed action plans which continue to be monitored via the Business Delivery Group and the Executive Management Team.

Workforce

Statutory & Essential Training:

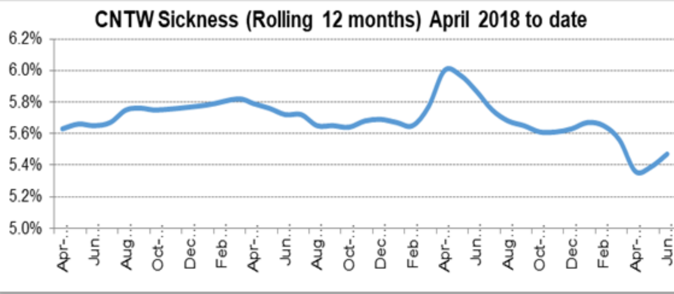
Number of courses Trajectory Achieved Trustwide:	Number of courses <5% below trajectory Trustwide:	Number of courses trajectory not achieved (>5% below standard):
9	4	6

Clinical Risk training (82.6%), Clinical Supervision training (80.2%), Information Governance (93.2%) and Rapid Tranquilisation training (80.6%) are within 5% of the Quarter 1 trajectory. PMVA basic training (39.2%), PMVA Breakaway training (74.5%), MHA combined training (61.4%), MHCT Clustering Training (59.1%), Seclusion training (70.1%) and, Safeguarding Children Level 3 (74.7%), are reported at more than 5% below the Quarter 1 trajectory.

Appraisals:

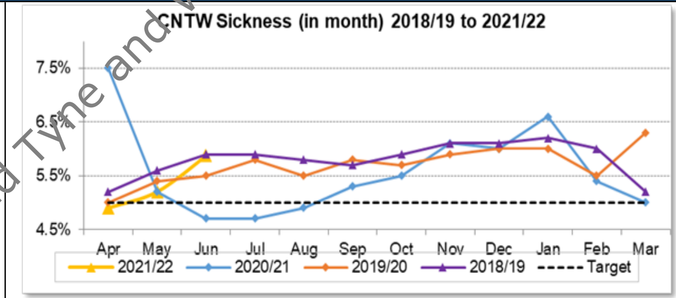
Appraisal rates have decreased in the month to 77.1% in June 2021 (was 77.5% last month).

Sickness Absence:



The provisional "in month" sickness absence rate is above the 5% target at 5.87% for June 2021

The rolling 12 month sickness average has increased to 5.47% in the month



Finance

At Month 3, the Trust has a surplus of £0.2m which is slightly below plan. Agency spend at Month 2 is £4.5m of which £2.6m (59%) relates to nursing support staff.

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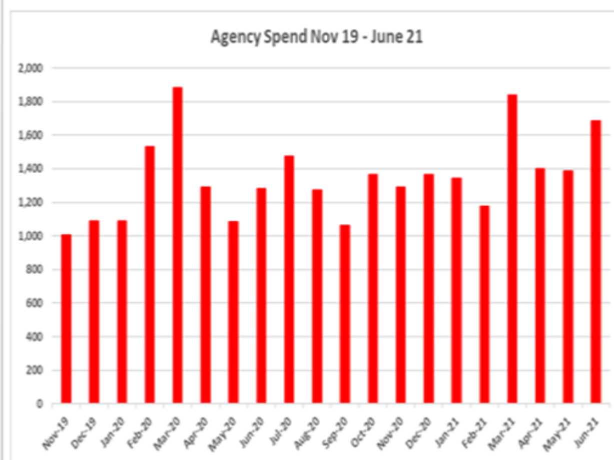
Financial Performance Dashboard

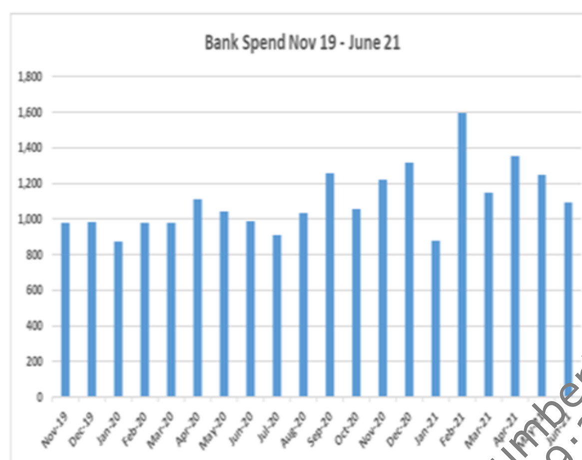
Income & Expenditure

	Plan £m	Actual £m	Variance (£)
Income	121.5	121.0	0.5
Pay	(86.3)	(86.3)	0.0
Non Pay	(34.8)	(34.5)	(0.3)
Surplus / (Deficit)	**0.4**	**0.2**	**0.2**

Key Indicators

Key Indicators	Year To Date
Surplus/ (Deficit)	£0.2m
Agency Spend	£4.5m
Cash	£57.1m
Capital Spend	£5.8m





Key Issues/Risks

- At month 3 the Trust has a delivered a £0.2m surplus.
- Income arrangements are a continuation of the block contracts implemented in 2020/21 in response to COVID. These arrangements will continue for at least the first 6 months of the year (H1).
- The Trust has agreed to deliver break-even at the end of H1 as part of the North ICP/ICS financial plan.
- The Trust has agreed the MHIS funding for 2020/21 and 2021/22 together with investment from the Service Development Fund and Spending Review funding provided for Mental Health.
- The Trust is the Provider Collaborative lead for the North East & Cumbria for Specialist CYPs services and Adult Secure services. As a result the Trust will manage an additional £53m income and expenditure in 2021/22.
- Cash – £57.1m at month 3 which is more than historical cash levels (pre-COVID) due to improved working balances, capital spend being less than plan in 2020/21 and increases in provisions.
- Capital Spend - £5.8m at month 3 which is £4.5m less than plan.

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

	31/05/2021		07/06/2021		14/06/2021		21/06/2021		28/06/2021	
Medical	106	57	106	46	96	46	96	41	82	36
Qual Nursing	180	169	211	188	192	181	168	156	181	172
Unq Nursing	1,504	72	1,763	94	1,571	101	1,623	88	1,677	97
A&C	53		72		48		60		63	
	1,843	**298**	**2,152**	**328**	**1,907**	**328**	**1,947**	**285**	**2,013**	**305**

In June the Trust reported an average of 309 price cap breaches (45 medical, 173 qualified nursing and 90 nursing support). At the end of June 8 medics were paid over the price cap.

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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 Quarter 1 and has moved back to OPEL Level 2 on the 14th July 2021, leading to a further risk to compliance against trajectories and standards.
- There continues to be over 18 week waiters across services. Work continues to monitor and improve access to services across all localities.
- Please note the change in requirement and reporting due to COVID-19 are not reflected in this report.
- Quality and training standards have been impacted as a consequence of responding to COVID-19.

Recommendations

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

Allan Fairlamb
Deputy Director of Commissioning & Quality Assurance

Lisa Quinn
Executive Director of Commissioning & Quality Assurance

15th July 2021

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Training Trajectories 2021-2022 – Appendix 1

Metric ID - Training Name	Standard	Q1 North	Q1 Central	Q1 South	Q1 N.Cumbria	Q1 Corporate	Q1 Trust Trajectory	Q2 North	Q2 Central	Q2 South	Q2 N.Cumbria	Q2 Corporate	Q2 Trust Trajectory
3001 - Clinical Risk and Suicide Prevention Training	85%	85%	85%	85%	85%	70%	85%	85%	85%	85%	85%	75%	85%
3002 - Clinical Supervision	85%	85%	80%	85%	75%	80%	83%	85%	82%	85%	77%	85%	84%
3004 - Equality & Diversity Introduction	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3006 - Fire	85%	85%	85%	85%	85%	80%	85%	85%	85%	85%	85%	85%	85%
3008 - Health & Safety	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3015 - Infection Prevention & Control - Inoculation Incidents – Hand Hygiene	85%	85%	85%	85%	85%	83%	85%	85%	85%	85%	85%	84%	85%
3018 - Medicines Management Training	85%	85%	85%	85%	83%	70%	85%	85%	85%	85%	84%	75%	85%
3019 - Moving & Handling Awareness Training	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3022 - PMVA Basic	85%	~~50%~~	~~28%~~	~~35%~~	~~50%~~	~~50%~~	~~43%~~	~~60%~~	~~38%~~	~~50%~~	~~65%~~	~~65%~~	~~56%~~
3023 - Rapid Tranquilisation Training	85%	85%	85%	85%	85%	80%	85%	85%	85%	85%	85%	85%	85%
3026 - Safeguarding Adults Level 1	85%	85%	85%	85%	85%	83%	85%	85%	85%	85%	85%	85%	85%
3027 - Safeguarding Children Level 1	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3030 - Information Governance (Data Security Awareness)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
3042 - Seclusion Training	85%	85%	85%	85%	80%	75%	83%	85%	85%	85%	82%	85%	85%
3043 - PMVA Breakaway	85%	85%	71%	85%	75%	65%	80%	85%	78%	85%	77%	75%	82%
3046 - Safeguarding Children Level 3	85%	85%	80%	85%	80%	75%	82%	85%	85%	85%	82%	85%	84%
3047 - Safeguarding Children Level 2	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3075 - MHA MCA DoLS Combined	85%	80%	75%	80%	65%	60%	79%	85%	78%	85%	75%	63%	83%
3501 - Complete JDR's	85%	85%	71%	80%	76%	73%	77%	85%	75%	85%	80%	77%	80%
3514 - Proportion of staff with management supervision recorded in the past 3 months	85%	70%	65%	70%	85%	65%	71%	80%	85%	80%	85%	75%	81%

Shaded trajectories are where standard is already met or exceeded.
PMVA Basic trajectories are currently under review and will be updated as soon as possible.

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Metric ID - Training Name	Q3						Q4					
	North	Central	South	N.Cumbria	Corporate	Trust Trajectory	North	Central	South	N.Cumbria	Corporate	Trust Trajectory
3001 - Clinical Risk and Suicide Prevention Training	85%	85%	85%	85%	80%	85%	85%	85%	85%	85%	85%	85%
3002 - Clinical Supervision	85%	83%	85%	82%	85%	85%	85%	85%	85%	85%	90%	85%
3004 - Equality & Diversity Introduction	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3006 - Fire	85%	85%	85%	85%	90%	85%	85%	85%	85%	85%	90%	85%
3008 - Health & Safety	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3015 - Infection Prevention & Control - Inoculation Incidents – Hand Hygiene	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	88%	85%
3018 - Medicines Management Training	85%	85%	85%	84%	80%	85%	85%	85%	85%	85%	85%	85%
3019 - Moving & Handling Awareness Training	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3022 - PMVA Basic	~~70%~~	~~50%~~	~~65%~~	~~75%~~	~~65%~~	~~66%~~	~~85%~~	~~60%~~	~~85%~~	~~80%~~	~~75%~~	~~78%~~
3023 - Rapid Tranquilisation Training	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3026 - Safeguarding Adults Level 1	85%	85%	85%	85%	90%	85%	85%	85%	85%	85%	90%	85%
3027 - Safeguarding Children Level 1	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3030 - Information Governance (Data Security Awareness)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
3042 - Seclusion Training	85%	85%	85%	84%	85%	85%	85%	85%	85%	85%	85%	85%
3043 - PMVA Breakaway	85%	85%	85%	82%	75%	85%	85%	85%	85%	85%	85%	85%
3046 - Safeguarding Children Level 3	85%	85%	85%	84%	85%	85%	85%	85%	85%	85%	85%	85%
3047 - Safeguarding Children Level 2	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
3075 - MHA MCA DoLS Combined	85%	82%	85%	85%	70%	85%	85%	85%	85%	85%	85%	85%
3501 - Complete JDR's	85%	78%	85%	85%	80%	83%	85%	80%	85%	85%	85%	85%
3514 - Proportion of staff with management supervision recorded in the past 3 months	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

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Quality Trajectories 2021-2022

Metric ID - Quality	Standard	Q1 North	Q1 Central	Q1 South	Q1 N.Cumbria	Q1 Aggregate	Q2 North	Q2 Central	Q2 South	Q2 N.Cumbria	Q2 Aggregate
155 Care Plans Discussed	95%	95%	93%	92%	84%	91%	95%	95%	95%	85%	93%
156 Current Service users clustered within threshold (previous 2 reviews)	85%	80%	85%	80%	58%	76%	83%	85%	83%	65%	79%
157 Current service users clustered within review threshold	85%	80%	84%	80%	71%	79%	83%	85%	83%	73%	81%
11 % of service users with a record of CPA/non CPA status	95%	85%	94%	85%	68%	83%	90%	95%	90%	75%	88%
34 Current service users on CPA reviewed in last 12 months	95%	97%	95%	97%	95%	96%	97%	95%	97%	95%	96%
401 CPA reviews where cluster performed +3/-3 days either side of CPA review	85%	80%	79%	80%	68%	77%	83%	81%	83%	75%	81%
984 Current service users with valid ethnicity	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
1427 Number of Service Users on the EIP caseload Screen Using the LESTER tool	90%	90%	90%	90%	68%	85%	90%	90%	90%	75%	86%
298 DTOC	<7.5%				13%	13%				13%	13%
101 Risk Assessments	95%	95%	95%	95%	65%	88%	95%	95%	95%	75%	90%

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		Q3					Q4				
Metric ID - Quality	**Standard**	**North**	**Central**	**South**	**N.Cumbria**	**Aggregate**	**North**	**Central**	**South**	**N.Cumbria**	**Aggregate**
155 Care Plans Discussed	95%	95%	95%	95%	90%	94%	95%	95%	95%	95%	95%
156 Current Service users clustered within threshold (previous 2 reviews)	85%	85%	85%	85%	75%	83%	85%	85%	85%	85%	85%
157 Current service users clustered within review threshold	85%	85%	85%	85%	75%	83%	85%	85%	85%	85%	85%
11 % of service users with a record of CPA/non CPA status	95%	95%	95%	95%	85%	93%	95%	95%	95%	95%	95%
34 Current service users on CPA reviewed in last 12 months	95%	97%	95%	97%	95%	96%	97%	95%	97%	95%	96%
401 CPA reviews where cluster performed +3/-3 days either side of CPA review	85%	85%	83%	85%	85%	85%	85%	85%	85%	85%	85%
984 Current service users with valid ethnicity	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
1427 Number of Service Users on the EIP caseload Screen Using the LESTER tool	90%	90%	90%	90%	85%	89%	90%	90%	90%	90%	90%
298 DTOC	<7.5%				13%	13%				13%	13%
101 Risk Assessments	95%	95%	95%	95%	85%	93%	95%	95%	95%	95%	95%

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Quality Trajectories – Quarter 1

Appendix 2

Quality Indicator	Trust level		North		Central		South		N.Cumbria		Actions
	Q1 Trajectory	Q1 Actual	Q1 Trajectory	Q1 Actual	Q1 Trajectory	Q1 Actual	Q1 Trajectory	Q1 Actual	Q1 Trajectory	Q1 Actual	
Care Plans Discussed	91%	90.3%	95%	93.6%	93%	87%	92%	89.4%	84%	82.3%	Action plans are in place to address the improvement towards the trajectories. There has been continued inmprovement throughout the Quarter to meet the set trajectories within the localities.
Current Service users clustered within threshold (previous 2 reviews)	76%		80%		85%	82.1%	80%	78.5%	58%		
Current service users clustered within review threshold	79%		80%		84%	83.2%	80%	78.6%	71%	73.4%	
% of service users with a record of CPA/non CPA status	83%		85%		94%		85%	75.5%	68%		
Current service users on CPA reviewed in last 12 months	96%	95.6%	97%	96.5%	95%		97%		95%	91.2%	
CPA reviews where cluster performed +3/-3 days either side of CPA review	74%	71.5%	80%	72.6%	79%	73.7%	80%	76.2%	58%	53.6%	
Current service users with valid ethnicity	90%		90%		90%		90%		90%	86.0%	
Number of Service Users on the EIP caseload Screen Using the LESTER tool	85%		90%		90%		90%		68%	68.5%	
Delayed Transfers of Care	13%								13%		
Risk Assessments	78%		95%		95%		95%		26%		

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NHS Foundation Trust

Report to Board
4th August 2021

Title of report	**Service User and Carer Experience Report (Q1 2021/22)**
Report author(s)	**Paul Sams, Feedback & Outcomes Lead 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)		**Management Group meetings where this item has been considered (specify date)**	
Quality and Performance	28.07.21	Executive Team	26.07.21
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	26.07.21
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)	

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

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CNTW Service User and Carer Experience Summary Report

Quarter 1 2021-22

Executive Summary

This report discusses feedback received by CNTW from service users/patients and carers through available internal and external options during quarter 1 of 2021-22.

1. The report layout and structure has changed since quarter 4 2020/21. This is to improve the flow and quality of the information within the report which will develop further in future quarters.
2. The Trust continues to gain good levels of feedback through Points of You surveys. A 5% increase on the previous quarter.
3. Online surveys can now be completed for a team or ward without their code by typing the name into a box or choosing the appropriate team from a list.
4. The Trustwide Friends and Family Test score is 8.52 out of 10 (8.58 in the previous quarter.
5. CNTW continues to lead a national collaborative that develops and shares good practice in collecting and using service user and carer feedback.
6. Only two comments were posted to Healthwatch websites during the quarter, both were reshared on the Care Opinion website.
7. Patient Advice and Liaison Service had 85 contacts from service users or carers. Four contacts are awaiting an outcome, an update will be offered in quarter 2.
8. Points of You was introduced in September 2020. 99 teams still have no feedback attributed to them, Children's services are currently excluded from mail shot which affects the levels of feedback offered by this demographic, there are plans to reintroduce this during quarter 2. Supporting all teams to seek feedback on the service they deliver will support them to be reactive to service user and carer need.
9. All staff have access to the Points of You dashboard and should be supported to see what service users and carers have said about the service their ward or team delivers.

Recommendations

The Board is asked to:

- Note the content of the report and the next step actions being taken to improve feedback that the Trust receives.
- Note the developing nature of the report.

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Service User and Carer Experience Report

Quarter 1 2021-22

This report will follow the principles of Ask-Listen-Do. This is an NHS England initiative that's supports provider organisations to learn and improve through the experiences of service users and carers.

Ask Section:

Feedback through Points of You
During Quarter 1 2021/22 the Trust received 967 Points of You (PoY) surveys. This is an increase of 1% on the previous quarter and continues a trend of increasing levels of feedback through this mechanism. Of these 967 surveys, 931 people offered a response to the Friends and Family Test (FFT) question 'Overall, how was your experience with our service?', this will be discussed in the 'Listen' section.

Table 1. PoY uptake by locality**Locality**	**Total PoY responses**
South	316
Central	204
North Cumbria	287
North	152

During the quarter changes were made to the online version of PoY. People can now type the name of the team they want to discuss, a list of team names similar appears, allowing one to be chosen. People can also scroll through the full list to choose a team.

Patient Advice and Liaison Service
Service users and carers can contact the Patient Advice and Liaison Service for a range of advice and support. Currently contact is by email, freephone and letter as face to face and ward drop-in contact has been impacted by coronavirus restrictions.

Table 2. Contacts with PALS from service users and carers by locality
Information collated by North of Tyne PALS.

Care Group	Q4 2020/21	Q1 2021/22
Central	17	17
South	5	6
North	12	14
Non-Service Specific	42	48
Total	76	85

NHS.net and Care Opinion
During the quarter the Trust received feedback twice on the NHS.net platform and was reshared through Care Opinion. These were both from people who had experience services as a service user. Both received a response from the Trust and options to continue the discussion should the service user wish. Feedback will be discussed in the 'Listen' section.

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Healthwatch
The Trust received feedback twice through the Healthwatch platform in this quarter, a reduction on the last quarter, both received a response from the Trust. Feedback and outcomes will be discussed in the 'Listen' section and plans to engage more closely with Healthwatch will be outlined in the 'Do' section.

Listen Section:
This section will discuss what is being said, what the Friends and Family Test (FFT) score is. This section will also look at themes from the comments received as well as explore responses by demographics.

Table 3 Average FFT score in current and previous quarter

	Average FFT Score for Quarter (out of 10) Quarter 4 2020/21	**Average FFT Score for Quarter (out of 10) Quarter 1 2021/22**	**Total number of responses Quarter 1 2021/22**
Trustwide	*8.58*	8.52	976*
South	*8.93*	8.80	316
Central	*8.73*	8.63	204
North Cumbria	*8.73*	8.32	287
North	*7.75*	8.26	152

*17 PoY are not attributed to a locality as they do not have a CQC code.

The majority of people (831 or 86%) answered 'good' or 'very good' when sharing their overall experience of a service. This response rate is similar when looking at feedback by locality. South locality had an average FFT score of 8.8 (out of 10) for the quarter, the highest average of all localities, this is higher than the Trust average score but a reduction in average score on their own position last quarter.

Table 4. PoY Comments received by broad theme

	Positive	**Neutral**	**Negative**	**Compliment**
Trustwide	75%	14%	10%	1%
Central	77%	14%	7%	2%
North	72%	13%	72%	1%
North Cumbria	71%	16%	12%	1%
South	79%	11%	9%	1%

Table 5. Themed comments during quarter 1 2021/22

Category	Compliment	Positive	Neutral	Negative
Access to Treatment or Drugs		7	9	4
Appointments		51	37	24
Clinical Treatment		18	7	3
Communications	6	720	120	124
Facilities		30	31	20
Other		10	50	1
Patient Care	3	805	163	124
Prescribing		11	5	4
Privacy, Dignity and Wellbeing		5	4	2
Staff Numbers		1	6	3
Trust Admin/ Policies/Procedures		2		1
Values and Behaviours	27	940	23	32
Waiting Times		16	21	20
Total	**36**	**2616**	**476**	**362**

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An example of a positive comment from Values and Behaviours theme:
'Outstanding care, I couldn't have asked for better. The entire team were extremely professional' – Crisis Resolution and Home Treatment, Northumberland.

An example of a positive comment from the Patient Care theme:
'The nurse and health care assistant did a great job' – Community Learning Disability Service.

An example of a positive comment from Communications theme:
'Understood Mam's problems and explained very carefully and fully to her. Very attentive to her anxiety' - South Tyneside Older Adult Community Treatment Team.

There are two negative themes that are dominant this quarter. They are communications and patients care, both having 124 comment themed within this category.

The most common sub-category within the communication theme is 'being listened to. A comment from this theme:
'I have not yet been offered any care or treatment as there was no doctor present to complete the assessment' – Sunderland West Community Treatment Team.

The most common sub-category in the patient care theme is 'care general'. A comment from this category:
'A lot of unresolved things which left me feeling self-harm was the answer' – Personality Disorder Service.

Table 6. Average FFT score by sexuality

Sexual Orientation	**Average FFT Score**	**Number of Surveys**
Blank	9.1	32
Gay/Gay Man	8.8	13
Other	8.8	49
Heterosexual	8.6	501
Asexual	8.5	5
Not Stated	8.5	337
Bisexual	7.2	23
Lesbian/Gay Woman	6.9	4
Pansexual	3.3	3

The first six designations in the sexual orientation demographic are either the same as or above the Trust average FFT rating and account for 97% of everyone who completed a survey.

Negative comments from the bisexual group account for 18% of the total comments from this group and the majority (7 comments) related to three surveys, all of which related to a different community treatment team. All the comments related to a feeling that staff had lacked empathy or understanding.

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Table 7. Average FFT score by religion

Religion	Average FFT Score	Number of Surveys
Humanism	10	4
Jehovah's Witnesses	10	2
Mormonism	10	2
Islam	9.2	6
Spiritualism	9.2	3
Christianity	8.8	421
Sikhism	8.8	2
Other	8.7	151
Not Stated	8.3	280
Blank	8.1	44
Hinduism	7.9	6
Rastafari	7.5	1
Atheism	7.4	39
Buddhism	6.9	4
Paganism	5	2

This quarter people identifying with the religions of Humanism, Jehovah's Witnesses and Mormonism offered an average score of 10 for the FFT question, all offered the response of 'very good' to this question and between the 8 surveys offered a single negative comment of 'sometimes it can be difficult to get in touch with staff and they often don't call you back so it's difficult to get in touch when needed'.

Buddhism and Paganism scored the lowest average score and account for 6 surveys and 9 negatively themed comments. These comments predominantly relate to communications and patient care themes, the latter relates to continuity of staff with a comment of 'always helpful but sometimes I have to go back for more treatment and have to see someone different so I have to explain all over again'.

Table 8. Average FFT score by age

Age	Average FFT Score	Number of Surveys
55 to 64	9	140
Blank	9	9
65 to 74	8.9	123
85+	8.8	76
75 to 84	8.8	173
35 to 44	8.7	88
25 to 34	8.5	84
45 to 54	8.3	132
19 to 24	7.7	50
Not Stated	7.5	45
0 to 18	7.2	35
Prefer not to say	6.3	12

The top six age ranges for satisfaction, when combined account for 63% (609 surveys) of all feedback received. Most of their feedback comes from surveys that the Trust has posted out either once a person has been discharged or shortly after their birthday in the event they are not discharged.

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When people under 24 years of age are compared with the groups discussed above, they are firstly less satisfied in their responses. They also offer less feedback, something that is being addressed currently, directly in asking more people for feedback but also indirectly in wider changes to the way the Trust offers as ways of feeding back and how that's presented to the public. These changes will be made in consultation with service users and carers to make sure they meet the needs of as many people as possible.

Patient Advice and Liaison Service
All of the information on all of the issues raised with PALS is sent to the relevant managers. A feedback monitoring form has been cascaded to capture any actions taken as a result of PALS issues raised within the Trust.

NHS.net and Care Opinion
Both times poor experiences were relating to interactions with crisis teams, unfortunately attempts to contact the authors were unsuccessful, leaving us unable to attribute either comment to a specific team.

Healthwatch
Feedback posted on Healthwatch was negative in both cases. The first comment from an individual who felt their mental health wasn't being taken seriously. The second comment was dissatisfaction at the length of time waiting for contact from a mental health professional. Both referred to a community mental health team and both received a response from that team that was empathetic and offered a variety of options to resolve the situations.

Do Section:
This section is an opportunity to show what the Trust is doing in response to people's feedback and how we are acting on themes, identified problems and identifying good practice. Future developments relating to patient feedback is also shown in this section.

Action	Rationale	Status
Produce accessible films to explain PoY to Service Users/Carers/Staff	Feedback suggests that understanding of PoY and the system is increasing with awareness resources and training.	Currently developing storyboard and have agreement from comms to produce when ready.
Support accessibility for people with a learning disability and autistic people to feedback.	It is noted that very little feedback was being offered for learning disability and autism services, this is being addressed through collaboration with self-advocates.	Awareness of the new PoY survey has been offered to learning disability and autism teams. This has increased feedback levels. Awareness sessions are ongoing as is dialogue to support feedback to be as accessible as possible as part of the health literacy agenda currently ongoing in the Trust.
Develop feedback landing page	Currently the page is heavily weighted towards complaints. Efforts to make	A proposal has been accepted by the team and steps are

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	all feedback options clear and in one place are needed.	being taken to explore getting the changes implemented.
Play a leading role in a national collaborative (Learn and Share Together formerly NUPACED) to develop good practice in collecting and acting upon feedback offered by service users and carers.	EURIPIDES research found that most MH Trusts do not effectively listen to or act upon feedback from people accessing services. The Trust supported the setting up of a national collaborative that brings Trusts, Private Providers, Learning Disability Self-Advocates, Service User and Carers together to problem solve and share good practice.	The first event in May 2021 was successful, leading to a number of actions that have already been resolved or have plans of action to resolve. The 2nd event is happening remotely on July 27th, 2021.
Develop links with Healthwatch.	Healthwatch is currently an underutilised way of interacting with service users and carers. The Trust currently receives very little feedback through these websites, and it is often negative in theme.	Contact has been made with all Healthwatch in all areas within the CNTW footprint to discuss ways of better utilising the web-based platform to speak with service users and carers.
Develop awareness of PoY developments with staff.	Due to the new version PoY going live during the coronavirus pandemic, it has been difficult to communicate the changes with staff through the usual routes. We have embarked on awareness raising through group, service and team meetings and supported this with an infographic to explain the feedback system and a guide to using the PoY dashboard.	Regular requests to attend meetings are being received. Continuing this alongside the development of a communication strategy will ensure better understanding of feedback and its importance.
Develop awareness of PoY with service users, carers and self-advocates.	The more service user and carer awareness there is of the feedback options available, the more likely it is that people will be aware of a way of feeding back that suits their needs.	Feedback and Outcomes Lead now attends local and Trustwide service user/carer experience meetings as well as self-advocacy groups that are supported by the Involvement Team to discuss feedback trends, developments and explore new ideas for gaining and using feedback.
Make feedback accessible to as many service users and carers as possible.	Service users and carers offer less feedback about learning disability and autism services than mental	Feedback and Outcomes Lead Caroline Wills, Associate Director for Learning Disability and Autism as well as Fiona

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	health services. It is possible that some people can't navigate our feedback processes.	Regan, Carer Governor for Learning Disability Services are developing an action plan to develop strategies that make feedback more inclusive.
Support teams to share what changes have been made as a result of feedback through You Said We Did (YSWD) function on the PoY dashboard.	Teams will all have the ability to create a monthly poster that is populated with comments offered through feedback and respond.	The YSWD tab in the dashboard is in a test phase. A number of teams will test the function and feedback before a full roll out commences.

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Report to Board
4th August 2021

Title of report	Quality Priorities Quarterly Update (Quarter 1 2021/22)
Report author(s)	Paul Sams, Feedback & Outcomes Lead, 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)		Management Group meetings where this item has been considered (specify date)	
Quality and Performance	28.07.21	Executive Team	26.07.21
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	26.07.21
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)	

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	
Quality, safety, experience and effectiveness	X	Service user, carer and stakeholder involvement	X

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

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Quality Priority Update

Quarter 1 2021/22

Executive Summary

This report is an update on the Trust's Quality Priorities for quarter 1 of 2021/22

This table offers an at a glance position for each priority. More detail on each is offered in the report.

Quality Priority	Lead	Aims & Objectives	Timeline & Milestones	RAG
Quality Priority 1: Safety - Improving the inpatient experience.	Patrick Keown	Monitoring inappropriate out of area treatment days. Monitoring average bed occupancy on adult and older people's mental health wards (including Psychitric Intensive Care Units (PICU)) against the plan. Monitor service user and carer experience feedback.	Continual monitoring in all quarters of 2021/22	
Quality Priority 2: Service User and Carer Experience – Improving waiting times.	Russell Patton	This Quality Priority has the ambition to ensure that Trust services are responsive and accessible, and that noboy waits more than 18 weeks to access community services.	Continual monitoring in all quarters of 2021/22	
Quality Priority 3: Patient Care – Increasing time staff are able to spend with service users and carers.	Elaine Fletcher	This quality priority aims to support Trust staff to spend more time with service users and carers by improving processes and promoting person-centred approaches.	Development of plan Quarter 1. Implementation Quarters 2,3 and 4 2021/22	
Quality Priority 4: Clinical Effectiveness – Equality, Diversity, Inclusion and Human Rights (in relation to the core values of Fairness, Respect, Equality, Diginity and Autonomy (FREDA)).	Chris Rowlands	This quality priority has set out to implement a trustwide approach working across Locality Groups. The Equality & Diversity Lead, CNTW Academy, Chaplaincy, Commissioning & Quality Assurance, Accessible Information Standard Group and Communications and Staff Networks	Developing and monitoring all quarters of 2021/22	

Recommendations

The Board is asked to note the content of the report and the next step actions being taken.

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Quality Priority 1: Safety - Improving the inpatient experience

Director Lead: Patrick Keown

This Quality Priority has three elements;

1. Monitoring inappropriate out of area treatment days.
2. Monitoring average bed occupancy on adult and older people's mental health wards (including Psychiatric Intensive Care Units (PICU)) against the Royal College of Psychiatrists recommendation – occupancy rate of 85% as optimal for effective care.
3. Monitor service user and carer experience feedback.

During quarter 1 the average occupancy level against commissioned beds across the Trust's adult acute wards was 98%, a rise compared to that of Quarter 4 2020/21 (96%) and is above the aspirational RCPsych recommendation of 85% as being optimal. Adult acute inpatient services experienced significant pressures during the 2020/21 and continue to do so in 2021/22.

Within the older adult wards, the average bed occupancy against commissioned beds was 63% for the quarter. The average bed occupancy against operational beds* across the Trust's older people's wards has been included (end column of Table 1) and was at 90%.

Average % Occupied Beds Including Leave	Adult acute mental health wards	Older People's mental health wards	Older People's mental health wars - % Occupied Beds Including Leave based on operational beds* at end of Q1
	Q1	**Q1**	**Q1**
Trustwide	98	63	90
North	*105*	*69*	*95*
Central	*93*	*54*	*80*
South	*103*	*81*	*87*
North Cumbria	*94*	*90*	*96*

Table 1: Average % Occupied Beds Including Leave against Commissioned Beds by Trust and Locality Care Group

The Trust recognises the significance of this quality priority on quality and safe of inpatient care and as an indicator of pressures within the system. The Urgent & Emergency Care Group remains in place and focuses on reviewing key elements of a number of pathways that has a direct impact on ward admissions, patient flow and discharge.

Supporting Project	Lead	Aims & Objectives	Timeline & Milestones	RAG
Monitor inappropriate out of area treatment days	Gillian Keane, Head of Income and	No service user receives their care outside of CNTW	Zero achieved in December 2020 and maintained to date (June 2021)	

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	Contracted Services		Temporary closures of beds in North Cumbria to allow for refurbishment will increase pressure on acute beds in an already pressurised area.	
Monitor average bed occupancy on adult and older people's mental health wards (including PICU)	TBC	TBC	TBC	
Monitor service user and carer feedback	Paul Sams, Feedback and Outcomes Lead	Monitor and report on feedback offered through Points of You, Patient Advice and Liaison Service, Healthwatch, NHSuk and Care Opinion.	Quarterly through Service User and Carer Experience Reporting. Engagement with localities and teams to discuss themes and specific feedback as appropriate.	

Quality Priority 2: Service User and Carer Experience – Improving waiting times

Director Lead: Russell Patton

This Quality Priority has the ambition to ensure that Trust services are responsive and accessible, and that nobody waits more than 18 weeks to access community services.

This quality priority has three elements;

1. Monitor and report waiting times to treatment for adult and older people's mental health services against the 18 week standard.
2. Report Children and Young People's Services (CYPS) waiting times by pathways (using 2nd contact as treatment proxy).
3. Monitor and report Gender Dysphoria, Adult Attention Deficit and Hyperactivity Disorder (ADHD) and Adult Autism Spectrum Disorder (ASD) waiting times.

During quarter 1 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 72 as at 31 March 2021, to 19 as at 30 June 2021. The number of people waiting overall has increased (by 8.6%) from 3645 as at 31 March 2021 to 3990 as at 30 June 2020.

**Note that the above data excludes services with continuing long waits (CYPS, Adult ADHD, adult autism diagnosis, gender dysphoria). These are scrutinised further below.*

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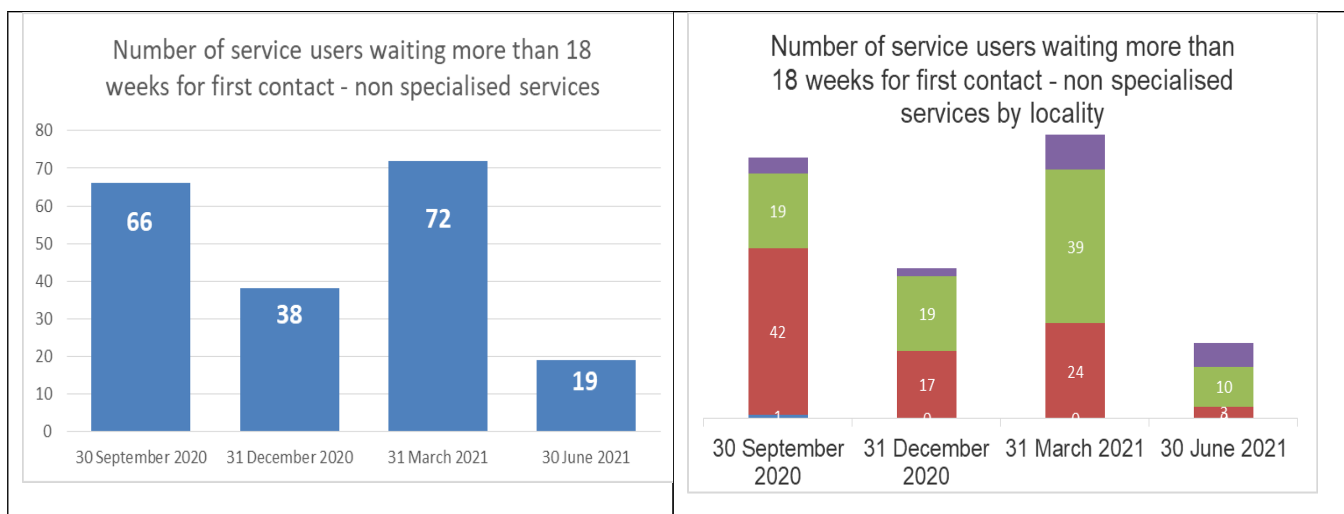
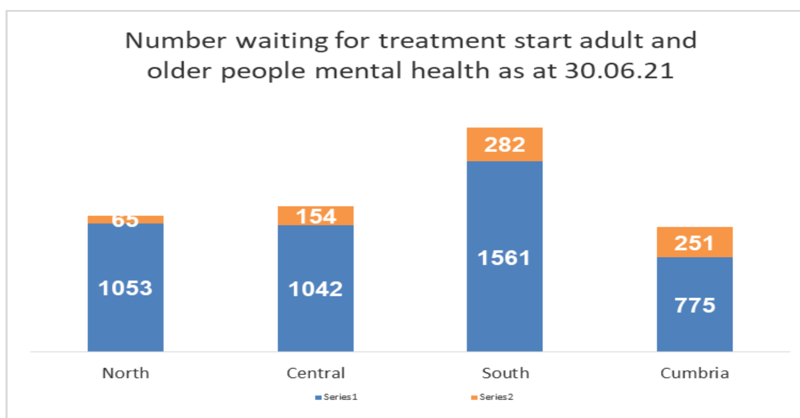


The graphs above show the numbers by quarter across all localities since September 2020:

Adult & older peoples community mental health teams waiting times __to treatment__

As at 30 June 2021, the number of patients waiting over 18 weeks to start treatment* within adult or older peoples community mental health teams decreased to 752 from 938 as at 31 March 2021. There has been an increase in the proportion of people waiting less than 18 weeks for treatment from 85.5% as at 30 June 2021 compared to 83.1% as at 31 March 2021.

**treatment within these services is defined as starting with the first contact post mental health cluster allocation.*



The number of people waiting for treatment is highest in South (1843, compared to 1196 in Central, 1118 in North and 1026 in North Cumbria).

The proportion waiting less than 18 weeks remains higher in the North locality (94%) compared to Central, South and North Cumbria (87%, 85% & 76%).

Waiting times to the start of assessment are the same for both adult and older people's services (4 weeks), the wait to start of treatment (from referral) for adults is 20 weeks and for older peoples services 15 weeks.

Activity continued during the quarter to reduce waiting times to adult and older peoples community services includes:

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1. Ongoing data quality analysis of the new waiting times dashboard
2. Continued enhanced reporting and scrutiny of over 18 week waiters, average waits and longest waits
3. Ongoing issues affecting waiting times include:
    - COVID-19
    - DNA attendances and cancelled appointments due to COVID-19
    - Delayed record keeping such as unoutcomed appointments
    - Delays in clustering of cases impacts reported waiting times to treatment

Community Services for Children and Young People (CYPS)

The methodology to measure waiting times in CYPS services has been introduced based upon a national methodology of considering a second appointment as a proxy for the start of treatment. The data below is at 01.07.2021.

Newcastle / Gateshead CYPS		
No. Weeks Waiting to Treatment	New CYPS Waiting Times Dashboard	
	No. CYP Waiting	%
0-4 weeks	215	16.20%
4-6 weeks	99	7.46%
6-8 weeks	119	8.97%
8-10 weeks	97	7.31%
10- 12 weeks	62	4.67%
12- 18 weeks	178	13.41%
8 + weeks	557	41.97%
Total Waiting	1,327	100.00%

Newcastle CYPS Tier 2		
No. Weeks Waiting to Treatment	New CYPS Waiting Times Dashboard	
	No. CYP Waiting	%
0-4 weeks	76	49.35%
4-6 weeks	57	37.01%
6-8 weeks	13	8.44%

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8-10 weeks	3	1.95%
10- 12 weeks	1	0.65%
12- 18 weeks	3	1.95%
18 + weeks	1	0.65%
Total Waiting	154	100.00%

Northumberland CYPS		
	New CYPS Waiting Times Dashboard	
No. Weeks Waiting to Treatment	No. CYP Waiting	%
0-4 weeks	142	64.84%
4-6 weeks	37	16.89%
6-8 weeks	32	14.61%
8-10 weeks	6	2.74%
10- 12 weeks	2	0.91%
12- 18 weeks	0	0.00%
18 + weeks	0	0.00%
Total Waiting	219	100.00%

Sunderland CYPS		
	New CYPS Waiting Times Dashboard	
No. Weeks Waiting to Treatment	No. CYP Waiting	%
0-4 weeks	137	31.42%
4-6 weeks	53	12.16%
6-8 weeks	53	12.16%
8-10 weeks	61	13.99%
10- 12 weeks	53	12.16%
12- 18 weeks	78	17.89%
18 + weeks	1	0.23%
Total Waiting	436	100.00%

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South Tyneside CYPS		
	New CYPS Waiting Times Dashboard	
No. Weeks Waiting to Treatment	No. CYP Waiting	%
0-4 weeks	60	15.75%
4-6 weeks	36	9.45%
6-8 weeks	22	5.77%
8-10 weeks	26	6.82%
10- 12 weeks	27	7.09%
12- 18 weeks	49	12.86%
18 + weeks	161	42.26%
Total Waiting	381	100.00%

North Cumbria (CAMHS East Team)		
	New CYPS Waiting Times Dashboard	
No. Weeks Waiting to Treatment	No. CYP Waiting	%
0-4 weeks	64	38.32%
4-6 weeks	28	16.77%
6-8 weeks	29	17.37%
8-10 weeks	16	9.58%
10- 12 weeks	9	5.39%
12- 18 weeks	20	11.98%
18 + weeks	1	0.60%
Total Waiting	167	100.00%

Adult Autism Spectrum Disorder diagnosis (ASD)

- The number of people waiting to access this service has increased throughout the quarter, and there were 1423 people waiting as at 30 June 2021.
- The proportion of people waiting less than 18 weeks for their first contact has increased to 34% from 28% at 30 June 2021.

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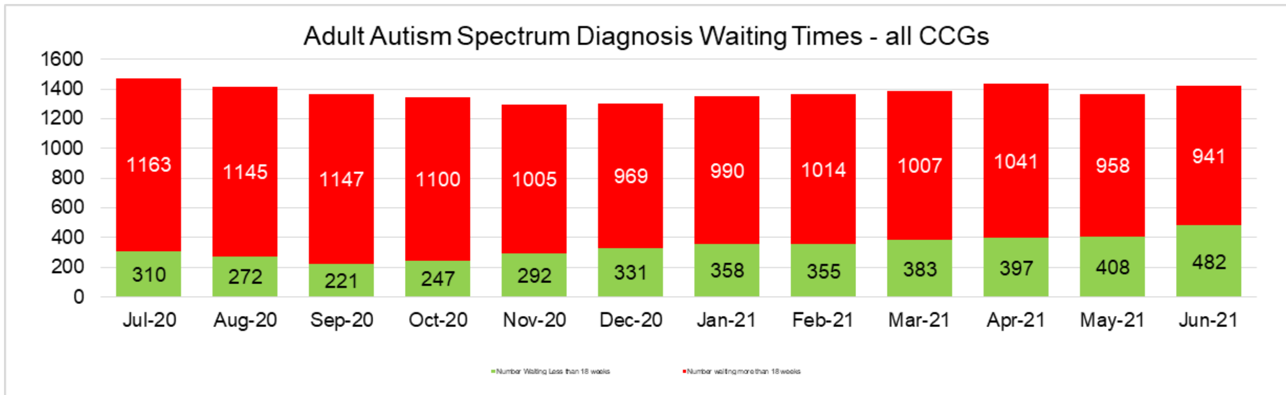
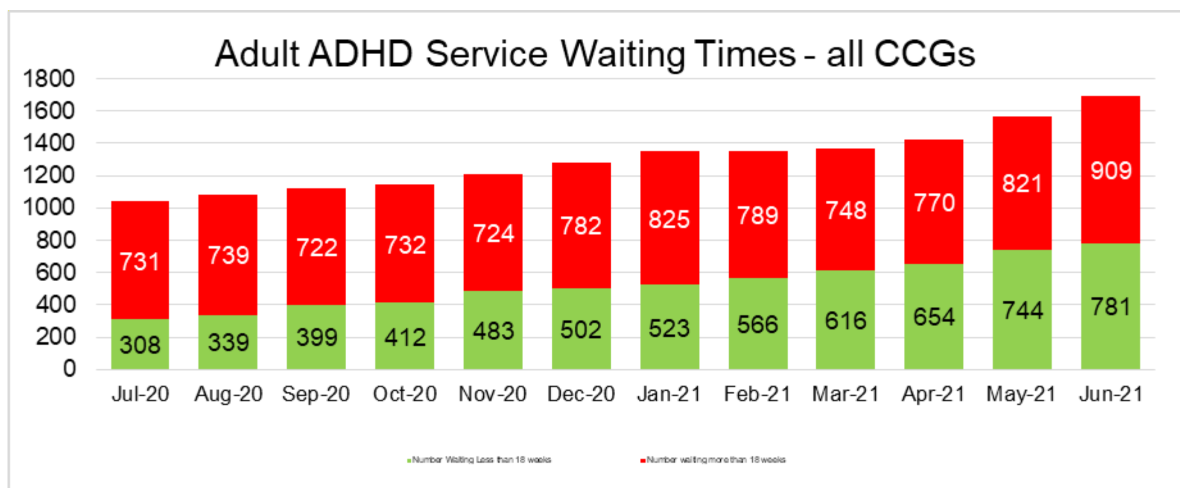


Adult Attention Deficit Hyperactivity Disorder (ADHD)

- The number of people waiting for first contact with this service has increased from 1364 as at 31 March 2021 to 1690 as at 30 June 2021.
- The proportion of people waiting less than 18 weeks for their first contact has increased to 46% at the end of June.



Adult Gender Dysphoria

Waiting lists to access this service have continued to increase in the period as expected.

- The number of people waiting for their first contact with the service has increased in the Quarter and stands at 1321 as at 30 June 2021 (was 1219 as at 31 March 2021).
- The proportion of people waiting less than 18 weeks for their first contact has remained the same at 12% as at 30 June 2021.

The locality groups continue to monitor 18 week waits and have identified the following reasons that are contributing to the 18 week breaches across both CYPS services and Adult and Older People. Action plans for recovery are currently under development.

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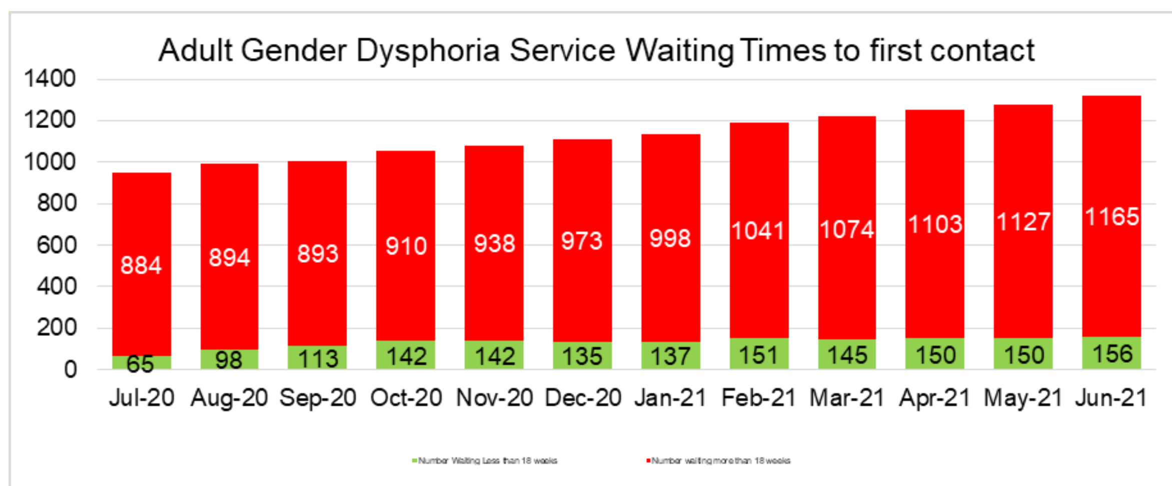

- COVID-19 has impacted on services
- There have been a number of DNA and cancelled appointments
- Staff sickness has impacted on services
- Circumstances which were outside the teams control
- Some service users were transitioning across services

Supporting Project	Lead	Aims & Objectives	Timeline & Milestones	RAG
Monitor waiting times in adult mental health services.	Russell Patton, Deputy Chief Operation Officer	Monitor and report waiting times to treatment for adult and older people's mental health services against the 18 week standard.	All quarters of 2021/22	
Monitor waiting times in young peoples services.	Russell Patton, Deputy Chief Operation Officer	Report Children and Young People's Services (CYPS) waiting times by pathways (using 2nd contact as treatment proxy).	All quarters of 2021/22	
Monitor waiting times in Gender Dysphoria, Adult Attention Deficit and Hyperactivity Disorder (ADHD) and Adult Autism Spectrum Disorder (ASD)	Russell Patton, Deputy Chief Operation Officer	Monitor and report Gender Dysphoria, ADHD and ASD waiting times.	All quarters of 2021/22 Covid-19 impact on people waiting more than 18 weeks in Adult ADHD and Gender Dysphoria in Quarter 1 leading to red rating.	

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Quality Priority 3: Patient Care – Increasing time staff are able to spend with service users and carers.

Director Lead: Elaine Fletcher

This quality priority aims to support Trust staff to spend more time with service users and carers by improving processes and promoting person-centred approaches.

This quality priority has four elements;

1. Promote person-centred care (face to face/telephone contact/zoom or Teams contacts)
2. Identify and remove tasks that can be removed, that do not add value to the service user or carer experience.
3. Develop and deliver Quality Improvement (QI) plan through task and finish groups.
4. Monitor feedback from service users and carers.

During Quarter 1 this Quality Priority was assigned a lead. Initial discussions between the lead, the Commissioning and Quality Assurance Team as well as Trust Innovations, developed an action plan (see below). Additional coronavirus pressures on patient facing staff will offer the leads of this priority to fully develop strategic ambitions prior to engaging with staff on the developing priority in a way that implements changes in service delivery.

Supporting Project	Lead	Aims & Objectives	Timeline & Milestones	RAG
Decide on data to be used and establish baseline. Decide engagement and communication strategey.	TBC	Exploring ways to test effectiveness of strategies developed. DNAs/Cancelations, Sickness Rates/Clinical times currently patient and carer facing/feedback.	Develop Quarter 1-Quarter 2 2021/22 Implement Quarter 2, Quarter 3 and Quarter 4 2021/22	
Develop action plan and assign workstream leads.	Elaine Fletcher, Group Nurse Director	Regular meetings to develop and implement plans. Recruit for task and finish groups.	Quarter 2 2021/22	
Implementation Phase	Elaine Fletcher, Group Nurse Director	Support and monitor work streams/Task and Finish groups. Report on datasets decided in Q2 against baseline.	Quarter 3 and Quarter 4 2021/22	

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

Director Lead: Chris Rowlands

This quality priority has set out to implement a trustwide approach working across Locality Groups. The Equality & Diversity Lead, CNTW Academy, Chaplaincy, Commissioning & Quality Assurance, Accessible Information Standard Group and Communications and Staff Networks will work towards;

1. Better health outcomes for service users.
2. Improved service user access and experience of services.
3. Champion understanding and support inclusion of diversity.
4. Raise awareness of and promote human rights and human rights based approaches.

During Quarter 1 the group charged with making recruitment/progression more inclusion has formed under the lead of the Director of Transformation. This group reports to the Equality Dirversity and Inclusion Steering Group on a month by month basis. The group has identified six workstreams, with each having a lead assigned to them and are working through the issues identified during the Rapid Process Improvement Workshop that took place in January/February 2021. The work remains on target to be delivered by December 2021.

Work on tackling discrimination is underway, the Respect Campaign has launched and some of the work under that umbrella has commenced. Delivery has started in the South Locality on the Show Racism the Red Card training, this is acting as a pilot prior to a wider roll out of the initiative. Workforce and Organisational Development Staff have formed a project delivery team to plan for the launch of the Respectful Resolution work that will begin to roll out in Quarter 3. The work is running to time at present.

Meetings have taken place to identify ways to best promote the role of the Cultural Ambassadors – this has included a presentation to BDG. This work is on target.

For the review of disability data we have identified who we have no data for and have drafted a letter inviting those staff to update their data. We delayed sending this out because we had to send letters out to EU Staff regarding the Settlement Scheme – this led to an additional pressure on the team that would have been processing the disability data. The letter is ready to go and this piece of work will be completed in early quarter 2.

Supporting Project	Lead	Aims & Objectives	Timeline & Milestones	RAG
Making recruitment/progression more inclusive	Director of Transformation	That recruitment processes are accessible, fair and transparent, with the desired outcome that our workforce better represents the community that is serves.	Quarter 3 for completion of Task and Finish Group. Regular audits of staff data analysed by protected characteristics and compared	

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			to population data	
Tackling Discrimination (part of RESPECT campaign)	Associate Director Organisational Improvement/ Equality, Diversity, Inclusion Lead	Implement Respectful Resolution Pathway. Training using the resources bought on a 3 year licence will enable to implement the 5 point pathway to include team discussions on bullying, reflection tools, speaking up tools, adoption of BUILD model.	Quarter 3 for roll out to commence	
Improving disciplinary and grievance processes	EDI Lead in conjunction with Cultural Ambassadors and Communications	Campaign to promote awareness of Cultural Ambassador Role.	To be completed Quarter 2 July 2021	
Review and cleanse all data to ensure staff disability is recorded appropriately	Chris Rowlands, Equality, Diversity, Inclusion Lead	That staff data is complete is complete regarding the recording of disability. The immediate impact will be that we have better information about our staff and will be able to support disabled staff more effectively.	To be completed Quarter 1 June 2021	

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Report to the Board of Directors

4th August 2021

Title of report	Annual Report for Infection Prevention and Control 2020 – 2021
Report author(s)	Anne Moore, Director of Infection Prevention & Control Alexia Pearce Head of IPC
Executive Lead (if different from above)	Gary O'Hare, Chief Nurse

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	X	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services	X	Sustainable mental health and disability services delivering real value	
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	X	Executive Team	
Audit		Corporate Decisions Team (CDT)	
Mental Health Legislation		CDT – Quality	X
Remuneration Committee		CDT – Business	
Resource and Business Assurance		CDT – Workforce	
Charitable Funds Committee		CDT – Climate	
CEDAR Programme Board	X	CDT – Risk	
Other/external (please specify)		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		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	

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

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2020/21 Annual IPC Report

Cumbria Northumberland, Tyne and Wear NHS Trust

Anne Moore, Director of Infection Prevention & Control
Alexia Pearce Head of IPC

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Caring | Discovering | Growing | **Together**

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Introduction and Context

The Annual Report of the Director of Infection Prevention and Control (DIPC) provides the Infection Prevention Control Committee, Quality and Performance Committee and the Trust Board with a summary of activity relating to assurance and developments which took place during 2020/21 relating to Infection Prevention and Control across the Trust. The IPC function carried out across the Trust meets statutory requirements and the Health and Social Care Act 2008. The Infection Prevention and Control team is responsible for the outline delivery of the 2020/21 Infection Prevention and Control Annual Plan.

Due to Covid-19 activity which has necessitated a significant IPC Team response to the implementation of national guidance to ensure patient and staff safety, via Gold Command Emergency Response, there has been reduced IPC activity against the planned workstreams for 2020/21.

Out with this Annual Report, the Board has been receiving a separate Covid19 update as well as an IPC Nosocomial Infection Board Assurance Report.

Infection Prevention and Control team structure

The Public Health and Infection Prevention and Control team consists of:

- Group Nurse Director, Safer Care Directorate and Director of Infection Prevention and Control (DIPC)
- Associate Director Safer Care
- Head of Infection Prevention Control (started March 2021)
- x2 wte Infection Prevention Control Lead Nurses
- x2 wte Infection Prevention Control Nurses
- Consultant Microbiologist/Infectious Disease Consultant support is obtained by a Service Level Agreement with Northumbria Healthcare Foundation Trust.

The IPC team have good working relationships with Clinical Care Groups, CBUs, wards and clinical teams which is vital to the success of both preventative and responsive and effective IPC measures. These working relationships have been strengthened further during the Covid 19 pandemic with the combined objective of reducing/minimising this infection whilst also providing advice and support for patient management.

The DIPC attends the Trust Board annually to present this report. Key Performance Indicators data is received by the Board on a quarterly basis in the Safer Care report or by exception.

The IPC Committee meets quarterly and is chaired by the DIPC. The IPC committee reports to Trust wide Quality and Performance group. IPC Committee meetings were held in 2020/21 on:

- 2nd April 2020
- 2nd July 2020
- 1st October 2020
- 14th January 2021

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Microbiology Support

The Trust holds Service Level Agreements or arrangements for Microbiology services with Northumbria Healthcare NHS Trust, Newcastle Hospitals NHS Trust, Gateshead Health NHS Trust, South Tyneside and Sunderland Hospitals NHS Foundation Trusts and North Cumbria Integrated Care NHS Foundation Trust. Results are available through the electronic ICE system. The Trust is assured that these services operate to the standards required for accreditation by Clinical Pathology Accreditation (UK) Limited.

External Accreditation Bodies

Registration with the Care Quality Commission (CQC)

The Trust received unconditional registration to the Health and Social Care Act and Associated Code of Practice in 2008 (2015)

Infection Incident reporting and monitoring

The data on infections is reviewed at each IPC Committee meeting and sent to the Locality Care Group Safe meetings. Incident data is shared on a monthly basis within the Safer Care monthly report to CDT-Q and quarterly report to Q & P and the Trust Board.

Infection and IPC Surveillance

Covid-19

2020 saw the emergence of a global pandemic caused by a new novel respiratory infection notably Coronavirus- Covid19, an event which has been unprecedented in the lifetime of staff, patients, and families within CNTW and the NHS

Three significant peaks of COVID19 infection, each impacted on how we have lived our lives during lockdown restrictions and delivered services over time adjusting to living with covid19.

Since the beginning of the pandemic, government and scientific advice has changed often daily with the specific objective of combatting the virus with a focus on minimising transmission. The main messages have been to continue to promote lockdown measures and promote social distancing so that the NHS may continue to work, save lives, and keep everyone safe, including the patients we care for.

Our priority has been to ensure the Infection Prevention and Control measures have been in place to protect patients and staff during the response.

The IPC team have been responsible in offering targeted advice and support to clinical teams such as cohorting, isolation, management of V&A and restraint, complex cases and review of environmental concerns.

The IPC Team worked daily with multi professional clinical leads to ensure PPE was worn correctly to ensure safe practice for both staff and patients, including supporting communications with providing visual aids to guide staff on how to wear PPE.

The IPC team provided advice and guidance on the implementation of patient and staff testing for Covid-19, including delivering training on how to complete Covid-19 testing.

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IPC information packs were developed for inpatient and community services and made available via the trust Covid-19 resources, these have been regularly reviewed and updated in line with changing national guidance and publication of IPC MH/LD specific IPC guidance.

The IPC team have offered advice and support on Aerosol Generating Procedures and Fit testing of staff for FFP3 masks.

Total number of Nosocomial (Healthcare Acquired Infection) Infections April 2020- 21

Nosocomial infection means "healthcare acquired". It is important to understand whether cases of COVID-19 may have been acquired as a result of the healthcare we provide. This helps us to identify and test any contacts who may have been infected, prevent further spread of the virus and identify where to target our infection control and clinical resources

In June 2020, evidence had begun to show that people infected with COVID-19 who are either pre-symptomatic or have very mild or no respiratory symptoms (asymptomatic) can transmit the virus to others without knowing so greater steps were introduced to stop the spread of coronavirus in healthcare settings.

Actions to identify the potential risk of transmission included testing on admission and between 5-7 days through a PCR swab. However it became evident that the timing of the swab following admission from the community surveillance screening wasn't picking up patients who were likely to be incubating the virus and then moving around the ward and interacting with patients on the ward increasing the risk of transmission.

Further National Guidance on this process wasn't introduced until the second wave in November 2020. This included swabs at day 0, day 3, day 5 following admission. The Trust then introduced a routine swab at day 7 for all patients during their stay as the incubation time can be up to 14 days from initial contact. For some patients who were admitted from the community or a care home or acute hospital they could be asymptomatic but infectious without anyone being able to confirm. Whilst swabbing is not a pleasant procedure, it has proved invaluable to ensure the early detection of risk, and also reinforce the importance to staff that there is a high risk of transmission between patients who are asymptomatic.

First positive specimen date:	CO (community onset)	HOiHA (healthcare onset indeterminate healthcare association)	HOpHA (healthcare onset probable healthcare association)	HOdHA (healthcare onset definite healthcare association)
< = 2 days after admission* ?	17			
3 – 7 days after admission*?		11		
8-14 days after admission*?			15	
15 or more days after admission*?				162

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Number of Healthcare acquired patients	177	
Total positive from Outbreak screening	135	19 outbreaks – patient to patient transmission
individual cases	42	Community/leave/indeterminate root cause

Whilst significant actions have been taken throughout the pandemic to minimise the risk of nosocomial infections there have been occasions where the movement of patients within the ward settings, and the inability to isolate on admission, social distance and wear face masks has increased risks of transmission and resulted in 19 outbreaks.

Of the 42 isolated cases, there was no causal link to PPE breaches or transmission from positive staff. However there is a notable link for patients who during the pandemic have been able to have unescorted leave or leave to an unsupervised setting as part of discharge planning and have subsequently tested positive on the 7 day screening and been asymptomatic. This suggests transmission and incubation from community activity.

Covid19 Outbreak Management

As part of Outbreak Management, the IPC team have been active alongside Gold Command in the management of outbreaks of Covid-19, supporting clinical teams with guidance on IPC practice and delivering training.

The trust reported a total of 38 Covid-19 outbreaks during 2020/21 which included inpatient and community teams. 13 outbreaks were exclusively in staff teams and 25 were in inpatient areas following patient to patient transmission.

Each of the outbreaks has resulted in significant learning which has been shared across all areas which includes specific actions to prevent patient to patient transmission ie isolation pending results if patient will comply, social distancing during mealtimes and activities, encouraging wearing of face coverings on the ward and on leave, ensuring all wares are well ventilated and use of outdoor space where weather permits.one of the key areas has been to ensure touch points and enhanced cleaning together with the focus on patient hand hygiene given the tactile nature of some patient groups.

MRSA and Clostridium difficile

Any incident where a patient develops a Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemia or a Clostridium difficile toxin-positive infection isolated from a stool specimen whilst in CNTW will have a Root Cause Analysis (RCA) undertaken. The case will be reported through the IPC Committee and the Governance Subgroups and where appropriate through the National Reporting System.

As required, mechanisms exist to formally report data on Clostridium difficile and MRSA bacteraemia in the six-monthly performance report reviewed by the Trust Board. This is supplemented by six monthly attendances at the Board by the DIPC

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IPC Dataset 2020/21

The following tables form the Infection Prevention and Control data set for Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust for the year 2020/21

KPI	Detail	2016/17	2017/18	2018/19	2019/20	2020/21
IPC-KPI 01	Cases of MRSA bacteraemia	0	0	0	0	0
IPC-KPI 02	Cases of clinical clostridium difficile infections	0	1	2	0	0

Source: Trust records

MRSA bacteraemia

There were no cases of MRSA bacteraemia in the period 2020/21

Clostridium Difficile infection

There were no cases of hospital acquired clinical clostridium difficile infections within CNTW. The reported clostridium difficile cases were followed up using route cause analysis and were found to be attributed to either the community or another hospital trust.

Reported diarrhoea and and/or vomiting outbreaks

There were 10 outbreaks of diarrhoea and vomiting reported during 2020/21, affecting patients and staff. From the clinical presentation the symptoms were suggestive of a viral cause in absence of laboratory confirmation. Learning from these incidents highlighted that each incident was managed in a timely manner with outbreak control measures implemented effectively and resolved in the expected timescales. Infection prevention control measures such as cohorting, isolation, environmental cleaning and handwashing were effective

Infections suspected/confirmed reported to IPC

The table below includes all the suspected and confirmed infections reported to IPC via the electronic incident management system. All confirmed infections are followed up by the IPC team to provide the necessary support and advice in the management of the infectious patient.

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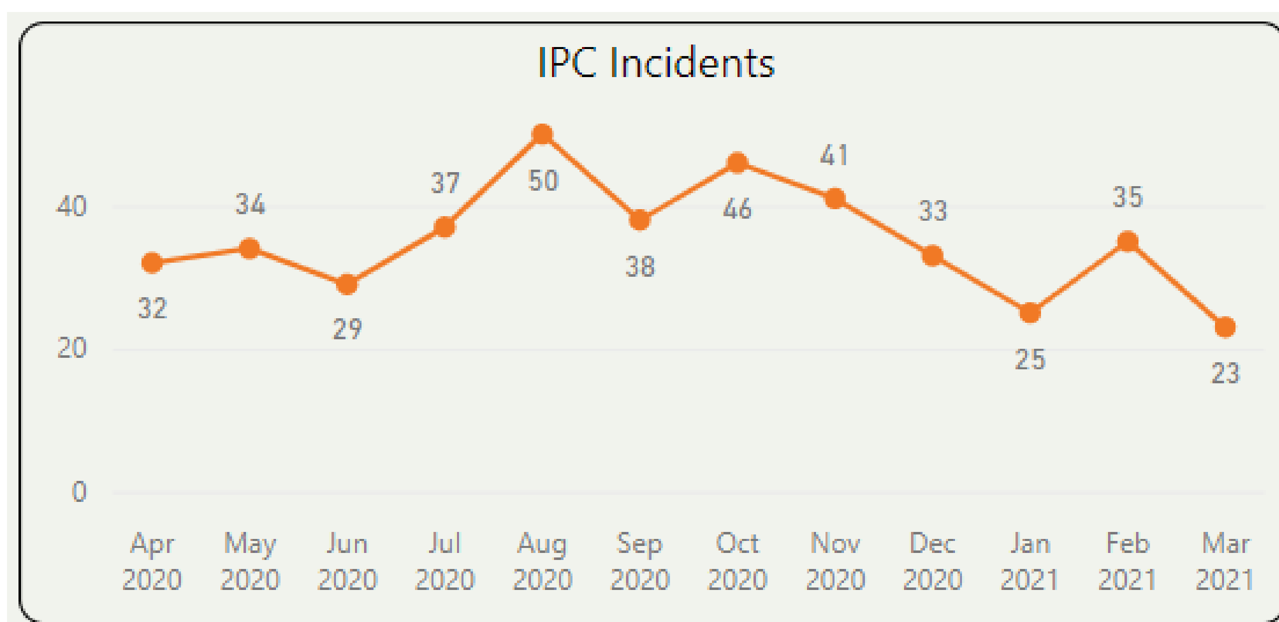
CAUSE_1	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Total
IPC09 Suspected/Confirmed Infection	15	10	6	10	12	16	18	18	10	12	12	4	**143**
IPC40 Urinary Tract Infection UTI	7	10	6	6	7	11	6	6	8	5	9	8	**89**
IPC23 Other	3	7	8	11	18	5	6	10	1	3	5	2	**79**
IPC41 Chest Infection	2	1		3	4	4	6	2	5	1		2	**30**
IPC06 Dental/Oral Infection	1	2	4	2	2		2	2	1		2	3	**21**
IPC25 SEPSIS					1		2		1		5	2	**11**
IPC07 Gastrointestinal Infection Viral		3	3	1	2								**9**
IPC13 Shingles	1				1	1	1		2				**6**
IPC18 Fungal Infection			1				2			1		1	**5**
IPC26 Clostridium Difficile GDH Positive Toxin Positive	1								2	1	1		**5**
IPC04 Staphylococcal Infection	1			1				1			1		**4**
IPC08 Gastrointestinal Infection Bacterial			1	1	1	1							**4**
IPC24 Influenza Like Illness									1	2			**3**
IPC16 Hepitisis - Type C							2						**2**
IPC20 Scabies					1				1				**2**
IPC27 Clostridium Difficile GDH Positive Toxin Negative								1	1				**2**
IPC42 Legionella Water Safety Test				1	1								**2**
IPC01 MRSA - Colonisation							1						**1**
IPC02 MRSA - Infection								1					**1**
IPC12 Chickenpox		1											**1**
IPC17 HIV	1												**1**
IPC28 Clostridium Difficile GDH Negative Toxin Negative				1									**1**
ME20 Medication Other												1	**1**
Total	**32**	**34**	**29**	**37**	**50**	**38**	**46**	**41**	**33**	**25**	**35**	**23**	**423**



Key achievements
This has been incredibly challenging year due to the arrival of Covid-19 global pandemic, which has had a major impact on how the services were provided across the trust. A major incident was declared, and the incident response enacted, which meant 'business as usual' IPC workstreams were put on hold until further notice.

Throughout 2020/21 the IPC team responded to the pandemic providing support to Gold Command, support to outbreak management and advice and guidance to clinical teams.

Infection Prevention and Control Link Workers

Infection Prevention and Control Link Workers are an important conduit to share good practice across the clinical services from the IPC team and equally from the clinical services to the IPC team. Their contribution is valuable, however due to frequent staff changes within clinical teams it has become more difficult and very labour intensive to ensure that each clinical area has an identified link work who has undertaken an IPC induction day. An approach was piloted to combine the Physical Health Link Workers with the IPC workers as they were often the same member of

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staff and also to reduce the amount of time staff were off the wards in order to optimise their clinical time and capacity to care. Due to the COVID 19 pandemic this combined role and specific training development has had to be postponed, this will form part of the IPC workplan 2021/22.

Infection Prevention and Control Practice Guidance notes (PGNs)

A number of PGNs have been updated this financial year in line with the three yearly Trust requirement. See appendix 1.

Seasonal Flu Vaccination Campaign

The seasonal flu vaccination campaign was launched on the 1st October 2020, with a series of clinics, drop in sessions, and attendance at staff events and meetings. By the end of February 2021, 84.62% of all front line staff had received their flu vaccine. CNTW staff continue to show year on year commitment to ensuring our patients are protected against flu.

Frontline Staff Group	2018/19	2019/20	2020/21
Doctors	72%	74.2%	80.25%
Qualified Nurses	77%	81.6%	84.62%
All other professionally qualified	77%	87.9%	88.96%
Support to clinical staff	76%	82%	83.80%

Vaccination uptake over the last three years amongst frontline staff

As in previous years we have offered vaccination to staff who deliver frontline care to our patients, but who are not employed by CNTW. This season we vaccinated 4959 of frontline staff.

As recommended by the Joint Committee on Vaccinations and Immunisations, the Trust offered patients who were 65 years and over the adjuvanted trivalent vaccine in the 2020 campaign. All staff were offered the quadrivalent vaccine. Staff aged 65 years and over who want to access the adjuvanted trivalent vaccine were signposted to access this vaccine via their GP. 2020/21 saw the introduction of vaccinating CNTW community patients.

A total 275 staff were trained via e-learning from both nursing and pharmacy in flu vaccination administration. This enabled all CNTW staff to have easy access to vaccination at a time and place that was convenient to themselves with minimal impact.

A Lessons Learnt event was held via teams in April 2021 to review the programme and inform the 2020/21 campaign.

Key achievements identified in 2020/21 Flu Campaign

1. Achieved 84.62% of front line staff vaccination uptake.
2. We continue to achieve a year-on-year increase in vaccination uptake rates in front line staff.
3. There were 275 staff trained as peer vaccinators trust wide
4. Patients who were 65 years and over were offered the adjuvanted trivalent vaccine.
5. Community patients were offered the flu vaccination.

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Covid Vaccination Programme 2020/21

In December the trust moved forward with the Government's plans to vaccinate Health care staff and patients with the COVID-19 Vaccination.

The first programme commenced mid-December in conjunction with North Cumbria Integrated Care Trust (NCIC) who supported the administration of the Pfizer vaccination for CNTW's North Cumbria staff, alongside their own staff.

CNTW commenced their own vaccination programme from the 8th January 2021, using the Oxford Astra Zeneca Vaccine. A three site model was implemented with vaccination clinic held at St Nicholas hospital and quickly moved to a three-site model at St George's Hospital and Hopewood Park.

A lessons learnt event was held via teams in June 2021 to review the delivery of the covid vaccination and identify learning to inform the booster programme.

Key achievements Covid Vaccination:

- Achieved 85.5% of fully vaccinated staff (2 doses)
- Partially vaccinated staff 89%
- Offer of vaccination to patients
- Implementation and delivery of 7 day clinics 7am – 10pm

Key challenges identified for the 2021/22 Flu campaign and Covid Booster Programme

1. The delivery of the 2021/22 flu vaccination alongside covid vaccination
2. The delivery of vaccinator training to ensure social distancing/safety measures.
3. Delivery of vaccination clinics, including social distancing in clinics.

Training in Infection Prevention and Control

Staff employed by CNTW must access IPC training via eLearning. The E-Learning programme is a national programme that fulfils statutory requirements. Infection Prevention and Control training is currently a requirement on induction and every three years thereafter for all staff. See appendix 2.

Bespoke sessions have been delivered via teams by the IPC team when required to groups of staff who require specialist knowledge specifically in relation to the roles that they undertake.

Training performance reports have been monitored by each locality care group via their Quality and Performance meetings, IPCC and are also monitored through the CQC Compliance meetings and during "mock" visits to wards and departments by service managers.

Audit

The IPC team audit areas to systematically measure the effectiveness of healthcare and service delivery against agreed standards to implement, where necessary, improvements and changes at individual, team or service level.

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This is implemented in conjunction with the CNTW Clinical Effectiveness Strategy, in particular Objective 2, which aims to ensure the culture of the organisation is to deliver clinically effective care. This ensures clinical teams and clinicians are actively involved with auditing practice and improving care.

Due to Covid-19 the audit programme was stood down for Lower Urinary Tract infections and Sepsis, this will form part of the 2021/22 IPC workplan.

Risk Assessments

It is a requirement that we as a Trust comply with the Health and Social Care Act for reducing Healthcare-Associated Infections 2008. Criterion 1 states that providers should demonstrate systems to manage and monitor the prevention and control of infection using risk assessments to consider the susceptibility of service users and any risks that their environment and other users may pose to them. Inpatient areas and community services in CNTW which conduct physical health screening will have a risk assessment by a member of the Infection Prevention Control Team accompanied by a senior member of the nursing team. This is an opportunity for the IPC team to observe practice and the environment to ensure practices comply with IPC PGNs and recognised national guidance.

The risk assessment was developed by combining audit tools from the Infection Control Nurses Association for Monitoring Infection Control Standards 2004 and the Infection Prevention Society Quality Improvement Tools for Mental Health 2013.

Each section has a percentage score, this indicates the level of compliance. IPC risk assessment tool has been developed into an electronic format and will be on a rolling programme throughout the year. This format will allow for more detailed analysis and developing themes as well as decreasing the time taken to complete.

Following the risk assessment an action plan is compiled ensuring that any comments raised in the assessment are also included. The formulation of this action plan is the responsibility of the service. The completed risk assessment is sent to the Ward Manager, Clinical Nurse Manager and Associate Director.

Due to Covid-19 pandemic the IPC audit programme for 2020/21 was stood down. A pilot electronic IPC audit tool was undertaken in South Locality December 2020. From this pilot it was agreed to roll out the tool to all other localities as part of Q1 2021/22.

Decontamination and Medical Devices

Decontamination

The IPC team have led on Decontamination in 2020/21

Contaminated equipment can lead to the spread of infection. Decontamination of equipment is reinforced during IPC training. This reminds staff the relevance and importance that this process occurs.

IPC continues to work closely with NTW Solutions to review and keep up to date with new cleaning products, to ensure we are using the safest, most effective and value for money products.

As part of control measures for Covid-19 all national guidance relating to cleaning frequencies have been implemented.

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Staff across disciplines clean equipment and the environment in line with this guidance.

Medical Devices

The IPC Team have previously led on Medical Device maintenance and procurement, however due to changes within the team there is now a trust designated lead for Medical Devices within Safer Care.

Water Safety Group Report

The Director of Infection and Prevention Control has ensured that water safety standards have been met in 2020/2021.

The Water Safety Group (WSG) has met on a regular basis throughout the year. The aim of the Trust wide group is to identify, analyse and propose remedies for risks relating to water safety including Legionella.

Key themes highlighted from the Water Safety report:

- Audits have been completed in all sectors and audit reports received. The results were overall of a high compliance with some minor actions noted.
- All sectors continue to make progress through the identified actions and that overall compliance is high.
- Risk assessments are ongoing and 95% are in date, outstanding RA's are planned. Any issues associated with those assessments are either completed or in progress.
- Training has now been delivered to all members of the TWSG and further training will be booked as necessary going forward.
- Water outlet flushing not fully compliant in all areas. Information on low compliance areas has been shared with the TWSG and IPC reps. This is being progressed with clinical managers with responsibilities for each area.

The focus of the group remains that multi-disciplinary management of infrastructure and services to ensure prevention of contamination, swift eradication, or control and minimisation of water borne bacteria including legionella.

Management Policies

The Trust has in place both Policies and Practice Guidance Notes which have been reviewed and ratified this year and along with specific Estates management procedures encompass all issues associated with water safety.

Training

Both the Trust and NTW Solutions has continued to invest in specialist training and a wide range of staff including, Estates Maintenance, Capital Projects, Facilities and IPC matrons have completed training with a number undertaking the detailed ILM Responsible Person course.

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Risk Assessments and Audits

The Trust is maintaining the requirement of having risk assessments in place across all premises, reviewed on a biannual basis or when major changes take place. The Trust also continues to have independent management audits carried out by external specialists in Legionella Management and Water Safety and the team are regularly complemented on their high standards and recognisable cross disciplinary working.

In the coming 12 months, the group will look to implement the revised Management procedures and ensure new/upgrade schemes incorporate designs and systems designed to reduce risk as far as reasonably possible.

Annual Cleaning Services Report

The domestic services are provided by NTW Solutions Limited which is a wholly owned subsidiary of the Trust. The cleanliness standards throughout the Trust have continued to remain consistently high as evidenced by the monthly inspections and the PLACE inspection scores which reflect the inspections carried out at the beginning of the period.

There continues to be an excellent working relationship between the Facilities staff responsible for cleanliness and ward managers/nursing staff and the IPC Team. This co-operation helps to promote a team approach in maintaining high standards of cleanliness in clinical environments. It also assists in identifying at an early stage any problems which enables them to be resolved in a timely way. Regular meetings take place between the senior Facilities Managers and the IPC Team. At these meetings any areas of concern are discussed and actions agreed.

Within the North Locality the domestic service staff are employed by CNTW however they are managed by North Cumbria Integrated Care NHS Foundation Trust through an SLA, NTW Solutions manage and monitor this agreement.

Cleanliness Audits

The cleanliness audits are carried out in all clinical areas monthly, and non-clinical areas less frequently determined by the risk. Taking part in these audits are a qualified nurse, Facilities supervisor, Estates officer and also an IPC modern matron as appropriate. This approach of having a multi-disciplinary team undertake this work enables all factors that can impact on the standards of cleanliness to be examined; it also assists in getting corrective action completed in a timely way

In 2020/21 the formal cleanliness Audits were stood down due Covid-19 from March to June to prevent unnecessary visits to the wards and also to use the Domestic Supervisory resources on duties related to Covid-19. The audits were reinstated from July to September, however due to increased pandemic activity were stood down for the remainder of 2020/21. The domestic supervisors throughout the pandemic have continued to monitor cleanliness standards in their designated ward areas.

Trustwide cleanliness audits are planned to recommence May 2020.

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Staffing

The Domestic staff teams have consistently achieved the organisations targets for all statutory and mandatory training and JDRs. There have been some occasions sickness has exceeded target levels, in some areas at different times of the year, however through careful monitoring of cleanliness conditions and management of staff, this has not led to any on-going drop in standards

PLACE (Patient Led Assessments of the Care Environment)

During 2020/21 no PLACE visits were undertaken due to Covid-19.

Summary

The IPC Team, alongside NTW Solutions Limited which provides the Estates and Facilities services to the Trust, have worked with clinical care groups to ensure the safe and effective implementation of IPC measures across the Trust during the 2020/21 period in line with the statutory requirements of the Health and Social Care Act 2008.

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Appendix 1

Infection Prevention and Control Practice Guidance Notes (PGNs) updated in 2020/21

Document No:	Document Name	Author	Responsible Person	POC/Co-author	Version/ Issue	Ratify Date
IPC-PGN-01	Access to IPC Advice PGN	Janice Clark	Anne Moore	Alexia Pearce	**V06-Iss1**	**Feb-21**
IPC-PGN-02.1	Standard Precautions PGN	Sam Cooke	Anne Moore	Alexia Pearce	**V06-Iss1**	**Feb-21**
IPC-PGN-03.1	Safe use and disposal of sharps PGN	Samantha Cooke	Anne Moore	Sam Cooke	**V05 Issue 1**	**Jan-21**
IPC-PGN-06	Major IPC Incidents (including major outbreaks)	Kay Gwynn	Anne Moore	Alexia Pearce	**V05 Issue 2**	**Jul-20**
IPC-PGN-12	Used Laundry	Janice Clark	Damian Robinson	Alexia Pearce	**V05 Issue 1**	**Jan-21**
IPC-PGN-13	Lice, Fleas and Scabies Prevention	Samantha Cooke	Anne Moore	Samantha Cooke	**V05 Iss 1**	**Mar-21**
IPC-PGN-14.1	IPC Considerations in the purchase and use of equipment: Water Coolers and Ice Making machines	Samantha Cooke	Anne Moore	Sam Cooke	**V06 Issue 1**	**Jan-21**
IPC-PGN-21	Management of MRSA in Hospitals	Samantha Cooke	Anne Moore	Sam Cooke	**V05 Iss 1**	**Mar-21**
IPC-PGN-23	Meningococcal Infection, Meningitis/septicaemia	Sharon Gibson/ Steven Allen	Damian Robinson	Alexia Pearce	**V05 Iss1**	**Feb-21**
IPC-PGN-29	Animals in Healthcare Environment	Samantha Cooke	Anne Moore	Sam Cooke	**V01 Issue 1**	**Feb-21**
IPC-PGN-31	Guidance for the management of patients with suspected or confirmed COVID19	Samantha Cooke	Anne Moore	Alexia Pearce	**V01-Iss2**	**Sep-20**

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Appendix 2

IPC Training 2020/21

Executive Directorate > Business Unit > Service > Cost Centre	Training complete	Total number of staff	Percent complete
North Cumbria Locality Care Group	1,224	1,353	90%
North Locality Care Group	1,207	1,315	92%
Central Locality Care Group	1,461	1,622	90%
South Locality Care Group	1,754	1,903	92%
Chief Nurse	138	164	84%
Chief Executive	27	28	96%
Deputy Chief Executive	150	165	91%
Medical	358	464	77%
Commissioning & Quality Assurance	157	157	100%
Workforce & Organisational Development	50	52	96%
NTW Solutions	716	739	97%
SUSPENSE	472	718	66%
Provider Collaboratives	3	3	100%
Chief Operating Officer	120	134	90%
Total	**7,837**	**8,817**	**89%**

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Appendix 3

IPC Risk Assessment Pilot results

DEPARTMENT	SITE	Locality	CBU	Audit score	Count No answers	Count number of Actions	Note
Aldervale	Hopewood Park Hospital	South Locality Care Group	Inpatients South CBU	99%	3	0	
Beadnell	St. George's Park	South Locality Care Group	Neurological & Specialist Services CBU	98%	3	0	
Beckfield	Hopewood Park Hospital	South Locality Care Group	Inpatients South CBU	93%	14	0	
Bridgewell	Hopewood Park Hospital	South Locality Care Group	Inpatients South CBU	96%	18	0	Completed audit twice
Brooke House	Brooke House	South Locality Care Group	Inpatients South CBU	96%	7	1	
Cleadon	Monkwearmouth Hospital	South Locality Care Group	Inpatients South CBU	98%	4	1	
Clearbrook	Hopewood Park Hospital	South Locality Care Group	Inpatients South CBU	99%	2	0	
Eating Disorders Service	Royal Victoria Infirmary	South Locality Care Group	Neurological & Specialist Services CBU	97%	6	0	
Gibside	St. Nicholas Hospital	South Locality Care Group	Neurological & Specialist Services CBU				Not completed audit yet
Longview	Hopewood Park Hospital	South Locality Care Group	Inpatients South CBU	92%	16	0	
Mowbray	Monkwearmouth Hospital	South Locality Care Group	Inpatients South CBU	99%	2	2	
Roker	Monkwearmouth Hospital	South Locality Care Group	Inpatients South CBU	100%	0	1	
Rose Lodge	Rose Lodge	South Locality Care Group	Inpatients South CBU	93%	15	0	
Shoredrift	Hopewood Park Hospital	South Locality Care Group	Inpatients South CBU	100%	0	0	
Springrise	Hopewood Park Hospital	South Locality Care Group	Inpatients South CBU	98%	4	0	
Ward 1	Walkergate Park	South Locality Care Group	Neurological & Specialist Services CBU	97%	5	0	
Ward 2	Walkergate Park	South Locality Care Group	Neurological & Specialist Services CBU	96%	7	0	
Ward 3	Walkergate Park	South Locality Care Group	Neurological & Specialist Services CBU	99%	1	0	
Ward 4	Walkergate Park	South Locality Care Group	Neurological & Specialist Services CBU	100%	0	0	

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Appendix 4

Statement of Compliance with the Health and Social Care Act Code of Practice 2008

This document details how the Northumberland, Tyne and Wear NHS Foundation Trust will protect service users, staff and visitors from Healthcare-Acquired Infections, and comply with the Health and Social Care Act 2008 Code of Practice, for the year 2020/21.

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them

Statement

- The Trust IPC policy incorporates the Trust statement reflecting its commitment to prevention and control of infection amongst service users, staff and visitors. This document also outlines the collective and individual responsibility for minimising the risks of infection and provides detail of the structures and processes in place to achieve this.
- The Trust has appointed a Director of Infection Prevention and Control accountable directly to the Chief Executive and Board (see below).
- Effective prevention and control of infection is secured through an IPC team, assurance framework, annual work and audit programme, and surveillance and reporting system (see below)
- Training, information and supervision is delivered to all staff through either face-to-face or e-learning.
- There is an annual audit programme in place, approved by the Board, to ensure implementation of key policies and guidance.
- We have a named decontamination lead.

Risk Assessment

- The Trust has developed an IPC specification for clinical areas, which details all the standards for IPC. Following a risk assessment, action plans for achieving compliance with the specification are developed where necessary. Ownership of the action plans lies within the clinical Groups, and is monitored in each Governance meeting a sub Group of Quality and Performance groups. Groups decide if identified risks are sufficient to enter on the Group's risk register or escalate to the Trust risk register. IPC nurses are members of the Groups meetings and are available to advise.
- The risk assessment tool is used annually to monitor improvements achieved through action plans. In addition, the risk assessment is triangulated against other assessments through the year (including, but not limited to, PLACE assessments, CERA assessments, root cause analyses, serious untoward incidents, quality-monitoring tool) to ensure that any new risks are identified and recorded. Risks are reported through the quality and performance meetings of the Groups.

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- The Trust has implemented an electronic patient record system (RiO) which has electronic admission and discharge criteria which include infection control issues.

Director of Infection Prevention and Control

- The Trust has designated the Director of Infection Prevention and Control, referred to as the DIPC. This post is held by Anne Moore, Group Nurse Director, Safer Care Directorate.
- The DIPC is directly accountable to the Chief Executive and Trust Board. The roles and responsibilities of the DIPC are detailed in the Trust Infection Prevention and Control policy
- The DIPC chairs the Trust wide Infection Prevention and Control Committee, which meets at least every three months and is a member of the Trust wide Quality and Performance Committee (a subgroup of the Trust Board),
- The DIPC produces an annual report for the Trust Board on the state of public health in the Trust. This also constitutes the annual report of the DIPC. This report is made publicly available on the Trust internet, and is available in print to any service user, staff member, or member of the public who requests it.

Assurance Framework

- The DIPC reports to the Trust Board on an annual basis to report on developments on public health services, including infection prevention and control. Data is provided on C difficile and MRSA bacteraemia, and modern matrons concerns regarding cleanliness and infection control are reported on each occasion. The annual work and audit plan and the annual report are presented to the Board each year for approval.
- All infection related incidents are reported to the Trust through the Trust wide incident reporting system, SAFEGUARD areas are provided with appropriate advice, by the IPC team relating to the reported incident. Statistics on incidents are produced monthly and reported at the quality standards meeting, for analysis and discussion. Full datasets are reviewed by the IPC Committee at each meeting for analysis of trends. This data includes, but is not limited to, MRSA infections and screening compliance, Clostridium difficile infections and outbreaks of gastrointestinal infections. The low level of infections in the Trust render year on year analysis of trends difficult.
- Serious untoward incidents related to infections are reported through the Trusts SUI reporting system and investigated accordingly. The results of SUI investigations, and action plans arising from them, are monitored through the Safe sub groups Quality and Performance meetings and the IPC Committee.
- The IPC team undertakes Route Cause Analyses for each case of MRSA bacteraemia and Clostridium Difficile infection identified. The results of root cause analyses, and action plans arising from them, are monitored through the quality standards meetings and the IPC Committee. They are also reported through the North of Tyne Health Care Acquired Infection (HCAI) reduction partnership meetings.

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• Data on MRSA bacteraemia and Clostridium difficile infections are Trust wide key performance indicators (KPIs) which are reported to the Board each quarter. • All inoculation incidents are reported through to the IPC committee and the Governance sub Group Q and P meetings and are subject to an after action review at local level if appropriate.
Infection Control Programme • Each year the DIPC and IPC team produces an infection prevention and control programme which set objectives for ensuring the safety of service users, staff and visitors, and identifies priorities for action over the year. The programme also includes audits to be undertaken to assure the Trust of compliance with key IPC policies. • This programme is presented to, and approved by, the Trust Board at the start of each year. Progress against the programme is reported to the Board in the annual report of the DIPC. • All staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information on and training and supervision in Infection Prevention & Control.
Infection Prevention and Control Infrastructure • Cumbria Northumberland, Tyne and Wear NHS Trust provides an Infection Prevention and Control service in house. The IPC team comprises, the IPC team comprises of 1 WTE Head of IPC 2 WTE Infection Prevention Control Nurses B7. • They work closely with other senior nurses in the Trust to support them in delivering the infection control and cleanliness agenda. • The IPC team and IPC Committee obtain expert microbiology advice through a service level agreement with Northumbria Healthcare NHS Trust to provide attendance of a microbiologist at the IPC committee meetings and support on the development of policies and guidance. • The Trust has 24-hour access to infectious diseases advice through SLAs with microbiology services. • The Trust receives information from the multi-agency North of Tyne Healthcare Associated Infections Reduction Group.
Movement of Service Users • IPC team provide advice and support to the bed management team relating to the admission and or movement of patients with known or suspected infections. • All wards have access via the intranet to the outbreak management PGN which provides information on restricting admissions, discharges and transfers during an outbreak. Also identifies need for good communication between services.

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Criterion 2: The Trust provides and maintains a clean and appropriate environment in managed premises which facilitates the prevention and control of infection
Statement • The Trust lead for the provision of cleaning services is the Head NTW Solutions. • Ward Managers are accountable for the cleanliness standards on all in-patient areas • The Trust has a range of buildings ranging from new, purpose built facilities to old or adapted facilities. • The CNTW solutions strategy envisages all clinical areas achieving category B standard for buildings. • Cleaning schedules detail the standard of cleanliness required and the frequency of cleaning. Cleaning schedules comply with the National Standards of Cleanliness. All schedules have been reviewed and will be signed off by IPC modern matron and ward managers. These schedules are displayed publicly in all clinical areas. • The cleanliness of the environment is assessed through, weekly ward checks, monthly standardised cleaning audits (SYNBIOTIX audits) and annual PLACE assessments. The results of these assessments are made available to the Groups, the IPC committee and are available on the Trust intranet. • The Trust has issued guidance on staff dress reflecting infection prevention and control and health and safety standards and requirements, including promoting good hand hygiene practice. The guidance includes advice on the correct laundering of uniforms and clothes worn at work.
Cleaning Services • Clear definitions of specific roles and responsibilities are identified in job descriptions and the cleaning strategy. • Service level agreements with each ward identify the cleaning specification including standards, cleaning frequency and responsibility for cleaning all equipment. These have recently been reviewed by IPC team, facilities and ward managers. • Sufficient resources have been identified to maintain clean environments. Where potential gaps are identified due, for example, to holidays or sickness, additional resources are identified including the use of overtime and agency staff. Any concerns that cannot be addressed are individually assessed and escalated where appropriate. • Routinely requests for additional cleaning are directed through the facilities department and all areas have appropriate contact numbers. Domestic supervisors visit areas weekly and any concerns are escalated to the appropriate level. Urgent and out of hours cleaning requests are escalated via the on call manager/director to CNTW solutions manager..
Policies on the Environment • IPC staff are members of the Trust water safety group. • The Trust has policies on Legionella control, potable water management, waste, laundry and food & nutrition.

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Decontamination • The Trust does not undertake sterilisation procedures for any reusable medical devices. A practice guidance note outlines disinfection and decontamination procedures. Wherever possible all medical devices are single use or single named patient use only. • The Trust PGN on decontamination was amended in 2019 to include some new guidance specifically relating to portable electric fans.
Linen, Laundry and Dress • All staff are required to adhere to "bare below the elbow" practice guidance note which was reviewed in 2019/20. • This review included guidance specifically relating to the IPS mental health guidance.

Criterion 3: Provide suitable accurate information on infections to the service users and their visitors
Statement. • The Trust utilises a range of written information to inform service users and carers about general principles of infection control and specific infections. These include information produced by Public Health England , Department of Health and Social Care and others • World Health Organisation 5 moments has been incorporated into hand wash guidance. • The annual report of the Director of Infection Prevention & Control includes information on the occurrence of infections in the Trust, and the general means by which infections are controlled within the Trust. This is publicly available on the Trust internet. • Where it has been decided not to install alcohol hand gels at the entrance to wards visitors are advised by a poster to ask staff for access to hand washing facilities. • During an outbreak of infection specific signs are displayed at the ward entrance to inform visitors. • Specific display stands have been displayed during the winter months to discourage anyone with flu like/respiratory illness from visiting.

Criterion 4: Provide suitable accurate information on infections to any person concerned with **providing further support or nursing/medical care in a timely fashion**
Statement • Arrangements are in place to prevent and control HCAI and demonstrate that responsibility for IPC is effectively devolved. This is detailed in the IPC policy and associated practice guidance notes. Staff have access to electronic versions of the IPC manual and core plans and advice on infection prevention and control is available from IPC services from 0900 to 1700 each day. Advice on the specific treatment of infected patients is

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available from local microbiology departments or the regional infectious diseases unit.
- An IPC/Physical Health link worker network has been developed with the aim of ensuring that all areas having a link worker. There is an active training and support programme in place for IPC link workers.
- The Trust has access to the electronic reporting systems of most pathology departments (ICE)
- We have robust reporting systems with other trusts.
- Outbreak communication demonstrates accurate, timely communication with other departments e.g. Facilities, Estates and other healthcare providers

Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

Statement

- All staff, contractors and others are offered written information, induction and access to IPC advice via NTW Solutions staff.
- It is recognised that IPC is everyone's business and this responsibility is reflected in all job descriptions

Criterion 6: Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

Statement

- Responsibility for infection prevention and control is detailed in the Trust IPC policy and is included in the job description of all staff
- Mandatory training is provided via e-learning every three years for all staff, both clinical and non-clinical. All new staff receive IPC training in their induction programme.
- The IPC team has robust relationships with CBU Senior nurses and NTW Solutions.
- Regular updates on the Hygiene Code are given at appropriate meetings.
- All staff have the opportunity to have a flu vaccination each year. Service users in risk groups who are inpatients are offered flu vaccination

Criterion 7: Provide or secure adequate isolation facilities.

Statement

- IPC Practice Guidance Note (IPC-PGN 08) details the procedures to be followed to isolate a patient with a known or suspected infectious disease.
- The availability of a suitable isolation area in each in-patient area is part of the IPC specification.

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- Most in-patient areas in the Trust have single rooms suitable for the isolation of patients with infectious diseases. In the event of a service user requiring isolation, and that not being available on their own inpatient unit, arrangements would be made to transfer the service user to a clinical area where adequate isolation facilities are available.
- In the event of a large scale outbreak of infection then affected service users would be cohort nursed in an identified area of an in-patient ward, or the entire in-patient ward would be regarded as an isolation area.

Criterion 8: Secure adequate access to laboratory support as appropriate

Statement

- The Trust does not provide laboratory services in-house.
- The Trust holds service level agreements or arrangements for microbiology services at Northumbria Healthcare NHS Trust, Newcastle Hospitals NHS Trust, Gateshead Health NHS Trust, South Tyneside and Sunderland NHS Foundation Trust and North Cumbria Integrated Care NHS Foundation Trust Results are available through the electronic ICE system.
- The Trust is assured that these services operate to the standards required for accreditation by Clinical Pathology Accreditation (UK) Limited.

Criterion 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

Statement

- The IPC nurses produce a range of practice guidance notes to assist staff implement adequate measures to control the transmission of infection and manage service users with infections. This guidance forms part of the Trust Infection and Control Policy and staff are expected to follow the guidance unless there is a compelling reason not to.
- Compliance with practice guidance notes is audited through the Quality Monitoring Tool, the IPC risk assessment and the annual audit programme
- The range of practice guidance notes covers the following topics:
- Standard infection control precautions
- Aseptic technique
- Outbreaks of communicable infections
- Isolation of service users
- Safe handling and disposal of sharps
- Prevention of occupational exposure to blood borne viruses, including prevention of sharps injuries
- Immunisation requirements of staff
- Management of occupational exposure to blood borne viruses and post exposure prophylaxis
- Closure of rooms, wards, departments and premises to new admissions
- Environmental disinfection
- Decontamination of reusable medical devices
- Antimicrobial prescribing

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- Single use
- Disinfection
- Control of outbreaks and infections associated with the following specific alert organisms
    - MRSA
    - Clostridium difficile
    - Blood borne virus, including a viral haemorrhagic fever and Transmissible Spongiform Encephalopathy
    - Tuberculosis
    - Diarrhoeal infections
    - Legionella
- The following alert organisms are unlikely to be experienced within the spectrum of activity of a mental health and learning disability trust and currently the Trust does not have practice guidance notes covering these:
    - Glycopeptide Resistant Enterococci
    - Acinetobacter
    - Viral haemorrhagic fevers

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Report to the Board of Directors
4th August 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, Chief Nurse

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	x	Work together to promote prevention, early intervention and resilience	X
To achieve "no health without mental health" and "joined up" services		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)	31.07.21

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	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
N/A

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Infection Prevention and Control (IPC) Board Assurance Framework
Trust Board Meeting
4th August 2021

1. Executive Summary

The IPC Board Assurance Framework issued by NHSEI in May 2020 is designed to help providers assess against the Infection Prevention and Control guidance for Covid19 as a source of internal assurance that quality standards are being maintained.

This report covers the Q1 period April to June 2021, during which the Trust experienced a significant decline in Covid infections in patients admitted to our wards from the community, and no reported Covid outbreaks. From the beginning of June there has been a steady increase in the number of reported staff household cases who have tested positive and subsequent staff who have had to self-isolate. This increase has coincided with the increase in local cases in the community of the new Delta variant, and the easing of national lockdown measures.

The tool provides assurance to trust boards that

- any areas of risk are identified and show corrective actions taken in response
- organisational compliance has been systematically reviewed for other potential Nosocomial or Hospital Acquired Infections (HAI's).

Since the last Board meeting, the tool has been updated to reflect new emerging evidence and national guidance, the assessment has been completed against the updated version 1.6 (June 2021) as highlighted in the appendices. There has been an update and addition of new standards in sections, 1,2, 4 and 5.

During April to June 2021 performance against the self-assessment for the Trust has been tested via

- the routine review of standards in all settings

2. Nosocomial (Healthcare Acquired Infection) Infections

Nosocomial infection means "healthcare acquired". It is important to understand whether cases of COVID-19 may have been acquired as a result of the healthcare we provide. This helps us to identify and test any contacts who may have been infected, prevent further spread of the virus and identify where to target our infection control and clinical resources. For the period of the report there have been no cases of nosocomial infection.

3. Compliance

Trust level compliance was demonstrated across all standards, with the exception of practice issues identified from staff Close Contact risk Assessment (CCRA), similar issues which emerged from previous outbreak control meetings. Actions are in place to resolve these:

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- Some gaps in staff compliance regarding cleaning, touchpoints, adherence to PPE, car sharing and exceeding Covid secure environments. Compliance and practice issues are raised at the point of CCRA and with line managers.

- Wearing of face masks by patients to help reduce the transmission of Covid-19 positive areas continues 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.

4. <u>Assurance mechanisms for the initial and new standards</u>

In addition, actions to support assurance of the self-assessment 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, Covid-19 secure workplaces and relaxation of lockdown.

- The Test and Trace processes, staff absence management, is a vital part of assuring staff are being assessed for close contacts and isolated accordingly.

- Reports to Covid-19 IMG by Group Nurse Director Safer Care/ Director for Infection Prevention and Control (DIPC) on national and emerging IPC guidance and implications, PPE position, staff, and index case testing. These meetings were stood down however due to the increased activity have been reinstated.

- IPC Assurance meetings fortnightly. Membership includes DIPC / Group Nurse Director for Safer Care, Group Medical Director Safer Care, IPC Team, Locality Group Nurse Directors and Deputy Director of Communications. It has been agreed to amend the terms of reference for this meeting to widen the scope to review and monitor wider IPC issues.

- Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff continues. All results logged via trust portal.

- The importance of regular lateral flow antigen testing has been promoted widely with communications and the development of short 'sound bite' videos facilitated by members of the IPC team.

- All inpatient Covid-19 seven day surveillance swabs are recorded on electronic patient record RIO and reported onto a centrally held database.

- All inpatient and community teams are monitoring IPC practices daily at handover using: Guidelines for maintaining a Covid-19 secure and safe workplace checklist, to monitor and reinforce IPC standards.

- All clinical areas in both inpatient and community complete the updated Infection prevention and control Covid-19 management checklist 1.4 (Feb

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2021). Locality Group Nurse Directors review monthly through Locality Quality & Standards meetings.

- Regular IPC/PPE communications included in the trust wide communications briefing, supported by guidance on the trust intranet.

- Pilot of clear facemasks within the Deaf Services to identify suitability to aid communication needs and maintenance safe practice.

- IPC team continue to undertake scheduled and adhoc 'Teams' Meetings with Clinical Nurse Managers, Ward Managers and clinical care groups to discuss complex cases, offer support and guidance for the practical application of 14-day isolation of patients.

- IPC Team have continued where possible and to minimise transmission, to make 'visit/walkabouts' to hospital and some community service sites to monitor hand washing, social distancing, advise on appropriate use of PPE.

- IPC Team have delivered Covid-19 training via teams to clinical and non-clinical on request.

- Re-commencement of environmental cleanliness audits Trustwide.

- The comprehensive roll out of Fit Testing of FFP3 masks continues to be led by the Academy Physical Health Leads to staff, including the refit of new models of mask and fit testing for PAM referrals, multiple failure referrals and those with work related difficulties.

5. Conclusion

The IPC standards for preventing the spread of Nosocomial Covid-19 have been implemented across localities and are continually updated via self-assessment and triangulation.

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

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Infection Prevention and Control board assurance framework

New standards highlighted in Yellow

v1.6 June 2021

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:
• local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;
• the documented risk assessment includes:
  ○ a review of the effectiveness of the ventilation in the area;
  ○ operational capacity;
  ○ prevalence of infection/variants of concern in the local area.
• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory
	All admissions into the Trust are screened on day 1, 3 and day 5 following admission and then at 7-day intervals thereafter.
	
	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.
	
	Use of PPE in line with PHE and trust guidance.
		None	

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Protective Equipment RPE for patient care in specific situations should be given; • there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative; • that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance; • resources are in place to enable compliance and monitoring of IPC practice including: ○ staff adherence to hand hygiene; ○ patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; ○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical; ▪ b) non-clinical setting; ○ monitoring of staff compliance with wearing appropriate PPE, within the clinical setting; • that the role of PPE guardians/safety champions to embed and encourage best practice has been considered; • that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented	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 homes or other settings of covid status Visitors area advised of PPE requirements and social distancing prior to visit. Inpatient and community team handover checklist: Guidelines for maintaining a Covid-19 secure and safe workplace: to monitor and reinforce IPC standards. Trust PPE guidance reflects the guidance issued nationally by PHE. Regular communications are released to update staff around any changes to national IPC guidance. LFT testing available for all patient facing staff. Staff are provided with	Clinically dependant	If the patients mental health or disability diagnosis is a priority, risk assessed and IPC measures in place.

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and that organisational systems are in place to monitor results and staff test and trace; • additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team; • training in IPC standard infection control and transmission-based precautions is provided to all staff; • IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training; • all staff (clinical and non-clinical) are trained in: ○ putting on and removing PPE; ○ what PPE they should wear for each setting and context; • all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance; • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace; • IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way; • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted;	kits and required to undertake LFT twice a week. All results logged via trust portal. As part of Outbreak control management and investigation of cause of nosocomial spread testing of staff maybe requested. Mandatory IPC training available via ESR. Bespoke sessions available on request. Spot checks visits by IPC team members to monitor compliance, in addition to individual case discussions. Signage available at all sites reminding the use of Face masks/face coverings and maintaining social distancing Regular communication briefings to provide an update in guidance and application to all staff groups. Daily contact with DIPC/Gold command to discuss any changes in guidance. Discussed with Executive		

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• risks are reflected in risk registers and the board assurance framework where appropriate; • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens; • the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep; • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board; • the Trust Board has oversight of ongoing outbreaks and action plans; • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	via IMG. Board members receive regular communications updates. Risks added to Trust risk register as appropriate. Staff continue to report infections via the web-based incident reporting system. IPC policies and advice provided. Data circulated to Executive Team IMG members daily reviewed and signed off by Gold Command led by Executive Director of Nursing and DIPC. include IPC BAF discussed at IPC assurance meeting. Reported to the board of Directors 3 monthly. Gold command and IMG		

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:			

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• designated nursing/medical 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 with PHE and other national guidance; • assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; • cleaning and decontamination is carried out with neutral detergent followed by 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; • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance; • a minimum of twice daily cleaning of: ○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance;	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. Decontamination and terminal decontamination included in Trust guidance in line with PHE advice. Domestic supervisors and support staff link in and meet with IPC team on a regular basis. All areas throughout the Trust utilise neutral purpose detergent and chlor-clean (a chlorine-based disinfectant) Staff have training and guidance on using this. Domestic staff have been made aware of the importance of following manufacturers guidance in use of all cleaning / disinfect products Domestic staff are instructed in the required standards and pay particular attention to cleaning of	North Cumbria locality using Tristel Fuse as per NCIC products. Currently being reviewed due to change in provider of cleaning.	

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○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails; ○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; ○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; • reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing or repair equipment; • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken; • single use items are used where possible and according to single use policy; • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk;	toilets/ bathrooms. All isolation areas decontaminated at least twice daily. Staff working with keyboards, desktops etc. are aware of increased frequency of cleaning for these areas. Ward managers advise domestic teams when to enter rooms for cleaning following patient movement or clinical interventions Reusable equipment is decontaminated appropriately and effectively after use in line with Trust Decontamination PGN and Medical Devices policy All linen from possible/confirmed COVID-19 patients managed as infectious linen and disposed of/laundered appropriately. Single use items used throughout the Trust in accordance with Single Use Policy Reusable equipment decontaminated appropriately and	Identified from outbreaks and CCRA risk of transmission from shared electronic equipment. Included in handover Covid checklist. Personal responsibility 'if you touch it, clean it'	

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• cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment; • where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	effectively after use in line with Trust policy. Cleaning standards monitored by facilities NTW solutions. Rooms in CNTW are not typically mechanically ventilated and openable windows is the only method. Risk assessments completed in clinical areas.		

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 for antimicrobial stewardship are maintained • mandatory reporting requirements is 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		

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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: • national guidance on visiting patients in a care setting is implemented; • areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have 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; • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice. • Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered	All visits are via booked sessions. Welfare checks completed prior to visit. PPE provided. Designated covid risk assessed visiting rooms. Access is restricted to core team members where COVID-19 positive patients is suspected/ confirmed. 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. Signage available at all sites reminding the use of Face masks/face coverings and maintaining social distancing. Regular communications on personal protective behaviours **in** and out of work.		

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[C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)](C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf)	Staff and Wellbeing resources available on trust intranet.		
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: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance; • staff are aware of agreed template for triage questions to ask; • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible; • face coverings are used by all outpatients and visitors;	All admissions into the Trust are screened on day 1, 3 and day 5 following admission and at 7 day intervals thereafter, and managed appropriately. Appropriate care plan re isolation until result known. Documented in RIO progress notes and alerts Patients with possible or confirmed COVID-19 are isolated from non-COVID-19 patients IPC screening guidance for inpatient and community teams. As part of booking arrangements for appointments/visiting face coverings are advised.	There are occasions when patients do not comply with isolation pending results.	Triage via Bed Management clinical team Staff wear full PPE at all times.

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• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;	Identified as part of admission process if clinically extremely vulnerable, additional measures included in care plan. Inpatients nursed in single rooms.	Some inpatient sites are configured with patient bays with a small number of single rooms available. Priority would be given to CEV patients.	
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	On admission patients are informed of the use of masks to reduce the transmission of covid-19, and encouraged to wear them. Each patient risk assessed re ligature risks.	This can be due to communication difficulties of sensory impairment or ligature risks of use of masks.	
• monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	Some patients do not wish to comply with social isolation or alternative mask use		
• patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	Covid risk assessments completed in all areas to identify room occupancy. Perspex screens are being placed insitu in reception areas where required following covid secure risk assessments		
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	All patients who develop symptoms are tested and isolated promptly with continued monitoring of the		

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	patient's physical health. Appropriate care plan re isolation until result known. Documented in Rio progress notes and alerts		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly;	Patients who are symptomatic are isolated, if continue to display symptoms following negative result they will be retested.		
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	All patient testing recorded on RIO		
• 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: • patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas;	Positive patients nursed in designated areas of wards in single rooms or cohorted areas. Clear signage of PPE requirements at entrances to wards.		

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• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe;
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;
• a record of staff training is maintained;
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk;
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:
  ○ hand hygiene facilities including instructional posters;
  ○ good respiratory hygiene measures;
  ○ staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care;
  ○ staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and
	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).
	
	Training records are maintained by training facilitators
	
	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 via trust wide communications and posters in every ward/department across the Trust
	
	Inpatient and community team handover checklist: Guidelines for maintaining a Covid-19 secure and safe workplace: to monitor and reinforce IPC standards. This includes wearing of PPE,		

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remind staff to follow public health guidance outside of the workplace; ◦ frequent decontamination of equipment and environment in both clinical and non-clinical areas; ◦ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. • staff regularly undertake hand hygiene and observe standard infection control precautions; • • the use of hand air dryers should be avoided in all clinical areas. Hands should be 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; • staff understand the requirements for uniform laundering where this is not provided for onsite; • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms; • a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for	decontamination of equipment and car sharing. Signage available at all sites reminding the use of Face masks/face coverings and maintaining social distancing All inpatient staff across the Trust undertake hand hygiene competency assessments/IPC on an annual basis Hand towel dispensers are available in all areas and are regularly maintained. Hand hygiene posters are readily available and clearly displayed in all prominent areas. Communications on personal Uniform laundering has been issued via Daily Communications briefings All staff displaying symptoms of COVID-19 are contacting the Central Absence Line within the Trust for advice and to access Trust based Testing Team for themselves and family members. Monitored via DIPC/ Gold command and IPC		

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hospital/organisation onset cases (staff and patients/individuals); • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported; • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	Fact find meetings to identify if two or more positive cases linked in time and place. OB management policy implemented when two or more positive cases linked.		
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: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff; • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas; • patients with suspected or confirmed COVID-19 are 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;	As above, all areas compliant facilities to support isolation/cohorting with the exception of Hadrian Clinic Compliance in line with PHE guidance All areas compliant facilities to support isolation/cohorting	Hadrian Clinic difficult to isolate due to the ward layout (no ensuite facilities)	Designated toilet facilities for patients isolating on Hadrian clinic. Frequent cleaning of high points in these areas.

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• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	No change in usual management of these infections. All patients managed in accordance with relevant trust PGN		
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 and other national guidance; • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available; • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data); • 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). Regular monitoring of testing turnaround times. All labs following letter from NHSE Mental Health to ensure rapid processing of tests for MH/LD settings. Reported daily via internal reporting mechanisms Screening takes place to rule out other infections/symptoms being displayed		

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• that all emergency patients are tested for COVID-19 on admission; • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; • that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission;	All patients who develop symptoms are tested and isolated promptly with continued monitoring of the patient's physical health. Appropriate care plan re isolation until result known. Documented in Rio progress notes and alerts		
• that sites with high nosocomial rates should consider testing COVID negative patients daily;	All patients screened on day 1, 3 and day 5 and at 7 day intervals thereafter in accordance with national guidance.		
• that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge;	Patients screened in accordance with local guidelines and IPC screening guidelines. Information shared with receiving organisation prior to discharge.		
• that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation;	Liaison with the care facility regarding isolation requirements as part of discharge planning arrangements.		
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	ECT patients are screened prior to each treatment		

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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: • staff are supported in adhering to all IPC policies, including those for other alert organisms;	IPC Team are in daily contact with clinical areas regarding IPC processes and advising wards/teams where other infections are reported		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff;	Any changes to PHE guidance communicated to staff as soon as possible via the daily communications and Team meetings		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance;	All waste related to suspected or confirmed COVID-19 cases is disposed of appropriately as infectious clinical waste into orange bags. Introduction of tiger waste for non-clinical areas for the disposal of face mask.	North Cumbria, some clinical areas have no access to lidded clinical waste bins for safe disposal of waste	Clinical waste bins on order. Orange clinical waste bags used, waste still disposed of into the correct waste stream.
• PPE stock is appropriately stored and accessible to staff who require it.	Central management of PPE has been introduced to ensure adequate stock for all areas based on usage		

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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 using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported; • that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff; • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally; • staff who carry out fit test training are trained and competent to do so; • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used;	Staff in 'at risk' groups identified and supported appropriately, including the completion of individual risk assessments As identified by risk assessment, all staff that are required to wear FFP3 masks undergo fit-testing by an appropriately trained individual. Training is recorded HSE approved training session of upto 3 hours and be deemed competent by an external contractor approved in RPE training All testing done is recorded on a fit test report including those who have failed the test and those who are unsuitable for masks All test reports are scanned to and inputted onto ESR. The data viewed as 'live' on the FFP3 dashboard which allows locality managers / clinical leads to receive the latest mask information for their staff groups.		

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• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation; • those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods; • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm; • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health; • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record; • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;	The original report is given to the managers for record keeping and those fit tested receive a business card with their mask and details on. Those who cannot undergo a fit test will be regarded as a failed fit test. Instructed not to enter areas where FFP3 masks are recommended or undertake duties where there are potential AGP's. Managers are asked to review any employees who falls into this category The data can be viewed as 'live' on the FFP3 dashboard which allows locality managers / clinical leads to receive the latest mask information for their staff groups. Recorded on ESR.		

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• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance; • all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas; • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone; • staff are aware of the need to wear facemask when moving through COVID-19 secure areas; • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing; • staff who test positive have adequate information and support to aid their recovery and return to work.	Staff teams remain on their allocated areas with minimal movement. This includes Domestic Teams. Staff are aware of the need for social distancing. Use of 2m floor spacers to prompt and remind staff re need for 2m distancing. Posters are on display in all wards/departments across the Trust. The Trust Covid19 Environmental working group has undertaken environmental risk assessments and recommended modifications required trust wide. Face masks are worn by all staff in all areas. 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.		

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Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
4th August 2021

Title of report	Safer Staffing Report Including Six Month Skill Mix – May 2021 data
Report author(s)	Anne Moore Group Nurse Director Safer Care, DIPC
Executive Lead (if different from above)	Gary O'Hare, Chief Nurse

Strategic ambitions this paper supports (please check the appropriate box)			
Work with service users and carers to provide excellent care and health and wellbeing	x	Work together to promote prevention, early intervention and resilience	
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	28/07/2021
Audit	
Mental Health Legislation	
Remuneration Committee	
Resource and Business Assurance	
Charitable Funds Committee	
CEDAR Programme Board	
Other/external (please specify)	Covid19 Gold Command

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

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Safer Staffing Quarterly Report including Six Month Skill Mix Review
Report to the Board of Directors
4th August 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.

The following report includes the exception data of all wards against Trust agreed Safer Staffing levels for the period May 2021. The report includes information on Allied Health Professionals and Medical staffing

The report includes a summary position from each locality alongside the narrative per ward area. It will be noted from the document that there continues to be a significant number of areas of high acuity and staffing pressures. However also during the month of May, following the lifting of Covid19 restrictions, there is evidence of increased staffing absence as a result of household close contact isolation. Together with Covid and Non-Covid 19 sickness, vacancies and maternity the staffing levels are becoming more challenged. Carleton Clinic in Cumbria and St George's Park continue to be areas requiring additional support.

To address this, all areas have managed their staffing levels to safe levels, by utilising additional bank and agency alongside daily huddles and resource allocation. It is evident that the TAER system doesn't enable the manual adjustments and staff movement across the organisation to be reflected in the report. The agreed plan to move forward with a replacement e-rostering system will greatly enhance the data available to support staffing analysis.

In addition, the Trust Chief Nurse, is leading the Recruitment and Retention Taskforce alongside Group Directors and the Chief Operating Officer to prioritise activity for increased recruitment, retention, and resource staffing into hotspot areas.

It should be noted that the daily scrutiny at CBU, Group and Executive and Gold Command levels to ensure the safe provision of services to patients.

Recommendation / Summary

The Board of Directors are 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

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North Cumbria Locality

North Cumbria CBU has 11 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Ashby	64.89%	261.85%	101.22%	250.71%	Overuse of non-registered staff due to long term segregation and increased observation levels. Staffing on day and night shift increased to reflect high acuity levels, increase in self-harm, assaults towards staff, damage to property and targeting of staff requiring movement between night and dayshift. Continuation of long term segregation to maintain his and others safety. Peer to peer risks resulting in safeguarding alerts 2 x registered staff going through HR process 1 Registered nurse sick leave 1 Registered nurse on maternity leave
Fraser	79.77%	159.77%	64.97%	233.96%	Band 6 on non-clinical duties following occupational advice. 3 Preceptor nurses 2 Qualified vacancies 1 Band 6 vacancy High levels of observations and acuity.
Lennox	94.52%	244.46%	104.92%	408.66%	High levels of observations on a night duty due to several patient's self-harm risk. Increased observations 2 days a week to escort patient to ECT treatment. Increase in patient acuity due to transition period and anxiety this provokes for young people. 5 Support worker vacancies. 1 Band 6 vacancy 1 Band 5 working from home - disciplinary reasons. 1 Band 5 relocated to Ferndene due to clinical need. 2 Support workers on long term sick leave. 1 Support worker supernumerary – pregnant. Some sporadic short term sickness.

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Redburn	77.47%	233.44%	125.24%	188.90%	Increase staffing on Redburn due to clinical activity, seclusions, and increased eyesight observations at mealtimes to support with an eating disorder diagnosis. Unfilled registered nurse shifts are also backfilled with Band 3 nurses to ensure safer staffing levels on the ward. Redburn and PICU qualified nurses cover the night POC's annual leave. There are several qualified nursing vacancies on Redburn. The ward is required to function on 1 qualified nurse per shift rather than 2 due to shortage, this is backfilled with Band 3 nurses to ensure safer staffing levels.
Stephenson	69.41%	252.23%	83.41%	221.85%	3 Pregnant staff working non-clinically due to risk assessment. Band 3/4/5 8 Band 3 vacancies 2 Band 5 vacancies 2 Preceptor nurses requiring additional support. High levels of acuity. 2 Long term segregations requiring high levels of support. Additional staffing on a night duty relates to twilight qualified to support with high levels of acuity being counted into night duty observations. Twilight shift finishes at 22:30.
Edenwood	114.46%	315.41%	81.97%	283.00%	4 Patients all on enhanced observations: 2 patients require 1:1; 1 patient requires 2:1 and 1 patient require 3:1 staffing. Enhanced observations to maintain safety and ensure care delivered as per care plans. Staffing increased both days and night Days 8; Nights 7
Hadrian	91.93%	291.50%	158.01%	499.80%	Due to high acuity agreement implemented to increase staffing levels to 6 staff (early and late shift) and 5 staff (night shift) to allow for safe and effective care and intervention. Bank and agency staff utilisation increased during periods of increased observation levels as supporting with annual leave and absence cover. Optimising full workforce resources where possible – shift cover gained from ward manager, nurse consultant, clinical leads, deputy ward manager and occupational therapy staff. Increased staffing by 2 per shift to support the management of a long term segregation. 5 Band 5 Registered Mental Health Nurse vacancies. 3 Band 3 Health Care Assistant vacancies. 2 Band 6 clinical lead vacancies 1 Band 7 Ward Manager on long term sick leave. 1 Band 3 Health Care Assistant on long term sickness. 2 Band 5 Registered Mental Health Nurses on maternity leave. 1 Band 3 Health Care Assistant on maternity leave.

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Oakwood	66.67%	177.20%	103.05%	152.86%	Numbers for Oakwood this month were based on a 5-5-4 model due to ward acuity. Breaches due to short and long-term sickness, whereby the day shifts were largely covered by Bank staff (Band 3s and Band 5s) and night shifts by Agency Health Care Assistants. Where 4 staff were on night shift and Oakwood acuity was less (towards the end of the month), the fourth night staff member was utilised as a "float" for the rest of the Clinic and more specifically Ruskin Unit. Long term sickness: 2 Band 3s (1 full time, 1 part time); 1 Band 4; all with no return to work date. 1 Band 4 on secondment for Nurse training. 1 Band 3 on Nurse Apprenticeship training.
Rowanwood	89.09%	232.26%	102.39%	365.91%	There were 3 shifts were there was only 1 registered nurse on nights, however this was supported via night co-ordinator being based on the ward. There were high levels of acuity on the ward which required increased observations. High levels of staff sickness due to injuries sustained from restraint and other illnesses. The daily staffing call supported the movement of staff onto the ward and there was high level of agency use due to ongoing vacant Band 5 positions (x10) and ward clinical acuity. Due to staffing pressures the bed numbers on the ward was reduced to 8 to ensure that the ward remained safe for both staff and patients.
Ruskin	76.36%	137.20%	187.37%	119.71%	Several early shifts which have been short staffed were supported by Occupational Therapy staff and other wards. Several late shifts which have been short staffed were supported by other wards. Several night shifts which have been short staffed but supported by twilight Health Care Assistant and floater. Several shifts in the month when support has not been available therefore worked 1 staff member down. High level of enhanced observations during May requiring an increase in staffing numbers and use of agency Health Care Assistants.
Yewdale	76.36%	119.74%	106.56%	173.29%	Use of Agency or Bank to cover shifts. 2 Health Care Assistants on long term sick leave and 1 Healthcare Assistant off with Long Covid. Bank continues to be used to the maximum. Agency are being used and are trying to cover wherever possible. Currently have 2 short term contracts with Ranstad. Vacancies: 1 Band 6 Clinical Lead 3 Band 3 Health Care Assistants 2.8 Band 5 Registered Mental Health Nurses. 2 Band 5 Occupational Therapy posts

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North Cumbria
All wards have been challenged through the month of May and have required an increase in staff to support therapeutic activity and safer staffing. Whilst the impact of Covid-19 infections has significantly reduced, there has been an increase in sickness related to stress and burnout. Clinical acuity has been high on all the wards, with this being reflected in the increased number of staff required to support patients. Short term contracts for agency staff were offered to support with the qualified staff deficiency. Rowanwood was reduced to 8 beds due to the chronic staffing shortages. Introduction of daily staffing call to review staffing across locality and level load agency use.

Due to high levels of vacancies, sickness and maternity leave on the 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 and the inpatient nurse consultants have been working within the wards. Skill mix and leadership within all the wards has continued during this period resulting in some of the substantive registered staff being redeployed to other wards to be able to supervise the preceptors. A tabletop exercise was undertaken with all wards to review staffing and opportunities for redeployment to areas which have chronic vacancies. There continues to be ongoing discussions with Staffing Solutions with regards to nurse bank support to reduce agency requests, however for North Cumbria this continues to be challenging.

Specialist CYPS CBU
Throughout May most Children and Young People's Services wards have continued to see significant pressures in relation to registered nurse vacancies. In addition, staff absence from clinical duties due to occupational health advice/recommendation, pregnancy risk assessment, HR disciplinary process and fact find creates further pressure. Further bespoke recruitment campaigns have taken place with limited success. Campaigns have been re-advertised on a rolling advert basis. Clinical acuity remains high within all wards including long term segregations which reflect high level of observation levels. As a result of this wards continue to use high levels of bank and agency to support the shortfall.

North Cumbria Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	**Vacancies**
Physiotherapists	2.8	1.0
Occupational Therapists	13.0	2.3
Psychologists	4.0	1.0
Dietitians – Specialist CYPS	4.1	1.0
Speech and Language Therapists	3.2	0.6

Recruitment & Retention
Recruitment campaigns continue to be ongoing with recruitment into North Cumbria Inpatients, Community & Access Community Business Units remaining a challenge with many vacancies, both qualified and unqualified, remaining unfilled due to the location.

Applications for vacancies do not attract large numbers and vacant community posts typically entice Band 5 & 6 nurses away from the inpatient setting. Furthermore, sitting on the borders of Scotland we may lose potential interested parties due to recent announcements by the Scottish Government regarding pay. There are also nearby private mental health facilities offering significant salary increases for Band 5 and 6 staff nurses. David Muir, Group Director, has undertaken a piece of work to review and pull together a slide set regarding the challenges faced in North Cumbria. All vacant posts continue to be advertised on a rolling advert and weekly meetings continue to take place to consider creative ways of managing the overall qualified nursing shortage.

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Specialist CYPS CBU
CYPS Recruitment campaigns have continued with limited success. There continues to be an ongoing challenge within Children and Young Peoples Specialist Services with Registered Nurse vacancies. Lotus Ward at Acklam Road Hospital opened mid-May but beds are not opened at full capacity due to recruitment challenges.

Advertising for Nursing Associate Posts has continued due to the recent success and high levels of interest. Recruitment campaigns continue social media and on-line recruitment engagement events have taken place with varying levels of attendance.

Developments:
A wider piece of work has been undertaken by the Group Director for North Cumbria regarding the challenges of nurse recruitment for North Cumbria and the other localities. It offered some considerations as to how we may look to make posts more attractive and sustainable. Alongside this, there is some operational development work being undertaken with wards where recruitment and retention is a significant issue to understand the culture and challenges on these wards.

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North Locality

The North CBU has 9 inpatient wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Alnmouth	68.14%	285.96%	49.91%	201.42%	High numbers of escorts out to Acute Trusts requiring 3:1 / 2:1 staffing ratios. Qualified staff isolating due to track & trace or close contact – cover from across the site at daily staffing meeting but not reflected in TAER numbers. On some shifts Alnmouth have had to work with one qualified which is breaching safer staffing levels. Agency Band 5 covering nights which does not show in numbers. Band 5 vacancies as reported within Trust Wide Recruitment Meeting.
Bluebell Court	81.51%	82.67%	91.94%	75.50%	Established for 15 patients which requires 2 Qualified and 2 Support Workers during the day and 1 Qualified and 2 Support Workers during the night. Currently they are operating 8 patients which do not require the safer staffing levels as above. Bluebell offer support to site when additional staff are on shift. Regular bank staff working both qualified and unqualified to backfill vacancies.
Embleton	86.00%	261.68%	100.30%	197.46%	Working on higher numbers of nursing assistants due to having the swing zone open. Seclusion in use during May as well as 15 patients requiring male only interventions. Agency band 5 was supporting 2 days per week - now ended. Band 5 vacancies as reported within Trust Wide Recruitment Meeting.
Hauxley	92.67%	115.66%	104.80%	124.59%	Increase in non-registered staff on nights due to escort at acute hospital for 15 nights and increase in eyesight observations.
Kinnersley	153.31%	277.79%	227.97%	235.18%	Staffing numbers are above the safer staffing numbers due to the increase in bed numbers from 21 to 28. Currently working 3 qualified per shift during the day and 2 qualified at night to meet the requirements of the Royal College expectations of patient : staff ratio. Currently working on 23 beds however their staffing establishment remains for transition to full occupancy post Covid-19. The Ward supports the site with additional staff which is not captured within TAER.
Newton	111.51%	218.55%	83.65%	294.39%	Higher Support Worker use to provide care to out of pathway patient and increased acuity/increased aggression due to substance misuse. Qualified shortfalls supported by additional bank staff/site support which is not captured within TAER.

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Warkworth	56.45%	238.07%	61.70%	192.09%	Staff isolating due to track and trace leaving gaps on day and night duty, site cover allocated at daily staffing meeting. Band 5 vacancies as reported within Trust Wide Recruitment Meeting. Seclusions and high levels of supportive observation causing increased need for support workers. Some shifts qualified nurses working alone due to inability to backfill or day staff who will flexibly move shift to work nights.
Woodhorn	46.96%	280.66%	84.05%	166.86%	Registered Staff working below numbers due to high levels of vacancies Band 5, covid restrictions x 1 Band 5 working from home and 1 Band5 maternity leave Increase in Nursing Assistant numbers to support Registered Nursing gaps and to cover high levels of eyesight observations due to acuity of patients
Mitford & Mitford Bungalows	144.25%	187.43%	89.77%	148.84%	Mitford: on going vacancies of Nursing Assistant and Registered Nurses which are on rolling adverts with recruitment. Some Nursing Assistant vacancies have been filled and staff have commenced employment but require PMVA training , bank and agency fill rate remain consistently high. Mitford Bungalows: Ongoing use of bank to support vacancies and non- PMVA trained staff. Agency not utilised for support.

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North Locality
Covid-19 continued to pose challenges to all wards throughout the month of May 2021 in the respect of maintaining high quality IPC interventions within practice and environments, however rates of infection have been minimal within our staff and patient groups.

Wards continue to require additional staffing to support increased acuity and complexity of patient needs. North Locality Acute Inpatient Wards throughout May 2021 continued to operate beyond maximum patient occupancy with a high flow rate.

The increased levels of acuity and Registered Nurse vacancies continue to be mitigated by daily staffing safety huddles and the deployment of flexi-pool staff according to risk level. Ward Managers and Clinical Managers are routinely working within the staffing numbers to ensure an acceptable skill mix level. Whilst this supports some of the immediate clinical pressure, frequent staff movements, supplemented using temporary staff is presenting challenges in sustaining continuity of care.

Staff absence marginally reduced to 7.39% in May 2021.

North Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	**Vacancies**
Physiotherapists	3	0
Occupational Therapists	13	0
Dietitians	3.3	0
Speech and Language Therapists	2.7	1.6
Psychologists	9.5	0

Recruitment & Retention
Recruitment campaigns are ongoing for the North Locality, with representation on the Trust Value Based Recruitment Meetings. All vacant posts are proactively being recruited into with interviews taking place for all bands of nursing staff. Bespoke adverts are live for Specialist Nursing posts, Registered Nurses and Unregistered Nurses with planned interview dates.

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Central Locality

Central Locality has 17 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Aidan	96.46%	146.59%	112.46%	200.95%	Increased unqualified staff due to clinical activity. Band 4 opt-in students are included in numbers.
Akenside	78.67%	105.59%	98.24%	106.83%	2 x B5 short term absence. 1 x B5 vacancy
Bede	82.59%	619.09%	83.78%	466.20%	Band 5 vacancies. Sickness absences: 1 x B5 short term, 2 x B3 short term, 1 x B3 long term. Staffing levels increased due to high levels of acuity requiring increased engagement and observations and seclusion usage.
Castleside	100.83%	139.29%	125.51%	173.91%	Increased engagement and observations requiring increased use of B3 support staff Night Pool Qualified allocated some nights to support clinical activity.
Cuthbert	73.45%	174.98%	99.51%	147.56%	Qualified staff vacancies B5 x 3 have now been recruited due to start September. 1 x B5 long term absence. Unqualified staff are on the Cuthbert safer staffing who also cover the Annexe which will show an increase on the staffing of unqualified staff.
Elm House	77.11%	90.68%	95.99%	109.48%	1 x B6 long term absence 1 x B5 long term absence 1 x B5 maternity leave
Fellside	87.06%	267.03%	89.16%	224.88%	Staffing levels increased due clinical acuity: increase in observations levels; high levels of eyesight observations. 1 service user requiring x 2 staff eyesight due to challenging and complex needs, seclusion usage. Staff sickness required backfill. 2 x vacancies backfilled with agency/bank.
Lamesley	82.85%	325.67%	98.77%	257.63%	Increase in observations levels and high levels of eyesight – one continued eyesight, and 1x2 person eyesight. Safer staffing levels increased due to ward acuity. 1 x B5 long term absence 2 x B3 long term absence

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Lowry	102.29%	297.60%	131.67%	196.18%	2 x B3 long term absence 1 x B3 non clinical duties 1 X B4 Nurse training requiring backfill of post with Bank/agency Increased ward activity requiring Bank/agency to increase staffing on night duty
Oswin	55.45%	127.19%	102.90%	78.96%	2 x Band 5 maternity leave. Increased unqualified during day shifts are Band 3 staff recruited for other services gaining experience. Band 4 opt-in students included in numbers.
Willow View	104.44%	175.42%	99.08%	170.07%	Increased engagement and observations requiring increased use of B3 support staff
KDU Cheviot	68.05%	179.27%	107.42%	161.32%	Currently B5 vacancies. Preceptees to commence in September. Due to risk 1 patient requires 3 staff (unqualified) to support activity, maintain effective risk management.
KDU Lindisfarne	68.69%	189.00%	108.13%	222.30%	Currently B5 vacancies. 1 x B6 long term absence. Preceptees commencing on the ward in September. 1 patient currently residing in prolonged seclusion. Additional unqualified nurses required to respond to clinical acuity and effective engagement and observation of patients.
KDU Wansbeck	84.00%	202.71%	107.37%	178.72%	Currently B5 vacancy. 1 patient requires additional staffing (2 male unqualified) due to risk – awaiting transfer to higher level of security. Additional staffing required to ensure engagement/observations with patient.
Tweed Unit	106.16%	214.76%	117.13%	291.20%	Tweed currently have 2 low secure areas, 1 hospital based rehab area and a patient in long-term segregation to support. Additional unqualified staff required for engagement/observation of patients.
Tyne Unit - LD	56.71%	352.40%	116.57%	462.15%	Currently band 5 vacancies. 1 adult nurse works part time. Additional unqualified staff required to support patient in long-term segregation. 1 patient in Acute hospital – end of life care. Staff escorts required. 1 patient residing in long-term segregation.
Tyne Unit - MH	76.80%	64.27%	103.89%	51.69%	Tyne MH Band 3 figures are incorrect they work on the correct safer staffing and have no vacancies. There seems to remain a discrepancy with the Tyne MH and Tyne LD Band 3 figures.

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Central Locality
Sickness absence rates increased across both CBU's in May Inpatients (6.53%) and Secure Care Services (3.91%). The CBU's began to see several staff being required to isolate due to family members reporting Covid19 symptoms. At the end of May, the CBU's were also carrying several qualified and unqualified nursing vacancies (B3 x 14, B4 x 2, B5 x 37.5 (all Secure Care Services, including 2 new services Hadrian and the Enhanced Care Area, B6 x 6). Staffing vacancies and sickness absences account for those wards reported as being under 90% of planned staffing numbers highlighted in red.

Daily Staffing Huddles and Locality Huddles continue to be held to ensure effective redeployment of skill mix/resource for nursing staff deficits and qualified cover. Increasing pressure noted on staff where sickness absence has resulted with only one qualified on duty e.g. Castleside and where clinical acuity requires reliance on agency staff.

Clinical activity remained high throughout the month with high levels of engagement and observation, use of seclusion across the wards requiring additional staffing above planned levels, those wards over 20% are highlighted in green.

A number of staff were released to attend PMVA 5 day training which required backfill.

Central Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	**Vacancies**
Physiotherapists	2.6	0.4
Occupational Therapists	14.0	0
Psychologists	4.0	1.3
Dietitians	2.4	1.6
Speech and Language Therapists	5.7	0.8

Recruitment & Retention:
Nursing: Bespoke recruitment campaigns are in place and ongoing. Student nurses due to qualify in September 2021 were recruited to a number of B5 vacancies with Inpatients being allocated 13 and Secure Care Services 10. Preceptorship programme will be arranged to support learning, development, and achievement of competencies.

Occupational Therapy: Inpatients: 1x B6 OT post to go out to advert replacing forthcoming retirement. This is being advertised earlier than planned due to low staffing numbers due to staff being on long-term sickness.
Secure Care Services: All OT vacancies out to advert

Psychology: Inpatients: There continues to be a psychology vacancy in Willow View. A member of staff from OA inpatient services is on long term sick leave. Some cover is being provided by other qualified staff and Assistant Psychology time.
Secure Care Services: Awaiting start date for 1 qualified psychologist.

Developments:
Occupational Therapy: Inpatients**:** B6 pregnancy who will be non-clinical in September and on maternity leave in December – maternity cover to be arranged.

Psychology: Inpatients: The CBU have agreed to support the appointment of two temporary Band 5 Assistant Psychology posts (12 month contract), one Band 7 1.0wte permanent post for Willow View and one Band 8b to develop a role focused on delivering training on psychologically informed interventions and scaffolding within the Acute inpatient teams.

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Secure Care Services: Psychology recruitment as part of agreed business plan for new Approved Premises service is about to begin (July 2021).

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South Locality

The South Locality has 20 wards

Ward Name	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Narrative
Aldervale	76.18%	260.05%	122.43%	200.65%	All vacancies recruited to, waiting start dates 6 x Band 3 Long Term Absence 1 x Band 5 Long Term Absence Staffing usage over due to complex needs requiring support with engagement and observations Currently supporting the needs of a service user in long term segregation (awaiting bespoke placement). Additional staff support required to meet their needs Filled bank shifts May- 100 Filled agency shifts May- 76
Beadnell	115.24%	108.59%	104.27%	229.26%	Unregistered staffing is high on night duty due to nursery nurses doing twilights to support mother and baby bedtime routine.
Beckfield	80.48%	254.66%	102.27%	200.69%	1 x Band 5 Staff Nurse vacancy All other vacancies filled & waiting start dates 1 x Band 5 Staff Nurse long term absent At present engagement and observation levels fluctuate based on service user need High clinical activity 2 x long term seclusions Within eyesight observations fluctuate through month creating increased use of Band & Agency Filled bank shifts May- 149 Filled agency shifts May- 227
Bridgewell	79.14%	192.81%	102.94%	203.25%	1 x Band 5 Staff Nurse vacancy Acuity of Patients on ward fluctuates due to physical health needs & challenging behaviours of patients which require increased support, engagement & observation levels 2 patients on 1:1 observations without additional care packages Increased acuity at meal times due to number of patients on SALT care plans Additional support for escorts at Acute Trust Filled bank shifts May- 176 Filled agency shifts May- 1
Brooke House	73.07%	89.85%	103.42%	102.55%	All vacancies recruited to 1 x Band 5 staff nurse maternity leave 1 x Band 4 working into Physical Health Team Filled bank shifts May- 29

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					Filled agency shifts May- 0
Cleadon	89.32%	133.84%	108.88%	199.40%	1 x Band 5 staff nurse vacancy 1 x Band 5 staff nurse long term absent 1 x Band 3 peer support worker long term absent Acuity of patients on ward fluctuates due to physical health needs of patients & an increase in 1:1 observations due to patient challenging behaviours & safeguarding issues Filled bank shifts May- 27 Filled agency shifts May- 41
Clearbrook	80.39%	282.41%	96.50%	169.81%	2 x Band 5 staff nurse vacancies 2 x Band 3 nursing assistant vacancies 1 x Band 3 nursing assistant long term absent 1 x Band 4 associate nurse and 1 x Band 3 nursing assistant on maternity leave 1 x Band 5 working staff nurse from home due to CEV 1 x Band 3 nursing assistant going through alternative employment process Increased use of bank and agency over May. Increased clinical activity and incidents have impacted on staffing levels Band 5 vacancies impacting on the clinical activity ward with clinical lead working into the numbers to support staffing Acuity fluctuates due to patient physical health needs, challenging behaviours. within eyesight observations & 1:1 interventions and Safeguarding issues Filled bank shifts May- 147 Filled agency shifts May- 58
Longview	73.08%	333.98%	143.44%	204.18%	2 x Band 5 staff nurse vacancies 2 x Band 3 nursing assistant vacancies 1 x Band 3 nursing assistant long term absence Bed occupancy at capacity and over during May Increased support required to meet the acuity of need. This is reflected in the therapeutic engagement & observation levels Filled bank shifts May- 78 Filled agency shifts May- 121
Marsden	0.00%	0.00%	0.00%	0.00%	N/A

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Mowbray	86.63%	154.25%	103.62%	250.40%	2 x Band 5 staff nurse vacancies 1 x Band 4 associate nurse vacancies 3 x Band 3 nursing assistant vacancies 2 x Band 2 nursing assistant vacancies 1 Band 5 staff nurse long term absent Due to vacancies Band 6 predominantly supporting staffing numbers to ensure that there are two registered nurses on duty High levels of engagement & observations for service users who have complex presentations Additional use of bank, experienced Band 3 nursing assistants staff to support Band 5 vacancies where unable to fill with bank / overtime Filled bank shifts May- 65 Filled agency shifts May- 87
Gibside	84.75%	180.52%	88.92%	120.97%	1 x Band 5 on maternity leave. 1 x Band 3 long term sick. Increased unregistered is partly due to increased acuity in May (patient now discharged) and partly due to maintaining appropriate safer staffing levels where short of registered nurses.
Roker	82.03%	151.31%	103.79%	227.32%	No vacancies 1 x Band 5 staff nurse long term absent 1 x Band 3 nursing assistant long term absence Numbers over to due to an increase in admissions & requirement for enhanced engagement & observation levels Increased support required particularly on a late shift and night duty 2 patients requiring 2:1 observations Filled bank shifts May- 109 Filled agency shifts May- 47
Rose Lodge	105.08%	296.15%	173.63%	382.09%	1 x Band 6 clinical lead vacancy 3 x Band 5 staff nurse vacancies 5 x Band 3 nursing assistant vacancies 1 x Band 5 staff nurse long term sick 5 x Band 3 nursing assistants long term sick 4 x Band 3 nursing assistants short term sick Staffing over to support an increase of engagement & observations to assistance with activities of daily living skills & management of risk behaviours, & in line with patients PBS plans Currently supporting the needs of a service user in long term segregation (awaiting bespoke placement). Additional staff support is required to meet their needs. To support Rose Lodge as a standalone unit 2 qualified staff (band 5 staff nurse) are allocated on night duty Filled bank shifts May- 288

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					Filled agency shifts May- 207
Shoredrift	72.74%	427.31%	91.82%	304.38%	1 x Band 5 staff nurse vacancies 2 x Band 5 staff nurses recruited, waiting start dates 1 x Band 5 staff nurse long term absence 1 x Band 5 staff nurse 28 weeks + pregnancy shielding High levels of need that requires an increase in engagement & observations levels. This is reflected in an increase in staffing levels required Formula in place to meet acuity with staff intervention and numbers Currently supporting the needs of a service user, out of pathway, in long term seclusion. Additional staff support is required to meet their needs Filled bank shifts May- 181 Filled agency shifts May- 94
Springrise	51.28%	393.02%	72.31%	305.05%	1 x Band 6 clinical nurse lead vacancy 1 x Band 5 staff nurse vacancy 1 x Band 4 assistant practitioner working into physical health team 4 x Band 5 staff nurses recruited, waiting start dates The ward is currently supporting high levels of need that requires an increase in engagement & observations levels. Filled bank shifts May- 72 Filled agency shifts May- 195
Walkergate Ward 1	85.57%	70.23%	108.40%	73.36%	Vacancies in both registered and non-registered staff. Band 3 sickness. Lower level of occupancy and patients on leave during May.
Walkergate Ward 2	78.43%	95.34%	106.08%	138.71%	2 x Band 5 short term sick,1 x Band 5 long term sick, 3 x Band 3 on long term sick, 5 x Band 3 on short time sick. Ward 1 supporting with some Band 6 support, not reflected in these numbers. Increase unregistered staffing night-duty to support engagement and observations
Walkergate Ward 3	96.82%	80.01%	102.56%	103.68%	4 x Unregistered short term sickness Vacant band 2 posts awaiting start dates
Walkergate Ward 4	78.18%	90.87%	88.56%	134.92%	3 X band 5 vacancies, 3 registered nurse maternity leave and sickness. Cover difficult due to need for RGN's. Acuity levels high on ward requiring additional unregistered on night duty to support patient care
Ward 31A	94.15%	61.65%	106.68%	103.39%	3 x long term sick unqualified – 1 going through redeployment and 1 ill health retirement. Recruitment in process. 1 x maternity leave Band 6. 1 x Band 5 awaiting start. Ward not at max capacity for part of month

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South Locality
All wards continue to support increased acuity of need which requires additional staff resource to implement safe engagement and observation plans. There is pressure on the adult acute and PICU pathway, the adult acute pathways operated in May at maximum patient occupancy. The acuity and maximum occupancy are reflected in percentage of staff used to support the level of need. All wards have accessed additional staffing through bank and agency to support the outlined vacancies, acuity and complexity of need. The quantity of shifts filled by bank and agency for each ward during May is summarised in the ward narrative.

Vacancies across South inpatients, in particular registered Band 5. Adverts are registered on TRAC for all available posts, however there are increasing pressures within each pathway. A biweekly manager's hub is currently in place to level load and review areas that have gaps to maintain safer staffing. This can involve registered nurses working on other wards to support and maintain safer staffing. This forum has overview and input by senior managers.

Staff absence has slightly decreased from 9.48% in April to 9.03% in May. Ward Managers are working with occupational health, staff wellbeing services and workforce to maintain support with colleagues who are absent and facilitate return to work at the soonest opportunity.

Neuro & Specialist:
Clinical pressures remain high across inpatient services combined with the associated challenges of Covid-19. All wards have accessed additional staffing through bank and agency, and this is coordinated through twice weekly staffing huddles. This ensures all clinical and staffing pressures are highlighted and problem solved at a local level where possible. Community based services join if they require mutual support.

Staff absence across the CBU has increased from 4.62% in April to 6% in May, although inpatient sickness levels range from 5.59% (Beadnell) to 13.34% (Eating Disorders). Ward managers continue to work closely with PAM, staff wellbeing services and Workforce to ensure support and facilitation of return to work at earliest opportunity.

South Locality Multi-Disciplinary Team Staffing Summary

	Staff in post	**Vacancies**
Physiotherapists	10.1	0.0
Occupational Therapists	18.1	2.6
Dietitians – Neuro	3.2	0.0
Dietitians - Inpatients	0.9	0.4
Speech and Language Therapists – Neuro	5.0	0.8
Speech and Language Therapists - Inpatients	2.9	2.0

Recruitment & Retention:
Recruitment campaigns are ongoing for the South Locality, with representation on the Trust wide recruitment meetings. A central advert for Band 3 Nursing Assistants recently closed with 60 candidates indicating a preference for South. Local Ward Mangers will interview shortlisted candidates and review where successful candidates can be placed.

The ability for student nurses to opt in and gain more experience has proved invaluable. It facilitated a greater depth of experience for the students and allowed wards to promote opportunities within their areas for post registration.

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Rose Lodge has recently held a recruitment campaign to recruit into vacant posts. This was a successful event with thirteen candidates offered Band 3 Nursing Assistants posts, subject to clearances. In addition to the Band 3 posts they were successful recruiting, two Band 6 Clinical Lead posts 1 internal and 1 external candidates.

The September 2021 allocation of student nurse qualifiers was held on the 25th May, all locality leads were in attendance. The students were offered their identified preference as stated during interview. In total 13 student nurse qualifiers were allocated to commence in September subject to passing their final placements and academic work. The wards are cautiously optimistic that this will support the Band 5 deficit within the wards.

Neuro & Specialist:
There continues to be a steady stream of recruitment across all disciplines. Pressures remain for Band 5 registered nurses, but some wards have been appointed preceptors which will begin to improve the situation going forward.

Recruitment is underway for posts within Community Eating Disorder Pathway and Community Perinatal teams across all disciplines. There is a possibility that this will put additional pressure on the associated inpatient services, however many posts are designed to work across the whole pathway to hopefully have a balance of attracting new staff and utilising existing experience.

Developments:
A Dual Diagnosis Therapist role is being advertised to work within the South inpatient pathway. A Dual Diagnosis Therapist role will offer a holistic response to clients who have a dual diagnosis – including appropriate screening, assessment, interventions and collaborative working/shared care. Workforce plans within all wards are being reviewed to support the development of our workforce. New opportunities are being considered with vacancies, not replacing like for like. Wards are considering what role would and add the greatest value to meet the need and experience of patients and carers. In some areas this includes looking at additional resources in existing provision, in particular exercise therapy and speech and language therapy.

The recovery and rehabilitation wards are particularly keen to support a psychological therapist role that will focus on Governed Psychological Therapies (GPT), this would increase access to evidenced based treatment so that we improve recovery outcomes. It is also in line with NICE guidance for complex psychosis, which identifies the need for us to be offering and delivering CBT & Family Interventions.

Medical Workforce Summary

On a monthly basis the Trust wide 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 May 2021. It is anticipated that the future arrival of a number of international Doctors will help improvements through further reducing the vacancy factor Trust-wide.

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Locality	CBU	2020/21 Budget	Monthly Payroll	Add PA's	Agency	Vacancies
SOUTH	Access	7.27	6.85	0.90	0.00	0.48
SOUTH	Community	36.10	35.16	1.03	0.00	0.09
SOUTH	Inpatient	19.33	18.28	0.70	0.40	0.05
SOUTH	Specialist	22.10	21.47	0.24	0.05	-0.34
SOUTH	**Total**	**84.80**	**81.76**	**2.87**	**0.45**	**0.28**
CENTRAL	Access	12.15	8.90	0.20	0.08	-2.97
CENTRAL	Community	36.08	33.75	1.13	2.10	0.90
CENTRAL	Inpatient	10.22	11.05	0.10	1.28	2.21
CENTRAL	Secure	14.46	12.14	0.10	0.60	-1.62
CENTRAL	**Total**	**72.91**	**65.84**	**1.53**	**4.06**	**-1.48**
N.CUMBRIA	Community & Access	15.94	13.40	0.77	2.00	0.23
N.CUMBRIA	Inpatient	16.61	16.30	0.03	2.00	1.72
N.CUMBRIA	CYPS	13.11	10.80	0.62	0.00	-1.69
N.CUMBRIA	**Total**	**45.66**	**40.50**	**1.42**	**4.00**	**0.26**
NORTH	Access	8.56	5.00	1.38	0.00	-2.18
NORTH	Community	32.72	25.39	0.98	1.50	-4.85
NORTH	Inpatient	14.35	13.70	0.48	5.00	4.83
NORTH	LD & Autism	4.60	1.60	0.10	2.20	-0.70
NORTH	**Total**	**60.23**	**45.69**	**2.94**	**8.70**	**-2.90**
TRUST	**Total**	**263.60**	**233.79**	**8.76**	**17.21**	**-3.84**

Trust wide value based recruitment and retention

Recruitment and Retention Update

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 during the pandemic. Whilst it can be seen from the summaries above some of the bespoke recruitment campaigns have been very successful including the recruitment of qualified nurses on completion of undergraduate and apprenticeship training, the Trust has identified a continued challenge in recruiting experienced practitioners. A task and finish steering group has been established led by the Chief Nurse which has focused on all measures being taken to improve the position to recruit, retain inpatient staffing numbers going forward. This includes a refocus on Central Recruitment, International recruitment, potential for recruitment premia/incentives, cross border impact of Scottish pay award and career progression. In addition, establishing a formal internal rotation/transfer process – transfer window opens twice yearly with Ward/Team manager involvement. Overall, the focus is to proactively protect inpatient staffing and promote inpatient care as an attractive career pathway for qualified nurses and doctors

Conclusion

To provide assurance on Safe Staffing Levels, 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 Covid-19 pandemic to ensure staffing levels remain safe during a further surge in covid related pressure.

Anne Moore, Group Nurse Director Safer Care
Deputy Chief Nurse, DIPC
July 2021

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Report to the Board of Directors
4th August 2021

Title of report	**Annual Safety & Security Management Report – 2020 / 2021**
Report author(s)	**Tony Gray – Head of Safety, Security and Resilience**
Executive Lead (if different from above)	**Gary O'Hare – Chief Nurse**

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

Board Sub-committee meetings where this item has been considered (specify date)	
Quality and Performance	x
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	X
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

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

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Annual Security Management Report - 2020 / 2021

Board of Directors Meeting
4th August 2021

1.0 Executive Summary

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust is committed to the delivery of an environment for those who use or work in the Trust that is properly safe and secure so that the highest possible standard of clinical care can be made available to patients. Security affects everyone who works for or uses the NHS. The safety and security of staff, patients, carers and assets is a priority of the Board within the development and delivery of health services.

All of those working within the Trust also have a responsibility to be aware of these issues and to assist in preventing security related incidents or losses. Reductions in losses and incidents relating to violence, theft or damage will lead to more resources being freed up for the delivery of patient care and contribute to creating and maintaining an environment where all staff, patients and visitors feel safe and secure.

The purpose of this report is to provide information and assurance of the controls currently in place to create a pro-security culture across the Trust, as well as informing of the work currently being carried out across the organisation to improve safety and security arrangements.

2.0 Background

Security Management in the NHS has been the sole responsibility of each NHS organisation, with the demise of NHS Protect in April 2017, arrangements for Security Management have been overseen by Boards of Directors and the resources available are with the agreement of the Board lead for Security. Within Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, this responsibility is discharged to the Chief Nurse (within Trust policy the term Security Management Director is still used to describe the responsibilities of this role).

There is also still a requirement to comply with the National Security Management Standards in line with the NHS Standard Contract, acknowledging that there is no national oversight of this.

There is an on-going conversation in relation to aspects of the standards being re-aligned to the National Violence Reduction Strategy which is currently overseen by NHS England / Improvement. The new Violence Prevention and Reduction Standards were released in December 2020 these are being considered by all Trusts across the North East and North Cumbia ICS footprint and are available here.

There are still external organisations such as the Health & Safety Executive that still have a legal responsibility to oversee and enforce any staff safety issues that are passed to them in relation to the Trust, and the Care Quality Commission would have a view of our safe staffing information as a regulated activity as well as any safety and security concerns that impacted on patient care.

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2.1 Security Management Director (SMD) and Local Security Management Specialist (LSMS)

The roles of the SMD and LSMS were previously defined in law to carry out the following functions:-

The Chief Nurse in their capacity as the Trust's Security Management Director shall assume responsibility on behalf of the Board of Directors for all aspects of Security Management within the Trust. They will ensure that all management arrangements are in place to ensure compliance with the Trust's policy arrangements and supporting Practice Guidance Notes which have all been reviewed an updated in the last year, which covers the following areas:

- Closed Circuit Television / Body Worn Video
- Lone Working
- Counter Terrorism Response (including bomb threats)
- Working in Partnership with the Police (including prosecutions where appropriate)
- Trust Search Dog
- Hospital Lockdown
- Nuisance and Malicious Calls

In order to maintain and improve the safety and security systems within the Trust, the Security Management Director has deemed it appropriate to maintain the Trust's Local Security Management Specialists, as part of the central Safety, Security and Resilience Team.

The three individuals provide cover across the organisation in relation to security management but have a greater portfolio than security management which covers the following areas:

- Emergency Preparedness, Resilience and Response
- Security Management (Including Lone Working System)
- Health & Safety Management
- Incident System Management and RIDDOR reporting
- Policy Administration and Management
- Central Alert System
- Body Worn Camera system management

2.2 Current position and review of the year

The Safety, Security and Resilience function regularly undertake security based risk assessments on behalf of the organisation. These assessments cover a range of subjects including:

- Targeted risks to Trust staff and support for lone working situations
- Security of premises
- Protecting property and assets
- Security preparedness and resilience
- Use of weapons / Use of illicit substances

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The results of security risk assessments and associated recommendations are shared with key stakeholders. Security risk assessments are carried out both reactively, pro-actively.

Clinical Environmental Risk Assessments also include aspects of security management when they are carried out on in-patient wards.

The Clinical Environmental Risk Assessment process is completed annually for each inpatient ward and the Trust's Section 136 facilities, and forms compliance with the Care Quality Commissions annual ligature assessment guidance.

All inpatient areas have a current clinical environmental risk assessment in place, and there is a full programme to ensure compliance.

The assessment process also considers safety and security of the following areas:

- CCTV
- Staff Attack Systems
- Door Access
- Asset Security
- Building Security
- Abscond Risk
- Substance Misuse / concealment / supply etc.
- Nurse Call Systems
- Falls Detection

2.3 Lone Working

Health care workers have long been identified as a high risk group when considering lone working. Issues identified in high profile incidents emphasise the scale of the risk faced by mental health care staff on a daily basis.

Lone workers face environmental risks and are increasingly exposed to incidents with regards to assaults, aggression, abuse and harassment. Most often, these incidents occur one to one situations with no other evidence available to support taking action against alleged offenders. This can result in a reluctance by lone workers to report incidents that occur, leading to a feeling that nothing can be done to protect them or deal with the problems they face. Lone workers, by the nature of their work, can feel isolated or unsupported, simply by the very fact that they do not work in an environment surrounded by their colleagues or others.

As per previous years, we have had number of genuine red alerts, which continue to be dealt with in an effective and safe manner. In some of these cases police assistance has been required and rapid response was provided.

The Trust has a robust contract and system provision in place to protect its lone working staff.

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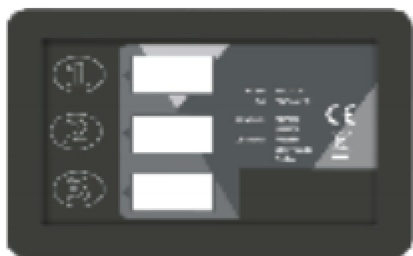
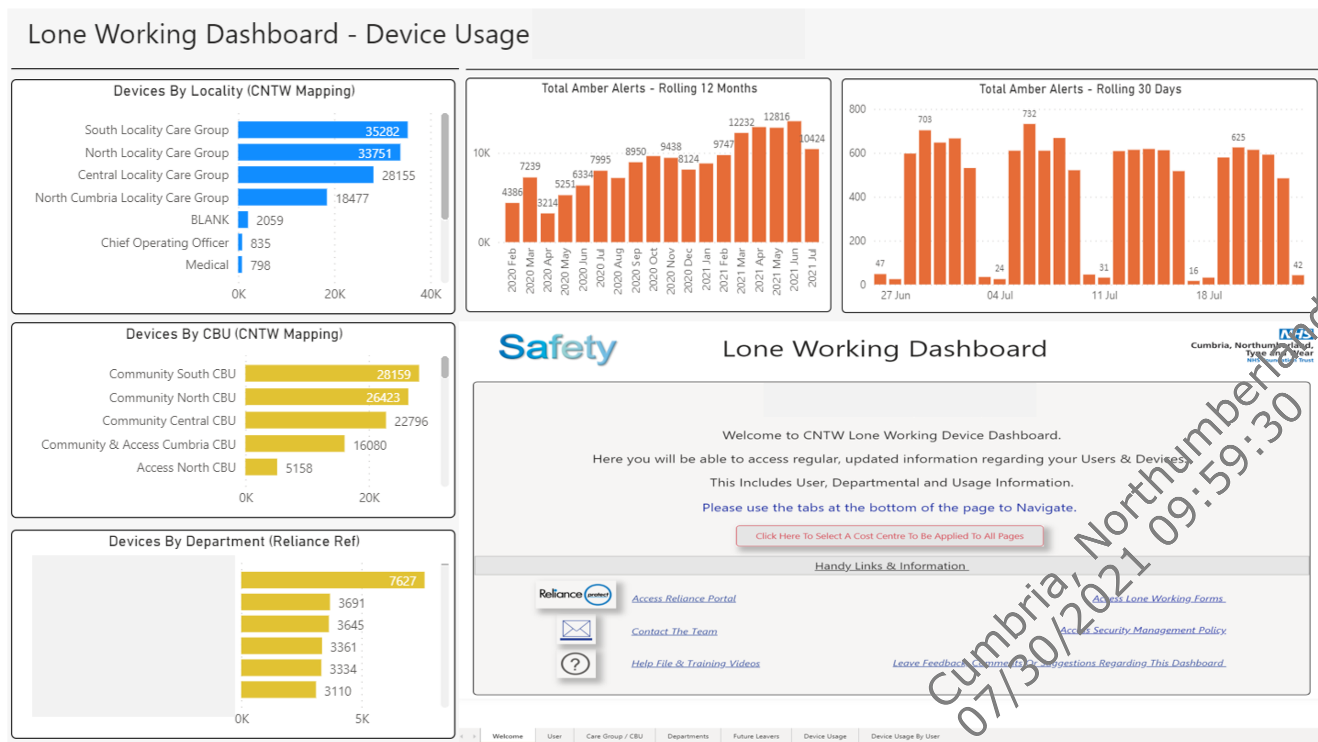


The provision predominantly comes in the form of an ID badge holder, however, the Trust have also recently implemented the provision of Pulse devices which is provided for staff who have physical difficulties in operating the ID badge. The Pulse device is also currently being utilised in some reception areas that have been identified as being at risk. All identified staff receive comprehensive training on the purpose and correct use of the device.

The system was originally commissioned as part of a centrally funded Department of Health initiative in 2009, and the Trust has maintained the system ever since, and now operates over 3,000 devices for community and at risk staff.

It is acknowledged that as one of the biggest users of this system nationally, there will always be opportunities for improvement of usage. Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust has worked with Reliance Hightech over the last year to develop an in-house performance dashboard integrated into the Trust's care group hierarchy and Electronic Staff Record data, to provide much more detailed information. The dashboard below went live in the Trust in February 2021, and has been shown to the Audit Committee, to provide assurance of robust systems. This is the only information of its kind in the NHS, and is currently attracting a lot of interest from other customers across the country.



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There will be a number of new developments coming on stream throughout 2021 which will improve our approach to lone working across the organisation as we continue to learn and build a stronger relationship with our lone working system supplier.

2.4 Clinical Police Liaison Lead (CPLL)

The Clinical Police Liaison Lead is an established role within the Trust for seven years this year. It has developed and changed throughout this time, adapting to national changes and Trust need. The post is embedded working within the Safeguarding and Public Protection (SAPP) Team after a move from patient safety team. The role still works closely with the safety team due to essential links in the area of work.

During 2020 and 2021 it has continued to be busy and active role in all matters Police Liaison, Multi Agency working, and Risk management.

This year has included maintaining the relationship and understanding within Northumbria Police, supporting new developed post of Mental Health Sergeant, and new liaison officers. As well as building relationships, and raising the profile of the CPLL role within Cumbria Constabulary. The CPLL has been working closely with Cumbria Police colleagues around training, improving crime investigations on wards, policy development. As well as most recently developing quickly a robust and clear relationship and guidance with Cleveland Police to support the development of CYPS services in Middlesbrough and ensure of staff teams are supported, and processes embedded. Links with British Transport Police remain and have expanded to cover the new areas also.

A key ongoing focus has been improving concerns around understanding crime investigation in Mental health wards, challenging views on 'capacity' and the necessity in some cases of crimes being progressed, to safeguard, our staff, service users and the public. This is across all three force areas. The PGN on working with Police and Criminal Justice System has been key in looking at this and reviewing the processes and agreed process.

The CPLL works closely with the Safeguarding and Public Protection development officer around these matters also, with this role taking a lead on the multi- agency risk management in Cumbria locality supporting Police Liaison with teams in this area also. We have set up a meeting with Northumbria, Cumbria and Lancashire Police to look at shared learning and understanding to prevent unnecessary boundaries issues also.

Training and education off new student officers has continued virtually during this time, with stepping up training needs identified, and ad hoc virtual training events accommodated. A focus also has been development of CNTW Police incident dashboard to ensure robust monitoring of Police activity across CNTW, and current focus on ensuring Police emergency attendance at wards are appropriate, and are reviewed jointly to look at lessons learnt and these are shared in the organisations. As well as work around ensure the correct people respond to call for welfare. With CNTW clear on our responsibilities as well as understanding what would necessitate Police or Ambulance call for concern for welfare. Further developments are occurring in this to ensure data quality and do more work around individuals in repeat contact with Police.

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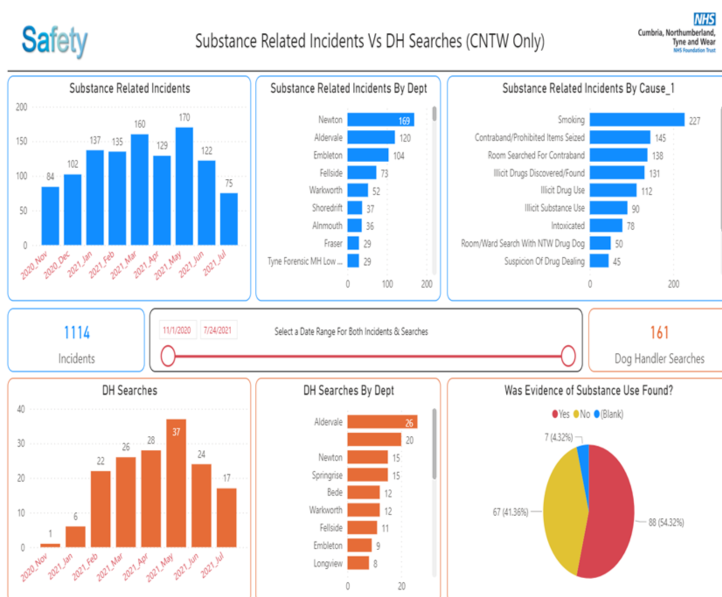
Police and Partner meetings have been stood down mostly during this time, but there has been more than ever, good and clear communication between Police and teams with support of the CPLL, and developments occurred where needed. Weekly meeting with Northumbria and Cumbria separately were put in with the CPLL so we can work together during pandemic on any areas of concern, and communicating into gold command relevant information.

Work continues to support Police liaison, with trust and force action plans of work ongoing. This includes development of Police liaison meetings in Lotus ward, continued development of Police training and policy development in Cumbria, and work sustaining what we have in Northumbria Police. Looking also to work more closely with the Violence reduction unit in the Police and Crime Commissioner office in Northumbria also. We are improving reviewing activity and ensure more joined up approach around crisis and risk management, information sharing and education both in CNTW and Police forces. The demand for attendance at clinical meeting has increased and often cannot get to all invited, so advice, information, or SAPP /Safety colleagues attend with Police where indicated.

2.5 Tackling Illicit Drug Use / Narcotics Search Dogs

The use of illicit drugs and new psychoactive substances (NPS formerly known as legal highs) continues to be a problem in some inpatient settings. A number of serious incidents have occurred relating directly to consumption of illicit substances both on the ward and following an episode of leave, media reports and national research have continued to highlight the problem the North East is facing. The Trust isn't an outlier in this, and the Trust recently signed a two year Service Level Agreement to provide a service in partnership with Tees, Esk and Wear Valley NHS Foundation Trust. We now have two Search Dog Handlers and Search dogs working across the whole North East and North Cumbria ICS and working closely with respective Police Forces that cover the geographical locations, to identify trends and report activity, sharing intelligence of vehicles that come onto Hospital sites and known sellers of illicit substances. In order to understand activity we have integrated our internal systems to provide up to information in relation to the activity that we experience across the Trust and the ICS. Below is a representative sample of the information we have and can share with our Police colleagues.



NHS
Quality Approved Resource
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Narcotics Search Dogs
Patient information leaflet

Caring | Discovering | Growing | Together

Cumbria, Northumberland Tyne a
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Both search dog handlers and their dogs carry out pro-active and reactive searches to support front line clinical teams, but where time allows, they also spend time on the wards as part of therapeutic activities and this has been really important and impactive in our Children's in-patient services both at Ferndene and the newly opened Lotus Ward at Acklam Road Hospital.

2.6 Understanding the national impact of aggression and violence on staff

This report has previously contained historical information in relation to national Reported Physical Assaults on Staff, however this has been removed from this report, due to the Annual Positive and Safe report containing much more detailed information, and also due to the fact that there is currently no nationally comparative data available.

NHS England / Improvement has release the new Violence Prevention and Reduction Standards in December 2020 available here. An initial assessment has been made against these standards, and the Trust is mostly compliant with the standards with juts a few development / improvement issues it needs to plan for, there is an internal team reviewing all aspects of the standards and supporting the work across the ICS with NHS England / Improvement to take the developments forward, the group is led jointly by the Medical Director and Chief Nurse.

In reviewing the standards, it was acknowledged nationally that there is no longer a view of violence against staff and impact on the NHS since the demise of NHS Protect's Security Incident Reporting System in 2017. The Trust has been approached to support the collection of violence information, due to our previous successful testing of the Patient Safety Incident Management System, which is now live and has been renamed the Learning from Patient Safety Events Service. The Trust is currently working with NHS E / I and the supplier of the Trusts Local Risk Management System (LRMS) to transition into the new system over the next few months, we have been asked to be one of the first Trusts to report through our LRMS.

The Safety Team works closely with clinical and operational services to reduce violence across the organisation, respond to it, and build safety plans for patients and staff, and use all of the technology available which aims to reduce and mitigate any risk to staff or patients to a reasonably practicable level.

2.7 Body Worn Video

The Safety Team adopted responsibility for the Body Worn Video system which is being rolled out across identified in-patient services within the Trust, whilst the planned rollout has been impact slightly due to impacts of COVID on in-patient wards, all services that were identified , now have access to their Body Worn Cameras, and are adjusting their internal processes to learn how this system can help to reduce the impacts of aggression and violence, and support internal investigations and de-briefs. We have been contacted by a number of NHS organisations across the country, to share our experiences of the project and the use of the devices on the wards. It is acknowledged as an early adopter of this system we are working closely with our clinical teams and the supplier to improve different aspects of the system, it is acknowledged that it will take a number of years for this to become an embedded safety system of the Trust, similar to the

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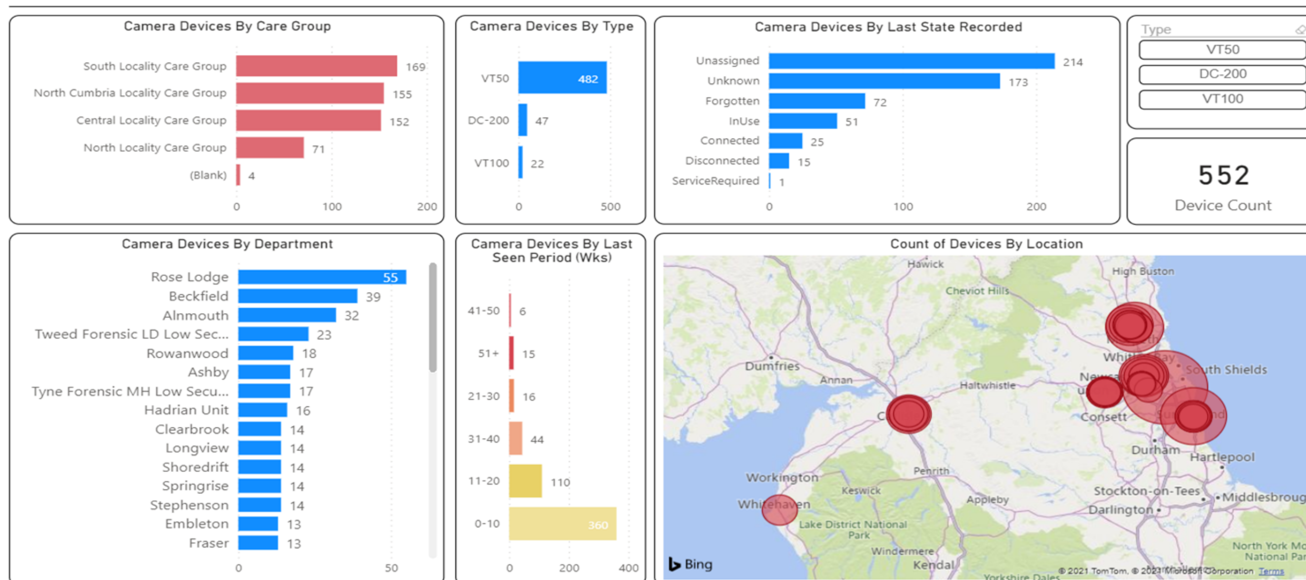
experiences of lone working systems in Community Services and CCTV on in-patient wards.



2.8 COVID Secure Workplace Risk Assessments (CoSWRA)

The Trust has developed guidance and a risk assessment process, to ensure that any workplace that staff are returning to is COVID secure, this guidance and assessment process is in line with Health & Safety Executive (HSE) standards, and the approach has been assessed by the HSE in 2020, no significant improvements have been suggested. The Safety Team are over-seeing the assessment process and where assurance has been gained and COVID certificates are being issued. As part of monitoring an internal dashboard has been created to oversee the activity. We have carried out and assessed 463 assessments across the organisation, with a number of re-assessments for specific areas where there have been outbreaks or physical changes to environments / services.

COVID-19 Secure workplace - Risk Assessment

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Department…………………………………….. Site…………………………………………

Risk Assessment reference No.:	**Review Date:** **Version:**
Calculating the risk: **Risk = Likelihood X Severity (L X S)** **L = Likelihood, S = Severity, R = Risk rating**	**Risk:** 20 - 25 **High**, Stop activity and take immediate action 12 - 16 **Urgent**, take urgent action but maintain existing controls vigorously 6 - 10 Monitor, look to improve at next review 5 - 1 No Action, ensure controls are maintained and reviewed **Persons at risk: e.g. staff, visitors, students, contracters, public, customers etc.**
Activities Covered:	
Likelihood	**Severity**
Rating 1 = Rare – Not expected to occur	Rating 1 = Insignificant
Rating 2 = Unlikely – Occurs infrequently	Rating 2 = Minor
Rating 3 = Possible – Once or twice a year	Rating 3 = Moderate
Rating 4 = Likely – Hazard will occur but is not persistent	Rating 4 = Major
Rating 5 = Very Likely - Constant threat is custom in practice	Rating 5 = Catastrophic

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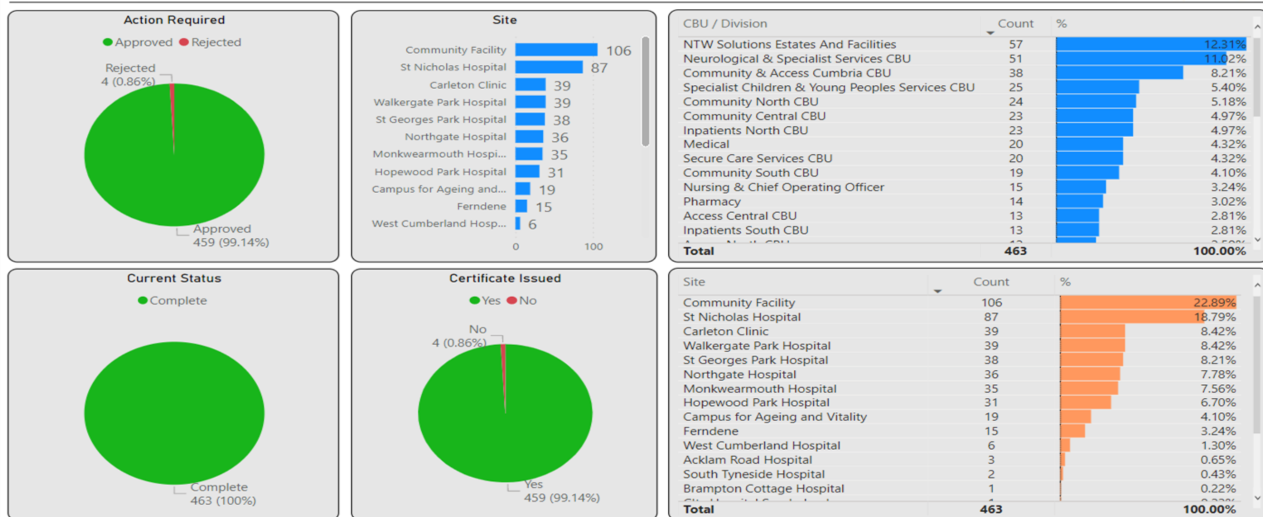

2.9 Future Work

With the change to the Executive portfolios in April 2021, the Safety Team and all its corporate responsibilities now sit with the Chief Nurse, and the following is a brief plan of the actions going forward for each of the areas of responsibility.

2.10 Safety Information , Data Integration and Learning

The safety team has access to a significant amount of information that can be triangulated in relation to incidents, safety systems, business continuity and emergency planning, all of which can be refreshed extremely easily. The team is supporting the Trust's approach to the corporate development of new Trust dashboards utilising Microsoft's Business Intelligence software (Power BI), but is also developing some in-house solutions to remove a significant amount of physical staffing resources and automation of data processing, an example of this is the lone working dashboard which without it, would have been impossible in person hours to quantify the information and correlate with internal trust systems, due to it's developments there is an on-going conversation to sell this system to other organisations to implement in their own Trusts, any income generated will be re-invested to improve quality and safety of care in the Trust.

2.11 Clinical Environmental Risk Assessments

The Trust has always had the highest priorities for safety for our in-patient services, but many serious incidents indicate that there will always be further work to do to continue the journey of improvement, and with such a large estate of varying quality from some very new buildings built to the required safety standards and some older estate that over time will need to be replaced, it is acknowledged that there will be work to do to focus on the areas that can mitigate self harm risk the most. There is currently nationally work ongoing to standardise the ligature harm reduction approach for all mental health Trusts, and guidance is due to be released in August 2021, at the same time the Care Quality Commissions guidance for providers is due to be updated and the Safety Team working with NTW Solutions and senior clinicians will be well placed to respond to any changes that are required.

In order to facilitate full understanding of our estate and risks it presents a new Clinical Environmental Safety Group has been created, with representatives from

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clinical and operational services, NTW Solutions and the Trust's Safety Team, who will support the review of the Trusts Estate and prioritise work going forward based on local risk activity or national changes.

2.12 Closed Circuit Television / Body Worn Video

The Safety Team in partnership with NTW Solutions are currently reviewing the specifications of CCTV across the Trust, due to a range of issues, of technology, age, and variability. A single specification is currently being drafted, to think about the latest technology, exploring cloud based systems, and protected access, for evidential purposes. A number of schemes have been progressed over the last year, but there are still a number of locations that do not benefit from CCTV, and these areas will be business cased throughout the year.

There is also an opportunity in a digital age to create a platform that brings the disparate systems we have together, so that clinical time can be saved by accessing all media from one digital platform, this is being explored as part of the above work.

2.13 Lone Working System

The system will continue to develop and improve and we will be adding in service desk monitoring, and reviewing new GPS location specific information to identify areas of weakness of coverage across the 4,800 square miles our lone workers currently travel.

2.14 Learning from Patient Safety Events Service (LFPSE) and National violence recording

Over the next few months the Safety Team will start the transition project to work with clinical and operational teams to re-build the Trust's incident reporting system, to allow information to flow from the Local Risk Management System (LRMS) provided by Ulysses into the new national system. The last national system change of this nature was in 2004, whilst the Trust is well placed having piloted the system in 2019 and 2020, it is acknowledged that COVID has had an impact on the plans both locally and nationally, but there is now an expectation that all organisations will transition by April 2022.

2. Risks and mitigations associated with the report

The Safety Team strives to complete the tasks asked of it, we deliver the following agenda:

Health and Safety

- Workplace Safety (including COVID Secure Workplace Risk Assessment)
- Clinical Environmental Risk Assessment
- Work with clinical teams to find safety solutions to reduce harm
- Safe Work Equipment
- Control of Substances Hazardous to Health (COSHH)
- Display Screen Equipment Guidance
- Health and Safety Inspections in partnership with staff-side
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Maintaining and updating policies to ensure they comply with national guidance and legislation

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Security Management

- Overseeing the Security Strategy of the Trust
- Monitoring Security Contracts
- Setting standards of CCTV and ensuring compliance
- Working in partnership with the Police
- Supporting the lone working agenda within the Trust
- Body Worn Camera system management

Emergency Preparedness, Resilience and Response

- Planning, reviewing and implementing Emergency Planning arrangements
- Reviewing and updating guidance in respect of Heatwave Planning
- Reviewing and updating guidance in respect of The Cold Weather Plan
- Working in partnership with NHS Improvement regional and national EPRR Teams
- Reviewing and improving Business Continuity Processes

In respect of this, the challenge of capacity and demand is significant, and this is a risk to delivery of all of the tasks above. However in law we believe that the team achieves a reasonably practicable outcome for the resources at its disposal, acknowledging there is always a new ask, based on the incidents and activity it is exposed to.

The Safety Team actively escalate risks as appropriate through the Trust's Risk Management processes, none of which have required escalation to the Board of Directors for concern.

3. Recommendation/summary

The Trust's Safety Team continues to work to mitigate the safety and security risks faced both internal / external to the organisation. As the organisation continues its journey of development, and the NHS as a whole goes through major transformational change, it is acknowledged that safety and security remains paramount and on the highest level of all agendas throughout the Trust.

In short, safety and security need to be considered by all levels of staff from the Board to the ward and the understanding at each level of the organisation for the parts to play to continue to improve the quality and safety of care that is delivered within the resources we have available. COVID 19 has brought a new dimension to the risk assessments that are being conducted for both people and place and the Safety Team is well placed to support this.

All of the Trusts Safety and Security systems have adapted well in the new era of living with COVID and will continue to do so based on any change to local or national guidance. This paper should be received for information.

Tony Gray
Head of Safety, Security and Resilience

Gary O'Hare
Chief Nurse (Security Management Director)

25th July 2021

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Report to the Board of Directors
4th August 2021

Title of report	Staff Friends and Family Test Summary Quarter One 2021/22
Report author(s)	Ross Phillips, Senior Information Analyst
Executive Lead (if different from above)	Lynne Shaw, Executive Director of Workforce & OD 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	
To achieve “no health without mental health” and “joined up” services		Sustainable mental health and disability services delivering real value	
To be a center 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	28/07/21
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	26/07/21
CDT – Business	
CDT – Workforce	19/07/21
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	x
Financial/value for money		Estates and facilities	x
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness	x	Service user, carer and stakeholder involvement	x

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

Key Points to Note:

- Please note the Staff Friends and Family Test questions were not requested for completion by staff during quarter one 20/21 due to COVID-19 pandemic
- This paper includes the results of the quarter one 20/21 Staff Friends and Family Test Survey administered to all staff accessing the Trust network via a CNTW Login.
- The Trust response rate this quarter was 43% which is a minimal decrease compared to quarter four 20/21 of 44%.
- There was a decrease in positive responses to the question "How likely are you to recommend the organisation to friends and family as a place to work?" decreasing to 74% from 76% in quarter four 20/21.
- There was a decrease in positive responses to the question, "How likely are you to recommend our services to friends and family if they needed care or treatment?" decreasing to 78% from 80% in quarter four 20/21.
- From July 2021 the Staff FFT will be replaced with a Quarterly Staff Survey for the months of July, Jan and April. This will contain additional questions to the current two Staff FFT questions. Annual Staff Survey will remain in quarter three each year.

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CNTW Staff Friends and Family Summary Report

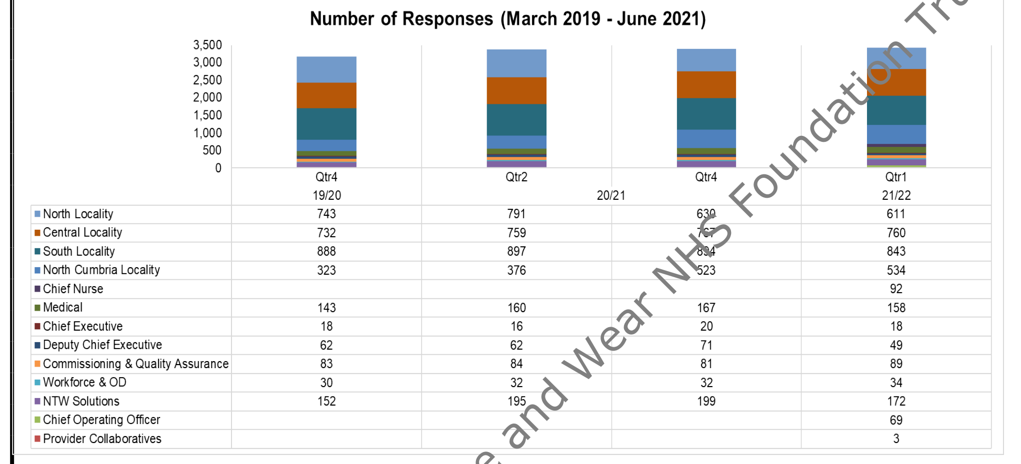
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Reporting period:	Q1 21/22

Staff FFT - Responses and Uptake

Number of surveys distributed	9,030	
Number of responses	3,848	
Trust	Response - %	↓1%
North Locality	Response - %	↓3%
North Cumbria Locality	Response %	↓1%
Central Locality	Response %	↔0%
South Locality	Response - %	↓2%
Deputy Chief Executive	Response %	↓11%
Chief Nurse	Response - %	-
Medical	Response - %	↓6%
Commissioning & Quality Assurance	Response - %	↑3%
Workforce & OD	Response - %	↑ 1%
Chief Executive	Response - %	↓5%
NTW Solutions	Response - %	↓5%
Chief Operating Officer	Response - %	-
Provider Collaboratives	Response - %	-

Feedback responses



	Qtr4 19/20	Qtr2 20/21	Qtr4 20/21	Qtr1 21/22
North Locality	743	791	630	611
Central Locality	732	759	7[illegible]7	760
South Locality	888	897	8[illegible]4	843
North Cumbria Locality	323	376	523	534
Chief Nurse				92
Medical	143	160	167	158
Chief Executive	18	16	20	18
Deputy Chief Executive	62	62	71	49
Commissioning & Quality Assurance	83	84	81	89
Workforce & OD	30	32	32	34
NTW Solutions	152	195	199	172
Chief Operating Officer				69
Provider Collaboratives				3

The Staff Friends and Family Test (FFT) asks respondents 'How likely are you to recommend the

Trust overall score	74%	↓ Compared to last quarter
Previous quarter	76%	
National MH Average	66%	↔ Compared to quarter 2 19/20 (Sept 19)
National Average	66%	↔ Compared to quarter 2 19/20 (Sept 19)

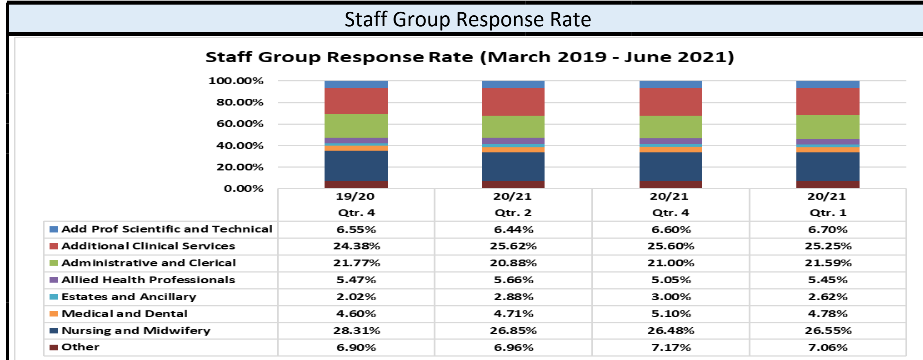
Note that a total of 7 Executive Directorate's received recommend scores of 74% or above in the

The Staff Friends and Family Test (FFT) asks respondents 'How likely are you to recommend our

Trust overall score	78%	↓ Compared to last quarter
Previous quarter	80%	
National MH Average	76%	↔ Compared to quarter 2 19/20 (Sept 19)
National Average	81%	↔ Compared to quarter 2 19/20 (Sept 19)

Note that a total of 9 Executive Directorate received recommend scores of 80% or above in the

Staff Group Response Rate



	19/20 Qtr. 4	20/21 Qtr. 2	20/21 Qtr. 4	20/21 Qtr. 1
Add Prof Scientific and Technical	6.55%	6.44%	6.60%	6.70%
Additional Clinical Services	24.38%	25.62%	25.60%	25.25%
Administrative and Clerical	21.77%	20.88%	21.00%	21.59%
Allied Health Professionals	5.47%	5.66%	5.05%	5.45%
Estates and Ancillary	2.02%	2.88%	3.00%	2.62%
Medical and Dental	4.60%	4.71%	5.10%	4.78%
Nursing and Midwifery	28.31%	26.85%	26.48%	26.55%
Other	6.90%	6.96%	7.17%	7.06%

Please note the Staff FFT questions were not requested for completion by staff during Q1 20/21 due to the COVID-19 pandemic. It is also not completed during Q3 due to the Staff Survey.

Other key points relating to response volumes this quarter include:
- Central Locality (49%) received the highest response rate across clinical areas .
- NTW Solutions received the lowest response rate of 37% (172) across the trust.

Top 4 with the highest response rates were:
- Chief Executive 78% (18)
- Provider Collaborative 75% (3)
- Workforce & OD 71% (34)
- Chief Nurse 59% (92)

Staff FFT - Analysis

Would you recommend the Trust as a place to work?	Would you recommend the Trust for Treatment?

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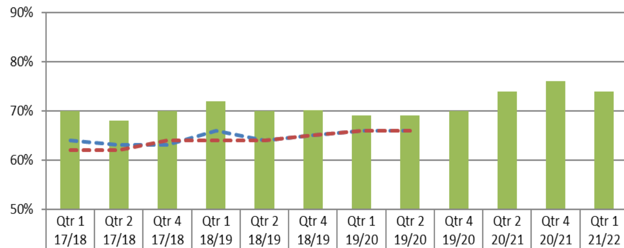
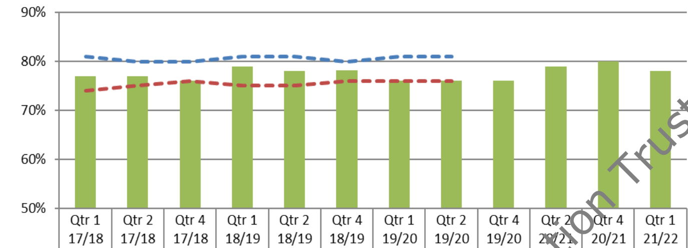


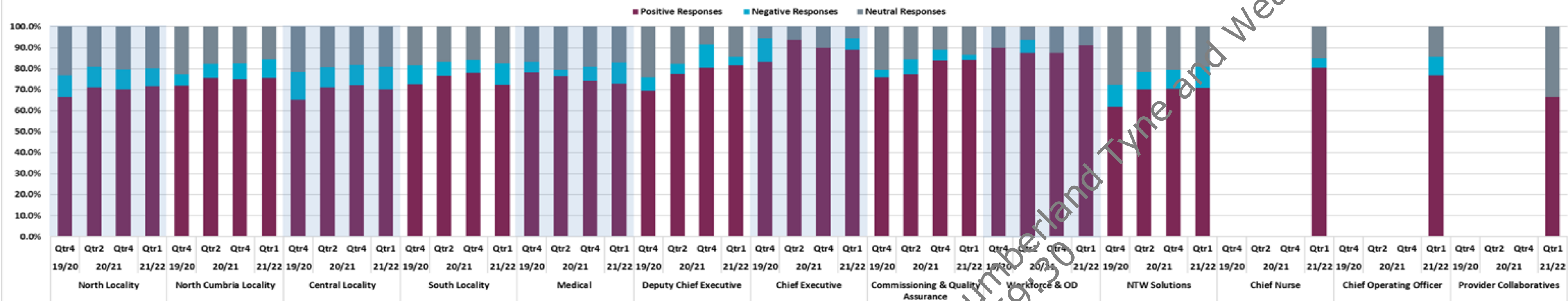
	Qtr 1 17/18	Qtr 2 17/18	Qtr 4 17/18	Qtr 1 18/19	Qtr 2 18/19	Qtr 4 18/19	Qtr 1 19/20	Qtr 2 19/20	Qtr 4 19/20	Qtr 2 20/21	Qtr 4 20/21	Qtr 1 21/22
CNTW Recommend Score - Work	70%	68%	70%	72%	70%	70%	69%	69%	70%	74%	76%	74%
National Average Recommend Score - Work	64%	63%	63%	66%	64%	65%	66%	66%				
National Mental Health Average Recommend Score - Work	62%	62%	64%	64%	64%	65%	66%	66%				



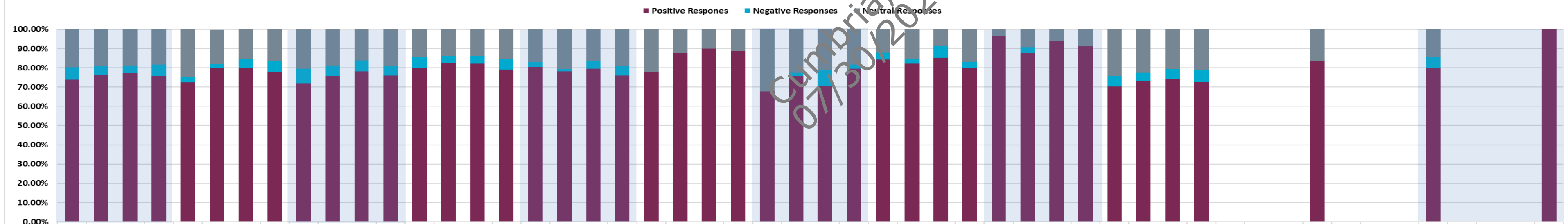
	Qtr 1 17/18	Qtr 2 17/18	Qtr 4 17/18	Qtr 1 18/19	Qtr 2 18/19	Qtr 4 18/19	Qtr 1 19/20	Qtr 2 19/20	Qtr 4 19/20	Qtr 2 20/21	Qtr 4 20/21	Qtr 1 21/22
CNTW Recommend Score - Care	77%	77%	76%	79%	78%	78%	76%	76%	76%	79%	80%	78%
National Average Recommend Score - Care	81%	80%	80%	81%	81%	80%	81%	81%				
National Mental Health Average Recommend Score - Care	74%	75%	76%	75%	75%	76%	76%	76%				

Please note: National data is yet to be published due to the COVID-19 pandemic. Most recent published data is for Q2 19/20. FFT was suspended nationally in Q1 20/21, but optional for Trusts since Q2

Would you recommend the Trust as a place to work?



Would you recommend the Trust for Treatment?



Cumbria Northumberland Tyne and Wear NHS Foundation Trust # 570372
07/30/2021 09:59:30

Qtr4 19/20 | Qtr2 20/21 | Qtr4 20/21 | Qtr1 21/22 — North Locality · North Cumbria Locality · Central Locality · South Locality · Medical · Chief Executive · Deputy Chief Executive · Commissioning & Quality Assurance · Workforce & OD · NTW Solutions · Chief Nurse · Chief Operating Officer · Provider Collaboratives

Themed Work Comments

Theme Category	Theme Rating	Total	% of Responses
Staff Feedback - Organisation Change	Neutral	3	0.50%
	Negative	2	0.33%
Staff feedback - Patient Care	Negative	66	11.93%
	Neutral	48	8.20%
	Positive	2	0.33%
Staff feedback - Policy and Practice	Neutral	94	17.44%
	Negative	87	15.79%
	Positive	4	0.67%
Staff feedback - Wellbeing	Negative	117	22.70%
	Neutral	105	19.13%
	Positive	17	2.80%
	Compliment	1	0.17%
Grand Total		**485**	**100.00%**

Key Points:

Themed Treatment Comments

Theme Category	Theme Rating	Total	% of Responses
Staff Feedback - Organisation Change	Neutral	2	0.37%
	Negative	2	0.36%
Staff feedback - Patient Care	Negative	177	37.41%
	Neutral	149	32.81%
	Positive	14	2.91%
	Compliment	1	0.18%
Staff feedback - Policy and Practice	Neutral	38	7.43%
	Negative	31	5.99%
Staff feedback - Wellbeing	Negative	35	6.55%
	Neutral	30	5.45%
	Positive	3	0.54%
Grand Total		**437**	**100.00%**

Key Points:

Cumbria, Northumberland Tyne and Wear NHS Foundation Trust # 570372
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Report to Board of Directors
4th August 2021

Title of report	**Update on CQC Must Do Action Plans (Quarter 1)**
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	28/07/21
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	02/08/21
Corporate Decisions Team (CDT)	
CDT – Quality	
CDT – Business	
CDT – Workforce	
CDT – Climate	
CDT – Risk	
Business Delivery Group (BDG)	03/08/21

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: The Trust will be the centre of excellence for mental health and disability. Risk 1688 Due to the compliance standards set from NHSI, CQC and legislation there is a risk that we do not meet and maintain standards which could compromise the Trust’s statutory duties and regulatory requirements. Risk 1691: As a result of not meeting statutory and legal requirements regarding mental health legislation this may compromise the Trust’s compliance with statutory duties and regulatory requirements.

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Update on CQC Must Do Action Plans

Board of Directors

4th August 2021

1. Executive Summary

This report provides an update on the 34 remaining areas of improvement (Must Do action plans) which were received following inspections undertaken during 2015, 2017, 2018, 2019 and 2020. Between August 2020 and May 2021 the Board of Directors agreed to close 13 of the 47 areas of improvement identified from these inspections.

Action plans specific to the North Cumbria Locality and those relating to the 2020 focused inspections (wards for people with learning disabilities or autism and child and adolescent mental health wards) continue to be monitored through the Locality Care Groups and Trust governance structures.

The report seeks approval from the Board of Directors that there is sufficient evidence and assurance to close five action plans listed as **appendix 1** relating to medicines optimisation, nurse call systems, section 17 leave and the use of mechanical restraint within learning disability and autism services.

On the 14th July 2021 the Trust returned to Opel 2 due to staffing pressures. Therefore the Executive Directors have agreed to re-open across all core services all must do action plans relating to staffing levels (see page 26).

At its May meeting the Board of Directors agreed to extend further the deadlines for those must do action plans that relate to quality and training standards to ensure alignment with the trajectories. When the Trust returned to Opel 2, all training and appraisals were paused due to current staffing pressures. Through the quarterly update the Board are asked to extend further those must do action plans relating to blanket restrictions, staff engagement, environmental issues and consent to medical treatment to enable further assurances to be gained that there has been an improvement.

Work continues to address each of the remaining action plans and the key pieces of work identified in the Quarter 1 update (appendix 2) will help to mitigate against the risks which have been raised.

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.

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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 five action plans listed in appendix 1 recognising the Trust will continue to monitor the impact of previous actions through appendix 2.
- Approve the date extension for must dos relating to blanket restrictions, staff engagement, environmental issues and documentation of consent to medication treatment.
- Note the reopening of all must do action plans in relation to staffing levels.
- Note the Quarter 1 updates on all 47 CQC must do action plans (including impact changes for those closed) listed within appendix 2.

Author:
Vicky Grieves, CQC Compliance Officer

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

22nd July 2021

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Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained **under the Mental Health Act 1983** **Treatment of disease, disorder or injury**	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **How the regulation was not being met:** 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.

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 adopt the policies and procedures for medicines management at CNTW ensuring appropriate audits and governance is in place.	
Who is responsible for the action?	Tim Donaldson, Chief Pharmacist
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?	
Audit to be undertaken to ensure adherence.	
Who is responsible?	David Muir, Group Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	30th June 2021
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
Risk to patients due to side effects.	
Recommendation:	
Complete and remaining actions transferred to Valproate Oversight Group for oversight and embedding of standards contained within PPT-PGN-25.	

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Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment**
	How the regulation was not being met:
	The trust must ensure patients have access to a nurse call system in the event of an emergency.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

- Baseline position of current Trust-wide nurse call systems.
- "Optimum standard" agreed for nurse call system for *acute wards for adults of working age and psychiatric intensive care units* that takes into account key features of the DoH Health Building Notes 03-01: Adult acute mental health units and Accreditation for Inpatient Mental Health Services (AIMS).
- Costings and timescales calculated to achieve the "optimum standard" for the *acute wards for adults of working age and psychiatric intensive care units.*
- Identified distance from "optimum standard" for all other inpatient core mental health services (cost, timescale and risks).
- Develop practice guidance note for the effective use of "optimum standard" nurse call systems.
- Work with regional and national providers to develop proposals re: appropriate/acceptable nurse call standards/systems for all service users within core service lines.
- Commence the installation of appropriate nurse call systems within the existing *acute wards for adults of working age and psychiatric intensive care units.*
- Updates will be provided to the CQC on a quarterly basis.

Who is responsible for the action?	Russell Patton, Deputy Chief Operating Officer Paul McCabe, Managing Director, NTW Solutions

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?

- Having agreed the "optimum standard" for the core service area, an implementation plan for the remaining acute wards for adults of working age and psychiatric intensive care units that do not have comprehensive coverage will be developed and actioned.
- We will ensure that service users have access to appropriate/acceptable nurse call standards/systems agreed both regionally and nationally within core service lines.

Who is responsible?	Russell Patton, Deputy Chief Operating Officer Paul McCabe, Managing Director, NTW Solutions

What resources (if any) are needed to implement the change(s) and are these resources available?

Two discrete costing exercises are being undertaken:

1) To identify costs to achieve the "optimum standard" for all of the existing *acute wards for adults of working age and psychiatric intensive care services.*
2) Ascertain costs associated with other inpatient core mental health services.

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Date actions will be completed:	Extended to 30th June 2021 to incorporate services transferred from North Cumbria
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
If we fail to address this “must do” then a number of service users will not have comprehensive access to nurse call systems during their period of inpatient stay.	
Recommendation:	
• Installation of nurse call systems have been completed across all acute wards for adults of working age and PICU across the CNTW patch. • Further conversations between NTW Solutions and other clinical service areas will take place during Quarter 2 and 3 to agree priorities and next steps linked to the available capital budget for 2021/22.	

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Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained **under the Mental Health Act 1983** **Treatment of disease, disorder or injury**	**Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment** **How the regulation was not being met:** The provider must ensure that all section 17 leave forms are individually completed for each patient and show consideration of patient need and risks.
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 work with the older people's wards to ensure Section 17 leave is patient centred and considers the risks of each individual patient.	
Who is responsible for the action?	Elaine Fletcher, Group Nurse Director Theme Lead: Dr Patrick Keown, Group Medical 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?	
North Cumbria monitor these weekly and action is taken where there are compliance issues. These are also reviewed at regular intervals within the North Cumbria inspection action group.	
Who is responsible?	Elaine Fletcher, Group Nurse Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
Date actions will be completed:	30th June 2021
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
Lack of clarify around purposeful leave Human rights	
Recommendation	
Recommendation to close this action, due to the assurance provided by the audit, the downward trend in number of expired Section 17 leave forms and the processes for monitoring this information that are now in place.	

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Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Diagnostic and screening procedures** **Treatment of disease, disorder or injury**	**Regulation 17 Good governance** **How the regulation was not being met:** 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. Regulation 17.2 (a)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Core Service Actions
The Ward Managers will be responsible to ensure all staff on Rose Lodge and Mitford adhere to the Trust's Positive and Safe approach. This expects the staff to use least restrictive interventions when caring for patients who exhibit behaviours that are challenging to manage.

This is underpinned in the Trust's Prevention and Management of Violence and Aggression policy CNTW (C) 16 (PMVA) and Practice Guidance note PMVA-PGN-01 which explicitly set out the responsibility and accountability expectations for staff and the primary safeguards they must apply when considering the use of Mechanical Restraint Equipment (MRE).

Staff at Rose Lodge and Mitford have received Positive and Safe training and we are continuing to increase the number of staff trained in the use of MRE. The completion of this training will enhance the safe care of patients and further support our staff's knowledge and responsibilities.

Duty rota's are managed to support a minimum safe number of MRE staff trained on duty per shift.

Trust-wide Actions
The Trust has undertaken a review of the use of MRE.

The current MRE PGN will be reviewed to reflect the findings from the report and recent national documents related to restraint reduction.

Who is responsible for the action?	
	Vida Morris, Group Nurse Director – North Locality Group Karen Worton, Group Nurse Director – Central Locality Group Anthony Deery, Group Nurse Director – South Locality Group Elaine Fletcher, Group Nurse Director – North Cumbria Locality Group

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?

Core Service Actions
The CQC action plans will be reviewed weekly at Rose Lodge and Mitford. These meeting will review progress; test the impact the actions are having and identify any additional actions to support continuous improvement.

Following each episode of MRE use the Clinical Manager will complete a review of the process to ensure the safeguards have been adhered to.

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Clinical Manager will work with CNTW Academy to ensure the training is achieved and trajectories monitored. CBU to be made aware of any exceptions. **Trust-wide Actions** All locality services have been directed to review the use of restrictive interventions annually within their services and produce a rationale for its use including an indication of compliance with relevant policy. This will be incorporated within the Positive and Safe care annual report. All wards using MRE will meet the Trust training standard. The Trust wide Positive and Safe Group will keep under review the Positive and Safe Dashboards and review all episodes of the use of MRE. Locality Groups will include a MRE section in their reports to the Trust's Quality and Performance Committee.	
Who is responsible?	Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
MRE Training - the training is physically interactive and therefore has been suspended due to the COVID-19 pandemic. As part of the next phase the Trust is looking at how training of this nature can be re-established using PPE. The Pilot is due to commence in late June and we expect to have results by September at which point the Training trajectories will be revised.	
Date actions will be completed:	30th June 2021
Recommendation	
Recommendation to close action plan. With the exception of Mitford within autism services, MRE continues to reduce within learning disability pathways across the Trust.	

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Regulated activity(ies)	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 **Treatment of disease, disorder or injury**	**Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment** **How the regulation was not being met:** 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.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
All environments to be reviewed and action plans put in place to address shortfalls.	
Who is responsible for the action?	Paul McCabe, Director of Estates and Facilities
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?	
CERA to be completed and monitored. Linked to inpatient model.	
Who is responsible?	Elaine Fletcher, Group Nurse Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
Cost of works to be undertaken.	
Date actions will be completed:	30st June 2021
Recommendation	
Recommendation to close. There is a different patient group utilising this ward since the original inspection was undertaken. There were two issues, line of sight and nurse call, the line of sight is mitigated by strategically placed mirrors and a nurse call system is in place.	

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Must Do Theme: (1) Personalisation of care plans	Lead: Vida Morris, Group Nurse Director
Planned timescale for closure: 31 March 2022	
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 at core service level during Quarter 4 20/21 (January, February & March):

As per Trust-wide response.

Actions taken Trust-wide during Quarter 4 20/21 (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.

Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):

- Roll out of visual materials i.e. posters and booklet.
- Roll out of training materials commenced in June 2021.
- Audit to be revisited pre and post new training materials to demonstrate any changes in practice. Audit commenced for pre training materials on 21/06/21 Trust-wide.
- Train the trainers session completed.

Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September):

- Additional animation to support training being completed during July 2021.
- Training roll out to be completed by end of Quarter 2 focussing on key areas (Learning Disability / Autism / CYPS) and to broaden to all clinical areas (Inpatient, Community, Access).
- Post training audit to be completed Trust-wide
- Review of documentation following evaluation of all new training materials

Evidence of Impact:

The metric for the number of current service users who have discussed their care plan has slightly improved in the North and Central localities during Quarter 1:

- North Cumbria Locality – 82% (March), 82% (June)
- North Locality – 93% (March), 94% (June)
- Central Locality – 92% (March), 93% (June)
- South Locality – 89% (March), 89% (June)

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Care planning was identified as an issue in 2 of the 10 wards visited by MHA Reviewers during Quarter 1.
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 August 2021 (30 September 2021)		
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 at core service level during Quarter 4 20/21 (January, February & March):		
As per Trust-wide response.		
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):		
• Policy ratification communicated via Trust Policy Bulletin. • A sample audit of restrictions with reason care plans was completed for Secure Care Learning Disabilities Services. Where in place there was evidence of personalisation with no blanket restrictions.		
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):		
• Blanket Restriction Registers to be held on Safer Care Intranet page. • Reintroduction of Peer Review process (maintaining IPC standards) when COVID-19 restrictions allow increased footfall across wards. • A snap shot review of Blanket Restriction Registers was completed for compliance with policy and CQC MHA Review Visit findings. • Monitoring of Blanket Restrictions and Restrictive Practice Incident Reporting ensures use of correct cause category BR01 or BR02.		
Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September):		
• A Blanket Restriction Register Dashboard is being created by Safer Care Team by end of July 2021. Wards will complete a monthly online submission form which will include the incident reporting number. • Peer Reviews have recommenced and will be completed by end of September 2021. The Peer Review schedule is now held centrally by the CQC Compliance Officer. • Agree standardised approach to Blanket Restriction Induction Training at a local level with CNTW Academy. • Policy to be refreshed to include introduction of dashboard reporting.		
Evidence of Impact:		
One concern relating to blanket restrictions was identified out of 10 MHA Reviewer visits during Quarter 1. This related to locked doors and a corridor on the ward being locked off limiting access to activity room and courtyard.		
Status:		
Further action required to make improvements. It is requested that an extension be given to end of September 2021 to this Must Do action to enable further assurances to be gained that there has been an improvement.		

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Must Do Theme: (3) Restrictive practices, seclusion and long term segregation	**Lead: Anthony Deery, Group Director & Ron Weddle, Deputy Director – Positive and Safe**
Planned timescale for closure: 30 September 2021	
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.
Planned timescale for closure: 30 September 2021	
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
Planned timescale for closure: 30 June 2021	
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
Planned timescale for closure: 31 December 2021	
CAMHS wards Year: 2020 Org: CNTW	The Trust must review the use of restraint and mechanical restraint in the Children and Young People'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.
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
LD and Autism wards 2019	• North Cumbria Locality completed an audit in February 2021 measuring against *'Restraint reduction policy - a policy to meet the requirement of Seni's law'*. A total of 144 restraint incidents were reviewed over the past year to investigate if there was a corresponding entry on RiO which detailed the body map. The body map must detail the holds and any markings or injuries. Recommendations from audit include: – All staff reminded of the current policy – All wards to ensure the correct version of the body map is used to ensure consistency of information detailed – Further work to be completed to identify if the body map could be available as part of RiO rather than ward staff having to upload a separate document – A smaller monthly audit to be implemented on selected cases to monitor change with a further full audit to be repeated in 3 months • Audit to be repeated during Quarter 1. • Consider during Quarter 1 whether audit should be carried out Trust-wide.
LD and Autism wards 2020	• 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.

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	• 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 Chief Nurse. • In March 2021 the Trust established a Long Term Segregation and Prolonged Seclusion Review Panel. The panel has oversight of all episodes of LTS and Prolonged Seclusion in the Trust and the review process will provide support to clinical teams, service users, families and carers and assurance to the Trust Board. The panel will also escalate cases where required with the newly established Clinical Ethical Group of the Trust. • 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 was considered at the February QRG by our commissioners and continues to be monitored through Trust governance structures. • Safety Pods have been introduced to 30 wards across the Trust. The use of Safety Pods within older people's services is being piloted on Castleside and Woodhorn wards and an evaluation will be undertaken following the six week pilot. • The installation of the Oxehealth system is complete and functional across the three pilot wards within Hopewood Park (Longview, Beckfield and Shoredrift), apart from 2 seclusion areas which have been occupied for some time. A fourth ward has also been equipped, Lotus ward the Trust's new CYPS facility based in Middlesbrough.
CAMHS wards 2020	• All inpatient areas completed a baseline audit to measure compliance against policy with debrief post any tertiary intervention and MRE. Audit carried out included both staff and patient debrief. Percentage of compliance varied across all ward environments ranging from 7%– 57%. Higher percentages were where MRE had been used i.e. more likely to be a debrief post MRE. Some fundamental issues regarding lack of understanding between post incident support and debrief and interpretation of policy identified.

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	• Trust-wide working group established to consider outcomes of debrief audits to inform CBU action plans to improve compliance with policy. • First meeting took place on 23 February 2021 and was attended by all localities with Associate Nurse Director's leading within own localities in developing a Trust wide response. Focus of the working group centred on: – Knowledge of policy – Education and training needs for staff carrying out debrief / Post incident support – RiO documentation (storage and completion) – Debrief documentation that is attached to policy – Learning from CYPS – Formulation and care planning i.e. how good quality debrief supports formulation / care planning
Actions taken at core service level during Quarter 4 20/21 (January, February & March):	
CAMHS wards 2020	• Task and Finish Group reviewed restraint data to better understand initial hypotheses for increases and involve the wider MDT to provide a narrative around the clinical presentations and interventions used within the service. • Ward Managers discussed report with staff to be clear about the expectations to review and reduce the use of mechanical restraint. • Ward Managers contacted all family members to seek feedback in regards to restraint and the findings of the report. • Group Directors and Ward Managers reviewed Talk 1st data to highlight themes and trends. • All use of mechanical restraint agreed and regularly scrutinised at Group Director level. All use of mechanical restraint are reviewed at After Action Reviews which are attended by a Group Director, to offer challenge and scrutiny.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June)	
LD and Autism wards 2019	• Further work to be completed to identify if the body map could be available as part of RiO rather than ward staff having to upload a separate document • A smaller monthly audit to be implemented on selected cases to monitor change with a further full audit to be repeated in 3 months. • Consider during Quarter 1 whether audit should be carried out Trust-wide.
LD and Autism wards 2019	• The newly established Empower Programme Board will coordinate all actions in relation to restrictive practices. • The formal membership and articulation of priorities for each of the 4 elements (HOPEs model, Positive and Safe, Human Rights and Trauma Informed approaches) will be developed during Quarter 1. • Areas which are already contributing to reducing restrictive practices are elaborated below: – Continue to establish and embed the LTS panels and review its impact on restrictive practices within the Trust. – Embed the Clinical Ethical Group and disseminate any Trust-wide learning.

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	– Further embedding of Safety Pods. – Continue to roll out PAUSE training at Trust induction during Quarter 1 and 2. – Continue to offer Post Graduate Certificate in Reducing Restrictive Interventions which is a joint development by CNTW, TEWV and Cumbria University – current cohort of staff are due to qualify in September 2021 and the next course is already significantly over subscribed.
CAMHS wards 2020	• Review of policy – format of debrief/post incident support to be altered to reduce to four questions (Is everyone safe, what happened, what went well, what do we need to do differently or what did we learn). Completed with Trust-wide representation. • Short training session to be incorporated into supervision agenda to ensure application of policy. • Formal audit tool and baseline assessment completed. • RiO – support to link debrief into case note / progress notes – action to be carried forward into Quarter 2 and 3.
Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September):	
LD and Autism wards 2019	• A scoping meeting to be held with identified lead to review audit tool and timescale for rolling out Audit Trust-wide. • Communication to all staff regarding the Policy, reinforcing the need for body maps after each incident of restraint. • North Cumbria has implemented a draft Audit, the first results have been completed and shared with teams and these have been reviewed within the CBU's.
LD and Autism wards 2020	• The Long Term Segregation and Prolonged Seclusion Review Panel is in place and will continue to, review cases across the Trust on a weekly basis, provide assurance to the Board and promote learning across the Trust around this area of practice. • With the exception of Mitford within autism services, MRE continues to reduce within learning disability pathways across the Trust. • The first meeting of the Empower Board was held on 20th July 2021 where updates were received from the four work stream areas including Long Term Segregation, Positive and Safe, Human Rights and Trauma Informed Approaches. • Plans have been identified to progress each of the priorities in the work stream areas. • Trust Innovation will be liaising with the work stream sponsors to project manage the programme.
CAMHS wards 2020	• Amendments to Policy and new templates to be submitted and agreed by Policy owner. • Supervision crib sheet re carrying out debrief to be agreed and circulated. • Pictorial debrief to be included within appendix. • Audit to be carried out to measure fidelity to Policy.
Actions taken at core service level during Quarter 1 21/22 (April, May & June):	
CAMHS wards 2020	• All staff to be trained in the CNTW Empower Programme which brings together initiatives such as Positive and Safe, Human Rights, Trauma Informed Care and HOPEs Model and will ensure the roll-out of this methodology across all Children and Young People's services. Three staff members have enrolled

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	for HOPEs training, one at each CYPS inpatient site. Training begins week commencing 28/06/21. • Individualised care plans continue to be reviewed and discussed in multi-disciplinary meetings; this includes patient and carer involvement, and will be evidenced and audited. • Clinical Lead Nurse continues to provide scrutiny and case load supervision to improve compliance with safeguards and embed review process. • CBU continue to review the de-brief process to ensure a robust de-brief happens after each incident of restraint, for both staff and young person involved. Clinical Nurse Managers to review the debrief process with a view to ensuring the full post incident review process happens after every incident.
Planned future actions to be taken at core level during Quarter 2 21/22 (July, August & September)	
CAMHS wards 2020	• Identified staff will attend HOPEs training. • The training programme for the CAMHS accredited training continues and a programme for staff attending has been agreed. The next cohort of CYPS accredited training to start in August 2021. • A process was implemented following the inspection where it was agreed that an After Action Review would take place after each MRE incident. At a recent review it was recognised that there were issues around the operational implementation and monitoring of the process. A robust process will be implemented and monitored through CBU and locality Quality Standards meeting. • Clinical Nurse Managers continue to carry out audits of all post incident debriefs and review the quality and frequency to ensure that these occur after every incident and that the standards are always as we would expect. Where debrief is declined by the patient there is an attempt to engage the patient in an informal discussion and reflection on the incident by nursing staff. • On occasions where staff decline de-brief this is addressed as part of clinical supervision to encourage engagement and also provide the opportunity for staff to have an informal debrief through discussion with their supervisor. • Debrief processes require further embedding and from July 2021 incidents and debriefs are to be reviewed monthly as part of the CYPS operational and governance meetings and presented quarterly to the locality Quality and Safety meeting.
Evidence of Impact:	
Current episodes of Long Term Segregation/Prolonged Seclusion 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 – 4 • Long stay rehabilitation ward for working age adults – 1	

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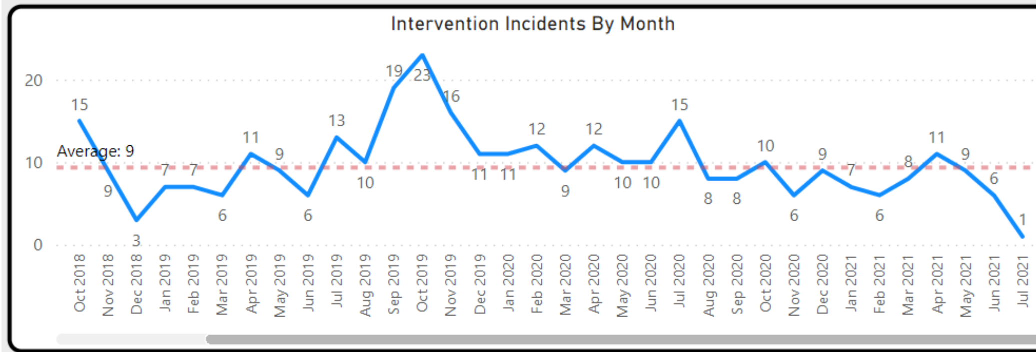
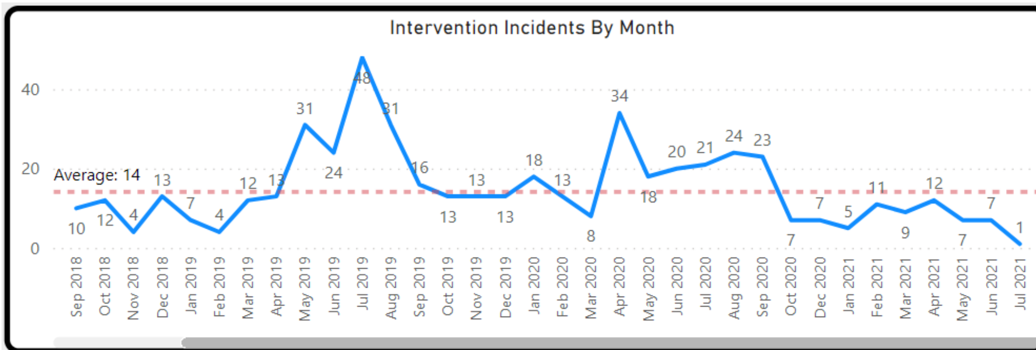
MRE use across Learning Disability and Autism wards:



MRE use across Child and Adolescent Mental Health wards:



Compliance with staff and patient debriefs in Children and Young People's Inpatient services is as follows:

- Ashby
  In June 2021, 15% of staff debriefs were completed. A further 29% were offered but were declined. 9% of young person debriefs were completed. A further 53% were offered but declined.

- Lennox
  In June 2021, 8% of staff debriefs were completed. A further 15% were offered but were declined. 23% of young person debriefs were completed. A further 23% were offered but declined.

- Fraser
  In June 2021, 100% of staff debriefs were completed and 13% of young person debriefs were completed. A further 80% were offered but were declined.

- Stephenson
  In June 2021, 60% of staff debriefs were completed and 69% of young person debriefs were completed. 0% were declined by staff and patients.

- Redburn
  In June 2021, 45% of staff debriefs were completed. A further 7% were offered but were declined. 35% of young person debriefs were completed. A further 7% were offered but declined.

- Redburn PICU
  In June 2021, 53% of staff debriefs were completed. 18% of young person debriefs were completed. 0% were declined by staff and patients.

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Status:	
LD & Autism wards Year: 2020 Org: CNTW	Propose to close action at Board of Directors on 4 August 2021.
LD & Autism wards Year: 2020 Org: CNTW	Ongoing further action required to make improvements in relation to Long Term Segregation and Seclusion safeguards.
CAMHS wards 2020	Ongoing further action required to make improvements in relation to MRE use.

Must Do Theme: (4) Appraisal and training	**Lead: Russell Patton, Deputy Chief Operating Officer** **Supported by: Marc House, Head of CNTW Academy**
Planned timescale for closure: 31 March 2022	
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 at core service level during Quarter 4 20/21 (January, February & March):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
Community LD	Consultation of New Appraisal Policy took place in January 2021 however rollout was deferred until April 2021.
Community CYPS LD & Autism wards	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.
Actions taken Trust-wide Quarter 1 21/22 (April, May & June):	
• Rollout for the New Appraisal Policy and training package developed. • The Academy will continue to offer relevant and sufficient training places to meet the targets required and support staff to access e-learning. • Training continues to be offered via Teams where face to face is currently not viable due to current restrictions on work practices.	
Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September):	
• During 21/22 there has been a concerted effort throughout the organisation in both clinical and non-clinical service areas to ensure high levels of training compliance within the mandatory training fields with a particular focus given to achieving the Information Governance compliance level of 95% by the end of June 2021 (this has been achieved). In addition, we are producing a report from the dashboard which confirms monthly those staff who will be non-compliant in their Information Governance training, this will allow for ongoing monitoring rather than a once a year annual focus. • Having reviewed the current Accountability Frameworks along with the training dashboards it has been agreed that the following areas will have a particular focus	

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during Quarter 2: Appraisals, Fire, Safeguarding Children level 3, Mental Health Act / Mental Capacity Act / DOLs. • Every week bespoke data will be obtained on these four priorities and considered by a representative group from clinical, corporate, and training departments. Progress against these training requirements will be shared with the responsible Directors on a regular basis. On the 14th July 2021 the Trust returned to Opel 2 and all training and appraisal were paused due to current staffing pressure.
Evidence of Impact:
• The standards for the following training courses have improved across the groups during Quarter 1 but remain below standard: Clinical Risk, Clinical Supervision, Safeguarding Children (level 3), Rapid Tranquilisation and Information Governance. • The standards for the following training courses remain below standard across the groups during Quarter 1: Safeguarding Children, MHCT Clustering, Mental Capacity Act/Mental Health Act/DOLS combined, Seclusion, PMVA Breakaway and PMVA Basic. • Appraisal compliance has improved within the Central and South Localities and Support and Corporate Directorates during Quarter 1: o North Cumbria Locality - 72.2% (March), 70.3% (June) o North Locality - 77.4% (March), 76.8% (June) o Central Locality - 72.3% (March), 75.1% (June) o South Locality - 83.9% (March), 85% (June) o Support and Corporate - 64.8% (March), 67% (June)
Status:
Ongoing further action required to make improvements.

Must Do Theme: (5) Clinical supervision	**Lead: Dr Esther Cohen-Tovee, Director of AHPs & Psychological Services**
Planned timescale for closure: 31 March 2022	
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 at core service level during Quarter 4 20/21 (January, February & March):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
• Audit report and recommendations completed and approved at CSOG (Clinical Supervision Oversight Group) on 25/03/21. • Recommendations for further improvements arising from Trust-wide audit shared with CBUs via CBU CSOG representatives for action. • These recommendations include that clinical supervision dashboard reports for all services are regularly reviewed at CBU meetings; to be implemented by 01/07/21. • Audit recommendations regarding increasing the emphasis of the clinical supervisor's responsibility to record the date and the duration of clinical supervision on the online	

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recording system, within both clinical supervision full day and update training was completed in March 2021. • 2020 Clinical audit data regarding quality of clinical supervision and the supervisory relationship were very positive. • Clinical Audit report and recommendations submitted for the Trust Clinical Effectiveness Committee agenda for 06/04/21. • Quarter 4 clinical supervision figures have been escalated to CSOG CBU representatives for action ahead of the finalising of the audit report and recommendations. The audit report provided a more positive picture with 89% of staff confirming that a record was kept of the dates and durations of their supervision sessions, however the sample size is smaller with 30.1% eligible staff participating in the audit.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):

• Targeted dissemination of the audit results and report regarding the clinical supervisor recording the date and duration of clinical supervision using the online recording system (CSOG Chair and CBU CSOG representatives).
  o Audit report has been shared at BDG.
  o Communication for all clinical staff and managers was sent out in the Trust Bulletin on 29/06/21.
  o CBU representatives not in attendance at CSOG have been prompted to respond with an update and to confirm they were still the representative for their CBU.
• Operational services implement regular monitoring of recording of clinical supervision through dashboard reports, and support clinicians to meet Trust standards regarding recording dates and duration of clinical supervision (CBUs and relevant corporate services leads).
  o Some (but not all) CBU representatives have confirmed this is in place. Two CBUs have set up specific groups to monitor and lead on this. Staffing solutions are monitoring and have set up group supervision sessions to increase access to clinical supervision.
• The 2020/21 Trust-wide Clinical Supervision audit report and recommendations have been approved at Trust Quality and Performance Committee.
• In addition to the above, system changes have been agreed to make recording and compliance easier for qualified bank only staff.
• The possibility of reliance on paper records in some areas has been identified. Communications in the Bulletin on 29/06/21 emphasised paper records can no longer be used, and any services using paper records must fully utilise the online recording system by 01/08/21.

Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September)
• Training video to be produced and made available to facilitate and support use of the online recording system. • Revised user guide and FAQs to be produced. • CSOG to consider any ways in which the system can be simplified, if acceptable in terms of governance.
Evidence of Impact:
Clinical supervision figures have slightly improved in the North, Central and South localities during Quarter 1: • North Cumbria Locality – 46% (March), 46% (June) • North Locality – 45.2% (March), 52% (June) • Central Locality – 38% (December), 56% (June) • South Locality – 50% (December), 55% (June)

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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: 30 June 2021 (30 October 2021)	
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 4 20/21 (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. Action above is on-going and planned work is discussed in below.	
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• To undertake analysis of the data and information received as above and information to be taken for discussion at the Older Persons Strategic Clinical Network. • To request updated data with regard to capacity to consent (initiation and review of antipsychotics) to provide comparison • To review consent to treatment/capacity to consent within wider services across CNTW. • Consent and Capacity to continue to be monitored via the MHL Steering Group.	
Planned future Trust-wide actions to be undertaken during Quarter 2 (July, August & September):	
• To review within a task and finish group the various places on RiO that this information can be recorded and along with the RiO team explore whether there is another option for recording of consent to treatment and capacity to consent. • Within the task and finish group explore the contents of the consent to examination or treatment policy to establish whether this is being followed. Policy includes consent forms for completion including for those patients who lack capacity. • To establish if by using CRIS (Clinical Record Interactive System) we could extract data with regard to this issue from progress notes or other areas of the electronic record. • To undertake a mini audit of notes in Older People's community teams to assess compliance.	
Evidence of Impact:	
There has been an improvement in Quarter 1 for the metric within North Cumbria, and North with an improvement in compliance. In Central and South both show a slight deterioration within service users who had a discussion recorded at the point of their detention (metric 916). • North Cumbria Locality – 58% (March), 60% (June) • North Locality – 56% (March), 74% (June) • Central Locality – 65% (March), 59% (June) • South Locality – 76% (March), 72% (June) Issues with consenting to medical treatment was identified as an issue in 5 of the 10 wards visited by MHA Reviewers during Quarter 1.	
Status:	
Further action required to make improvements. It is requested that an extension be given to end of October 2021 to this Must Do action to enable further assurances to be gained that there has been an improvement.	

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Must Do Theme: (9) Environmental issues	Lead: Paul McCabe, Director of Estates and Facilities & David Muir, Group Director
Planned timescale for closure: 30 June 2021	
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.
Planned timescale for closure: 30 September 2021	
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.
Planned timescale for closure: 9 July 2021 (30 July 2021)	
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 June 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.
Planned timescale for closure: 30 April 2021	
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
Actions taken at core service level during Quarter 4 20/21 (January, February & March);	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
Long stay / rehab wards	Approval has been given to ensure the following wards have nurse call systems. The timing of the work will partly be dependent on COVID-19 restrictions. • Hadrian • Edenwood • Rowanwood • Yewdale (West Cumberland)
Adult acute wards	• Completion of 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.

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OP wards	Work on Oakwood 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 has been carried out along with the creation of a Patient Toilet at Portland Square. Lillyhall has now been occupied. • Assurances received from Cumbria Estates regarding the maintenance of medical equipment.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
Long stay / rehab wards	Nurse call system installations are well under way for Hadrian and Rowanwood wards and will be completed in April 2021. Edenwood is being used as a decant and so a Nurse Call system is not required at this point. Yewdale ward has a system fitted.
Adult acute wards	Work has been done in conjunction with the supplier of the anti-ligature door (Safehinge primera) as there was a concern regarding the bottom bracket. The issue has been resolved and a recommendation will be made on this product that it is suitable to install. The roll-out will be determined across the Trust on a prioritised basis (as determined by the Environmental Safety Group). Yewdale ward will be considered in the prioritisation.
MH crisis teams	Consideration being given to centralisation of 136 Suites into Carlton Clinic site. Various repairs have been done to suite in Whitehaven.
OP wards	The Oakwood scheme has started and is due for completion mid-June 2021.
Planned actions to be undertaken during Quarter 2 21/22 (July, August & September):	
Long stay / rehab wards	There is a different patient group utilising this ward since the original inspection was undertaken. There were two issues, line of sight and nurse call, the line of sight is mitigated by strategically placed mirrors and a nurse call system is in place.
Adult acute wards	Hadrian Business Case submitted to CDT-B and accepted. Estates and operational planning underway, work to begin in September 2021. Yewdale condition is being reviewed by estates in liaison with NCIC estates.
MH crisis teams	Plan is to submit a £35-38k business cases for work to bring up to standard the Whitehaven suite as an interim measure.
OP wards	The Oakwood scheme will be completed in July 2021.
Evidence of Impact:	
To further develop the evidence of impact.	
Status:	
Adult acute wards	Ongoing further action required to make improvements.
MH crisis teams	
OP wards	
Community OP	Closed at Board of Directors on 26 May 2021.
LD & Autism wards	Closed at Board of Directors on 4 November 2020.
Long stay / rehab wards	Propose to close action at Board of Directors on 4 August 2021.

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Must Do Theme: (10) Risk assessment and record management	**Lead: Andy Airey, Group Director**
Planned timescale for closure: 31 March 2022	
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 Org: CNTW	The trust must ensure that risk assessments are regularly updated to reflect current risk and needs of patients.
Actions taken at core service level during Quarter 4 20/21 (January, February & March);	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (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.	
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Update from the Risk Clinical Reference Group taken at BDG Safety February 2021. A further discussion to take place, but looking to support an 18 – 24 month project that would not just be able changing the risk tools, but also looking at culture. • To continue to monitor compliance with the metrics below for improvement. • FACE Risk Assessment Tool now live in North Cumbria the first metric below shows that this information is now pulling through and North Cumbria is now 91% compliant. There are no issues with compliance within any of the localities with regard to these metrics as at June 2021. • Regular Audits of information continue to take place across the Trust, which monitors compliance with the issues raised.	
Planned future actions:	
The rollout for the transition from GRIST to narrative FACE (Functional Analysis of Care environments) is scheduled to commence on the 19th July 2021. Following this go live date, there is a planned period of monitoring to ensure that the new way of working has embedded satisfactorily across the locality.	
Evidence of Impact:	
CPA service users with a risk assessment undertaken/reviewed in the last 12 months at Quarter 1: • North Cumbria Locality – 29% (March) FACE risk assessment only (GRIST) not pulling through information, 91% (June) • North Locality – 97% (March), 98% (June) • Central Locality – 96% (March), 98% (June) • South Locality – 98% (March), 98% (June) Service users with identified risks who have at least a 12 monthly crisis and contingency plan at Quarter 1: • North Cumbria Locality – 95% (March), 91% (June) • North Locality – 95% (March), 94% (June) • Central Locality – 95% (March), 95% (June)	

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• South Locality – 98% (March), 96% (June) Clinical risk and suicide prevention training standards at Quarter 1: • North Cumbria Locality – 68% (March), 71% (June) • North Locality – 87% (March), 88% (June) • Central Locality – 86% (March), 88% (June) • South Locality – 87% (March), 89% (June) Issues with risk assessments not being updated was identified as an issue in 1 of the 10 wards visited by MHA Reviewers during Quarter 1.
Status:
Monitor rollout of transition from GRIST to FACE which started on 19th July 2021.

Must Do Theme: (11) Staffing levels	**Lead: Anne Moore, Group Nurse Director**
Planned timescale for closure: 30 September 2021	
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.
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 20/21 (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 20/21 (April, May & June)	
As per Trust-wide response.	

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Actions taken Trust wide in Quarter 2 20/21 (July, August & September)	
Community CYPS Adult acute wards	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. New Consultant Psychiatrist has been appointed to Rowanwood.
MH crisis teams	No further action required.
LD & Autism wards	No further action required.

Planned actions to be undertaken Trust-wide during Quarter 2 21/22 (July, August & September):

The Trust is currently experiencing significant staffing pressures. These pressures are a result of unprecedented levels of staff absence (Covid staff sickness, Covid related self-isolations and non-Covid staff sickness), a high level of staff vacancies, increased patient acuity and bed pressures across the system. The Gold Command has been reconvened and is closely monitoring these staffing pressures.

A Trust-wide Recruitment and Retention Taskforce has been established to support and monitor the position. Actions include:

- Deployment of Business Continuity Plans to maintain safe staffing.
- Redeployment of staff based on clinical risk and pressures. Including inter-locality support.
- Collaborative working with our partners across health and social care.
- Crisis and ICTS teams proactively working into patients' homes and acute Trusts via liaison to keep people safe and support in the community. Avoiding the need for unnecessary admissions.
- Non-essential activities have been stood down (training, corporate and external meetings). Recruitment and retention is currently the number one priority.
- Focus on recruiting to vacant positions via central values-based recruitment.
- Contacting retired staff with a view to returning.
- Following recent national guidance on returning isolating staff to work with robust risk assessment and with approval from the DIPC.
- Redeployment of corporate staff to support operational service delivery.
- Adjustment of risk registers to reflect current position relating to staffing.
- Daily operational monitoring through sitreps at Locality level.
- Exploring the potential in relation to incentivising recruitment within the Trust.
- Offering Bank staff substantive contracts.
- Offering part-time staff additional hours.
- Offering Retire and Return staff additional hours due to current pension rules.
- Ensuring that all staff due to retire are offered the opportunity to return.

Evidence of Impact:

- CYPS waiting times.
- Vacancy levels.
- Safer Staffing reports.

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Status:	
Community CYPS	Action plan reopened across all core services due to move to Opel 2 on 14th July 2021 due to staff pressures.
Adult acute wards	
MH crisis teams	
LD & Autism wards	

Must Do Theme: (12) Physical health and Rapid tranquilisation	**Lead: Anne Moore, Group Nurse Director and David Muir, Group Director**
Planned timescale for closure: 30 September 2021	
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.
Adult acute wards Year: 2019 Org: CPFT	The trust must ensure they have effective systems and processes to assess, monitor and improve care and treatment. This includes identifying, individually assessing and reviewing, blanket restrictions, clear oversight of staff supervision and ensuring all physical health monitoring is completed as required. [This must do is also linked to blanket restrictions and staff supervision]
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 at core service level during Quarter 4 20/21 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
• RT audit tool has been reviewed by R Ayre and R Jordan. • Small audit across all four localities to assess compliance by medical staff has been registered with Clinical Audit. R Jordan shared the audit tool we used in November 2019 (as the new tool for the 2021 audit had not been developed on-line at the time of the request) and offered to collate the results. No further update at present. • Article written for Trust Bulletin (19 January 2021) and Safer Care Bulletin (February 2021). Infographics poster now part of CNTW(C) 02 RT Policy (Appendix 4)	
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Confirmation given by IMG for audit work to resume (on-hold since January 2021 due to pandemic pressures). • Re-audit registered and underway using May data. • Audit results to be considered at next sub group meeting on 28/06/21.	
Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September):	
• Review Audit results • Cascade audit results via BDG, CQC Inspection Steering Group and Compliance Groups, Physical Health Care Group, Group Quality Standard meetings • Revisit training needs • Target Interventions as required	
Evidence of Impact:	
Results of re-audit.	
Status:	
Ongoing further action required to make improvements.	

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Must Do Theme: (14) Staff engagement	**Lead: Elaine Fletcher, Group Nurse Director**
Planned timescale for closure: 31 July 2021 (30 September 2021)	
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 at core service level during Quarter 4 20/21 (January, February & March);	
The planned facilitated listening and learning event with the ward team did not take place in January as a result of COVID-19 pressures within the locality.	
Actions taken during Quarter 1 21/22 (April, May & June):	
• Facilitated feedback session to be arranged with the staff on Rowanwood to discuss the theming from the Stress Risk Assessment. • Further sessions will be arranged and will cover the following: - Introduction to the programme, vision, values and agreed team charter/compact. - Session for staff to Identify areas of improvement and outline next steps. - Set up follow up sessions for improvement projects. - A date has been arranged for the relevant staff to meet in April to agree dates for the planned sessions.	
Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September):	
• Due to the delay since the initial introduction of this process 2 listening events are to be arranged, one of these took place in June and a further event is to be arranged during July 2021. The sessions have been structured and allow questions and answers. • Further focused development sessions will take place thereafter where the team will start setting the scene for the vision and values which will form part of the ward charter. • 2 half day sessions to be planned in September which will bring all the information together from the structured development sessions and will use these to complete the charter. On-going support will be offered from the innovations team.	
Evidence of Impact:	
Baseline survey results.	
Status:	
Further action required to make improvements. It is requested that an extension be given to end of September 2021 to this Must Do action to enable further assurances to be gained that there has been an improvement.	

Must Do Theme: (15) Medicines Management	**Lead: Tim Donaldson, Chief Pharmacist/Controlled Drugs Accountable Officer**
Planned timescale for closure: 30 June 2021	
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 at core service level during Quarter 4 20/21 (January, February & March):	
As per Trust-wide response.	

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Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):
All four locality CBUs have created valproate action plans on the back of presentation of interim POMH-UK data at BDG-Safety meeting 11 December 2020. Action plans continue to be monitored by BDG-Safety through to completion and include the following initiatives: • Remaining 49% (n=118) of women and girls of childbearing age, as identified by pharmacy colleagues, are being reviewed for compliance with the valproate PPP • North Cumbria locality have tasked a Nurse Consultant with undertaking all appointments and ensuring valproate PPP reviews are completed • CCGs have been approached to provide contemporaneous lists of patients whom are prescribed valproate for a mental health indication to enable cross-referencing with SNOMED-CT report • Local databases have been created and accessible on shared drives by Nurse Consultants • A standard letter addressed to all specialist prescribers has been circulated setting out specific responsibilities with deadline for action of end February 2021 • Masterclass training sessions have been authored and arranged by pharmacy colleagues in association with CNTW Academy. Classes underway March 2021 • Creation of a RiO 'virtual team' has been considered to overcome metric methodology implications (open referrals) of eligible patients who have been discharged • Amber shared care status of valproate in women and girls of childbearing age has been proposed at the NoT Formulary Subcommittee with Medicines Guidance and Use Group (MGUG) beginning work on this initiative. Proposal discussed at SoT Area Prescribing Committee • Trust notified by NHSE&I National Director of Patient Safety that a recently established Valproate Safety Implementation Group (VSIG) will drive forward work to reduce harm from valproate • PPT-PGN-25 Safe Prescribing of Valproate currently undergoing routine scheduled review by pharmacy; summary process flowchart to be incorporated to assist prescribers • Development of a Valproate Documentation section on RiO (under Service Specific Files> Physical Treatment) which will include electronic versions of side effect rating scales and hyperlinks to the Valproate PPP material
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):
• Presentation of BDG paper to MOC in Quarter 1 21/22. Local findings from additional questions added to POMH Topic 20a audit, presented to May 2021 MOC meeting • Presentation of POMH Topic 20a Trust report to MOC once received from POMH in Quarter 1 2021/22. Completed May 21; presentation of findings to MOC and Valproate Oversight Group. • Receipt of POMH-UK Topic 20a Trust report and interpretation of findings by pharmacy colleagues. Completed May 21; presentation of findings to MOC and Valproate Oversight Group. • Complete review of remaining women and girls of childbearing age as identified in BDG-Safety paper December 2020. Completed June 21. All localities are reporting that WGOCP identified as eligible for PPP (from the original n=242 cases appearing in the BDG-S paper December 2020) have been identified and reviewed. Some areas still working to ensure that all those not eligible for PPP have documentation updated to reflect this. • Contemporaneous CCG patient lists to be compared to SNOMED-CT report to establish if any patients have been overlooked. Update by locality: North – CCG lists requested and obtained from North Tyneside (none received from Northumberland); comparison to original n=242 cases identified within CNTW is underway.

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Central – Newcastle/Gateshead CCGs approached for lists; CCGs completed their own review in April 2021 and are hesitant about providing further lists due to additional administrative burden. CCGs have confidence in existing process (quarterly review by Pharmicus) to ensure all WGOCP are re-referred back to CNTW as per requirements of valproate PPP. South – Pharmicus carrying out similar work in Sunderland and South Tyneside North Cumbria - 39 GP Practices approached for data; to date all but 7 practices have submitted a return. Escalated the non-returns within the local CCG. Lists currently being compared. **Action transferred to Valproate Oversight Group – suggest closure** • Further investigation of an IT solution to identify annual Valproate PPP review (for all patients including those open to referral only) and alert prescribers. Action likely to be affected by national Shared Care Protocol – patients not to be discharged in interim (Internal CAS alert CNTW/INT/2021/010). **Action transferred to Valproate Oversight Group – suggest closure** • Locality SOPs to be drafted to detail process/roles/responsibilities going forward. PPT-PGN-25 currently being reviewed with process flowchart; SOPs unlikely to be needed.
Planned future actions:
None, remaining actions transferred to Valproate Oversight Group for oversight and embedding of standards contained within PPT-PGN-25.
Evidence of Impact:
• Raised awareness of prescribing standards contained within PPT-PGN-25. Presentation of interim POMH-UK findings at BDG-Safety in December 2020, resulting locality action plans and establishment of the Valproate Oversight Group (VOG) have all raised awareness of prescribing standards contained within PPT-PGN-25. Valproate Masterclasses undertaken by pharmacy colleagues have reached 172 staff as of 27 April 2021. Further regular six-monthly Masterclasses to be arranged to engage new medics joining the Trust (VOG action plan). • Accurate completion of SNOMED-CT alert on RiO will create contemporaneous register of females of childbearing age who are receiving valproate within CNTW services. Quarterly SNOMED-CT reports continue to be produced and circulated to locality valproate leads for comparison against locally held patient lists. Business as usual. • Compliance against PPT-PGN-25 standards will ensure annual risk assessment documentation is copied to the patient's GP and next appointment diarised. Q4 2021/22 Clinical Audit to be undertaken to review compliance against PPT-PGN-25 standards. Results to be fed back to MOC, VOG and BDG-S
Status:
Propose to close action at Board of Directors on 4 August 2021.

Must Do Theme: (16) Nurse Call Systems	**Lead: Russell Patton, Deputy Chief Operating Officer**
Planned timescale for closure: 30 June 2021	
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 at core service level during Quarter 3 20/21 (October, November & December	
As per Trust-wide response.	

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Actions taken Trust-wide during Quarter 3 20/21 (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-Business 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.
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):
• Installation of nurse call systems has been completed for the following wards: o Hadrian, Carlton Clinic o Rowanwood, Carlton Clinic o Yewdale Ward, West Cumberland Hospital o Gibside, St Nicholas Hospital • Edenwood is currently being utilised as decant office accommodation. Prior to any inpatient occupancy a nurse call system will be fitted.
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June)
• Installation of nurse call systems have been completed across all acute wards for adults of working age and PICU across the CNTW patch. • Further conversations between NTW Solutions and other clinical service areas will take place during Quarter 2 and 3 to agree priorities and next steps linked to the available capital budget for 2021/22.
Planned future actions:
No further action required.
Evidence of Impact:
Assurance of completion of work.
Status:
Propose to close action at Board of Directors on 4 August 2021.

Must Do Theme: (18) Section 17 Leave	Lead: Dr Patrick Keown, Group Medical Director
Planned timescale for closure: 30 June 2021	
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 at core service level during Quarter 4 20/21 (January, February & March):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 4 20/21 (January, February & March):	
• Audits have been evaluated and results showed that compliance was good or adequate in all cases. • The recommendations of the task and finish group following the findings from the data (i.e. compliance poor if falls on bank holiday or weekends) were shared by CBU representatives within their respective localities – to continue to monitor compliance with section 17 leave through the Mental Health Legislation Steering Group. • Small group met to discuss accompanied and escorted leave and to review the leave policy. The guidance was circulated by the CBU representatives. • Work remains on-going with RiO team to look at the possibility of setting up an alert system to assist with compliance.	
Actions take Trust-wide during Quarter 1 21/22 (April, May & June):	
• Monitoring of section 17 data continues as there has been a noted increase in non-compliance during holiday periods. • Share again the recommendation for expiry dates for section 17 leave forms to be mid-week days avoid weekends and Mondays; avoid end of the month; avoid settings forms	

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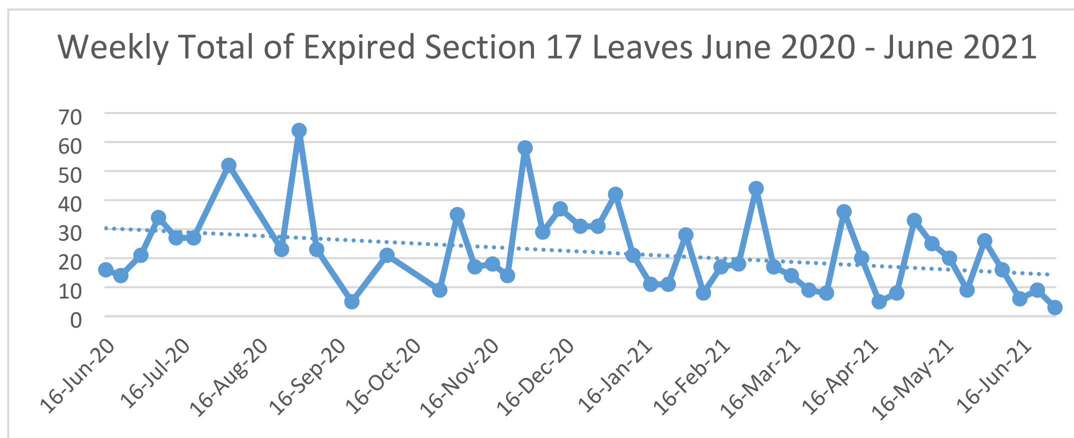
to expire during annual leave; use day of the week when there is regular Responsible Clinician input; use at a glance board. • Share again with Responsible Clinician's in each CBU the guidance produced on escorted and accompanied leave and the need for each patient to have an individualised section 17 leave form.
Planned future actions:
• Monitoring of section 17 data continues. This will be on-going through the Mental Health Legislation Group and the weekly reports which are sent out to all wards. • Information was shared with relevant individuals as discussed in points 2 and 3 above.
Evidence of Impact:
1. Evaluation of audit results. A sample of 45 section 17 leave forms from 23 wards were reviewed across CNTW in December 2020 and May 2021. These covered all four localities: 95% of section 17 leave forms were in date, 98% of patients had an inpatient risk management plan, and 100% had a recent risk assessment. These forms were assessed as to how well the information related to each other, 63% were rated as good, 33% as adequate and 4% as inadequate. Action was taken on the expired forms and those that were deemed inadequate. This sample of section 17 leave forms provides assurance that the majority patients had individualised section 17 leave forms that were linked with their risk assessments and risk management forms. 2. Section 17 compliance data below. The graph shows that non-compliance with section 17 leave forms is showing a downward trend from an average of 30 per week to under 20 per week. However numbers do still peak during holiday/bank holiday periods with people choosing Monday's as end dates. It is recommended that the end date is mid-week when the consultant is at work.    Issues with Section 17 leave was identified as an issue in 3 of the 10 wards visited by MHA Reviewers during Quarter 1.
Status:
Propose to close action at Board of Directors on 4 August 2021.

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Must Do Theme: (20) Management supervision	**Lead: Lisa Quinn, Executive Director of Commissioning and Quality Assurance**
Planned timescale for closure: 31 December 2021	
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 at core service level during Quarter 3 20/21 (October, November & December	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 3 20/21 (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.	
Actions taken Trust-wide during Quarter 4 20/21 (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.	
Actions taken Trust-wide during Quarter 1 21/22 (April, May & June):	
• Trajectories in place across all groups and corporate services. • Managed actioned taken to achieve trajectories.	
Planned future actions to be taken Trust-wide during Quarter 2 21/22 (July, August & September)	
Monitor improvement in line with agreed trajectories.	
Evidence of Impact:	
Current Position as of 15th June 2021 (Including improvement √ or deterioration from last quarter): 32%: √ Medical Directorate 33%: √ Deputy CEO Directorate 34%: √ Chief Nurse Directorate 48%: √ CEO Directorate 52%: √ North Cumbria Group 54%: √ North Group 55%: √ Central Group 60%: Provider Collaborative Directorate 61%: √ South Group 67%: √ Chief Operating Officer Directorate 78%: √ Workforce Directorate Areas achieving full standard of 85%: 87%: Commissioning & Quality Assurance Directorate	
Status:	
Process in place to record, focus now on delivering in line with trajectories.	

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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 at core service level during Quarter 1 20/21 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 1 20/21 (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.
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. • Board Development session in February 2021 to review risks, identify any emerging risks to be added to BAF, review risk appetite categories and scoring. • Development of future Strategy proposed.	
Status:	
Closed by Board of Directors on 5 August 2020.	

Action Closed

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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 at core service level during Quarter 1 20/21 (April, May & June):		
As per Trust-wide response.		
Actions taken Trust-wide during Quarter 1 20/21 (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.		
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: (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 at core service level during Quarter 1 20/21 (April, May & June):		
As per Trust-wide response.		
Actions taken Trust-wide during Quarter 1 20/21 (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 Trust-wide during Quarter 2 20/21 (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.		

Action closed

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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 at core Service in Quarter 1 20/21 (April, May & June)	
As per Trust-wide response.	
Actions taken Trust wide in Quarter 1 20/21 (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.	
Planned future actions:	
No further action required.	
Evidence of Impact:	
The number of OAP days during Quarter 1 has increased from 42 to 66. • Newcastle Gateshead – 25 (Quarter 1) • North Tyneside – 41 (Quarter 1)	
Status:	
Closed at Board of Directors on 5 August 2020.	

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 20/21 (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 20/21 (April, May & June):	
As per Trust-wide response.	
Actions taken Trust-wide during Quarter 2 20/21 (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 20/21 (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 1 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:	
Closed at Board of Directors on 3 February 2021.	

Action closed

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting on Wednesday 4 August 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	4 August 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

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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 end of March 2021 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..

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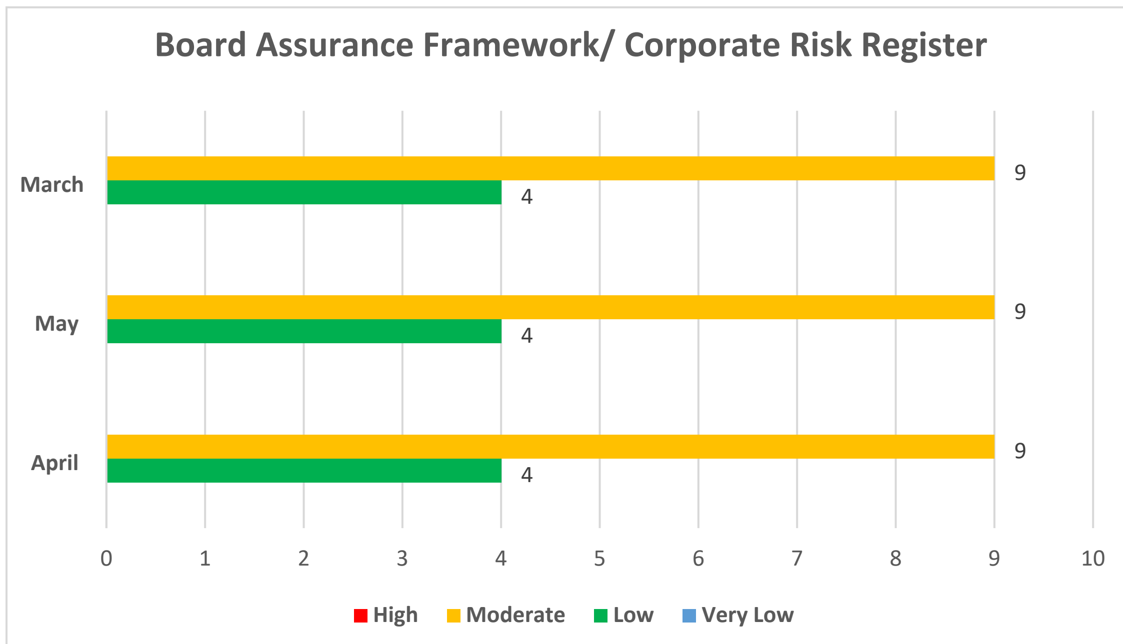
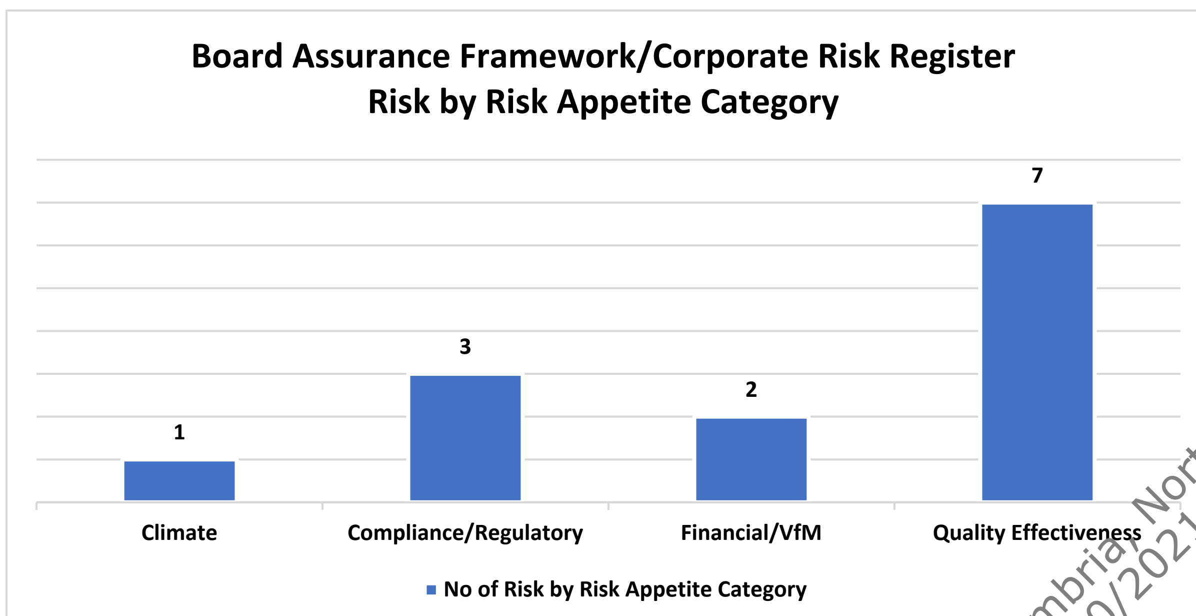
1.0 Board Assurance Framework and Corporate Risk Register

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 June 2021. In quarter 1 there are 13 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.



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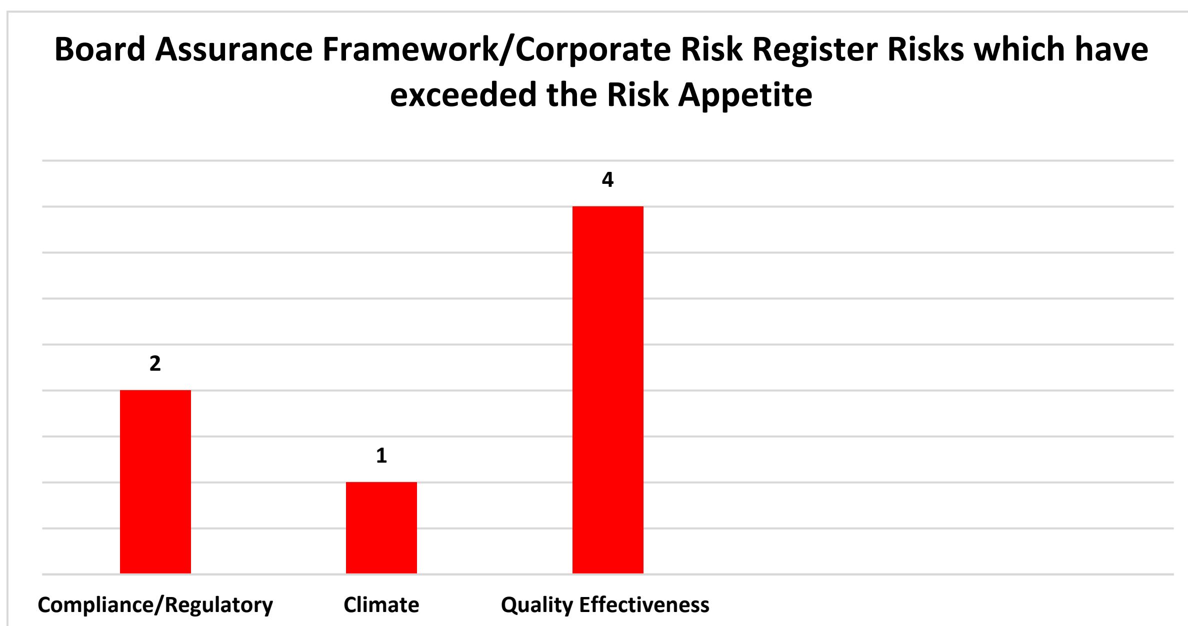
Each risk category has an assigned risk tolerance score. The risk tolerance score highlights when a risk is below, within or has exceeded a risk appetite tolerance. There are currently 13 risks on the BAF/CRR and 7 risks which have exceeded a risk appetite tolerance.

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.33 SA1	If the Trust were to acquire service level and additional geographical areas this could have a detrimental impact on CNTW as an organisation.	Compliance/ Regulatory (6-10)	3x4 = 12	Lisa Quinn
1683v.19 SA1	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands.	Quality Effectiveness (6-10)	4x4 = 16	Ramona Duguid
1685v.22	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.	Quality Effectiveness (6-10)	3x4 = 12	Lisa Quinn

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1691v.27 SA5	As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.	Compliance/ Regulator (6-10)	3x4 = 12	Rajesh Nadkarni
1694v.16 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	Ramona Duguid
1836v.8 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	Ramona Duguid
1853v.5 SA4	The climate and ecological change is effecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change.	Climate & Ecological Sustainability	3x4 = 12	James Duncan

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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 service level and additional geographical areas this could have a detrimental impact on CNTW as an organisation.	One action completed and closed. 2 new actions added	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.	Has moved from RBAC to the Provider Collaborative Committee. To be closed and a new risk created to combine both risks	Lisa Quinn
1683 SA1	There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands.	Risk Owner updated to Ramona Duguid. Updated the risk description, closed controls, and added new controls with assurances. Closed 1 action and added a new action	Ramona Duguid
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.	Has moved from RBAC to the Provider Collaborative Committee. To be closed and a new risk created to combine both risks	Lisa Quinn
1687 SA4	That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our transformation programme.	Risk description updated following the Board Review of BAF risks. Action added and action 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.	Action target date updated.	Lisa Quinn
1691 SA5	As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements.	One action added and one action completed. New control added.	Rajesh Nadkarni
1694	Inability to recruit the required	Risk Owner updated to Ramona	Ramona

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SA5	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.	Duguid. New action added	Duguid
1762 SA1	Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments.	Risk updated following the Board Review of BAF risks. Risk combined with risk 1819 as broadly the same issue. Risk description updated. Controls with assurances added and actions added	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	Has been moved from Quality and Performance to the Provider Collaborative Committee. To be revised to include the Lead Provider Model	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.	Risk Owner updated to Ramona Duguid. Controls with assurances updated. Action detail updated	Ramona Duguid
1852 SA4	There is a risk that the Trust 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.	Action and progress within the action updated	Gary O'Hare
1853 SA5	The climate and ecological change is effecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change.	Risk description updated, Controls and actions updated.	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

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

1.5. Current BAF and Emerging Risks

Following the review of risks with the Provider Collaborative Committee Chair regarding the aligned risks, there were several considerations. Firstly, that risks 1682 and 1685 will be closed and a new risk will be created to combine both risks. Secondly, risk 1831 will be revised to include the Lead Provider Model and thirdly, a new risk will be created that articulates the potential issues regarding the financial exposure that contractual arrangements may bring. Once the changes are approved by the Board the BAF risk register can be updated.

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
7 July 2021

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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

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

Risk Appetite Statement

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust recognises that its long-term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust will not accept risks that materially provide a negative impact on quality (safety, experience and effectiveness).

However, CNTW has a greater appetite to take considered risks in terms of their impact on organisational issues. CNTW has a greater appetite to pursue Commercial opportunities, partnerships, clinical innovation, Financial/Value for Money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated and/or it is in the best interests of the population we serve.

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

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Appendix 2

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER 2021-2022 Quarter 1

Cumbria, Northumberland Tyne and Wear NHS Foundation Trust # 570372 07/30/2021 09:59:30

Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
As a result of not meeting statutory and legal requirements regarding Mental Health Legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. SA5	Risk on identification (29/10/2018):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
SA5 The Trust will be the Centre of Excellence for Mental Health and Disability	**Risk Appetite (the amount of Risk NTW will accept)**	Compliance/Regulatory			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of governance	● Prompts for consent to treatment to be included on the to do list on RiO - NTW 1819 58: Plan to use the at a glance board
2 Trust Policies and Procedures relating to relevant acts and practice	2 Compliance with policy/training requirements NTW1617 33 MHA section 17 - good level of assurance NTW1718 42 MHA Statutory Function - Good Level of Assurance NTW181957 Compliance review of MHA Rights - Good Level - Feb 19	● Improvement review of MHA Training: (Feb 2021 63.6%) (Oct 2020 62.9%) (Jun 2020 62.6%) (April 2021 64.6%) ● Working Task Sub Group to monitor remote assessments and support the digitalisation of the MHA - Reported and monitored by IMG and BDG - ongoing
3 Decision making framework	3 Decision making framework document	● Manage the implications of MM Case - Impact on the ability to discharge detained patients (managed by LD Clinical Services)
4 Performance review/integrated performance reports	4 Reports to Board and sub committees	
5 Mental health legislation committee	5 Minutes of mental health legislation committee	
6 Process for 135/136 legislation with external stakeholders	6 135/136 action plan complete	

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Risk Report

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1 New process in place for monitoring themes from MHA Reviewer visits through MHL Steering Group	1 MHL Group papers and updates	Awaiting the Government response to the consultation to then know what changes will take effect within the Mental Health Legislation
2 CQC MHA Reviewer session delivered at learning and development group in November 2018	2 Minutes and papers from Learning and Development Group	
3 Internal Audit 18/19	3 NTW 2018/19/57 Compliance Review of MHA - Patient Rights. Good. NTW 2018-19/58 Compliance Review of Mental Health Act - Rolling Programme - CTO - Substantial	
4 Effectiveness of reporting on themes from MHA Reviewer visits	4 Mental Health Steering Group	
5 Legal Guidance for MH & LD during the Corona Pandemic	5 Regular updates to the Board - Board Minutes	
6 CNTW Internal Audit 19 20	6 CNTW 19 20-29 MHA - Holding Powers - Good Assurance	
7 Regular review and monitoring of CQC themes raised with Groups at the Mental Health Steering Group and BDG	7 Reporting and minutes of meetings	
8 Mental Health Act Reform Consultation ended on 21 April and CNTW submitted their response to the proposed changes on 20 April 2021 to the Government	8 Consultation paper	

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Risk Report

Ref: 1691 v.27

Risk Owner: Rajesh Nadkarni

Next Review Date: 31/07/2021

Review/Comments:
10/06/2021 - Lindsay Hamberg Discuss the BAF risk with Rajesh and Andrew

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Risk Report

Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing inpatient services in a timely manner due to bed pressures resulting in the inability to sufficiently respond to demands. SA1.4 SA1 Working together with service users and carers we will provide excellent care. Supporting people on their personal journey to wellbeing.	Risk on identification (15/03/2018):	4	4	16	Moderate
	Residual Risk (with current controls in place):	4	4	16	Moderate
	Target Risk (after improved controls):	1	4	4	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Urgent and Emergency Care Review Group	1 Monthly updates to BDG	Regularly monitor bed availability, consider use of decant beds as a contingency, further work on the bed census to timely discharge. Where appropriate the greater use of rehabilitation beds to free up acute beds.
2 Regular Reviews & Discussions at BDG and Q&P	2 Minutes of meetings	
3 Established focused pathway review meetings (weekly) looking at Adults, Older People and Children's services with a focus on service flow and efficiency	3 Notes of meetings	
4 The organisations Quality Priorities has given prominence to effective bed utilisation recognising the quality and safety aspects and its direct impact on service users.	4 Weekly reviews of bed utilisation for adults and older peoples. Quarterly reviews of the Quality Priority milestones. Regular reviews of the bed model in terms of capacity. Service user and carer feedback	

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Risk Report

1 Bed Management Admission Policy Purposeful Admissions Form 72-hour Inpatient reviews Utilization of anticipated discharge date	1 Compliance with policies and procedures Use of Discharge Facilitators	

Ref: 1683 v.19

Risk Owner: Ramona Duguid

Next Review Date: 06/10/2021

Review/Comments:

28/06/2021 - Ramona Duguid
Risk has been reviewed. Updated risk description, controls and actions

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Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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. SA 5	Risk on identification (15/03/2018):	3	5	15	Moderate
	Residual Risk (with current controls in place):	2	5	10	Low (Yellow)
	Target Risk (after improved controls):	1	5	5	Very Low
SA5 The Trust will be the Centre of Excellence for Mental Health and Disability	**Risk Appetite (the amount of Risk NTW will accept)**	Compliance/Regulatory			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of Governance - amber/green rating	Quarterly Review of compliance against standards through accountability framework
2 Trust policies and procedures	2 Compliance with policy and procedures	
3 Compliance with NICE	3 Internal Audit - rolling programme	
4 CQC Compliance Group and Compliance Steering Group - re-started fortnightly	4 Reports and updates to board sub committees	
5 Performance reviewed/integrated commissioning and assurance reports	5 Reports/updates to board sub committees	
6 Accountability Framework - Quarterly meetings	6 Accountability Framework document	
7 Regulatory framework of CQC NHSI	7 NTW18-19 - 19/05 CQC Internal Audit (well-led) - Process Substantial Assurance	
8 Agreement of Quality Priorities	8 Monitored via reports/updates	

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Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

1	NTW Internal Audit 20-21	1	Risk Based Audit of Performance Management & Reporting	
2	Monitoring of MHA Reviewer Visit actions and themes	2	MHA Reviewer Visit Database	

Ref: 1688v.34

Risk Owner: Lisa Quinn

Next Review Date: 05/09/2021

Review/Comments:

02/06/2021 - Lisa Quinn
Risk has been reviewed and updated

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Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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. (SA5.9)	Risk on identification (06/11/2018):	4	4	16	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
SA5 The Trust will be the centre of excellence for Mental Health and Disability	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Workforce strategy	1 Delivery of workforce strategy	(Red) Executive Awareness of International recruitment through Medical Director, Trust aware for medical recruitment as a whole through medical managers
2 RPIW Medical Recruitment	2 RPIW Medical Recruitment outcomes papers	(Red) Monitor 7 fellowship recruits still on placement - updated that they are enjoying their placements, gaining education and training experience
3 NTW International recruitment competency process	3 NTW International recruitment competency documents	(Red) Ongoing central recruitment and apprenticeships scheme for nursing
4 OPEL Framework	4 OPEL Framework Documents	(Red) Complete International Recruitment Campaign - Quarterly updates.
5 MDT Collegiate Leadership Team in place	5 MDT Leadership advice and support available	(Green) Risk to be discussed at the Medics Meeting and actions to be updated re: medical staffing
6 All seven fellowship international recruits arrived into the Trust in December 2018	6 All still in post and deployed across the Trust	
7 The medical recruitment functions have been moved to the medical staffing team	7 The medical staffing team manage the medical recruitment function	
8 Medical Induction Programme	8 Delivery of medical induction programme	

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Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 1694 v.16

Risk Owner: Ramona Duguid

Next Review Date: 31/07/2021

Review/Comments:
28/06/2021 - Ramona Duguid Risk has been reviewed - Action added to focus on medical staffing

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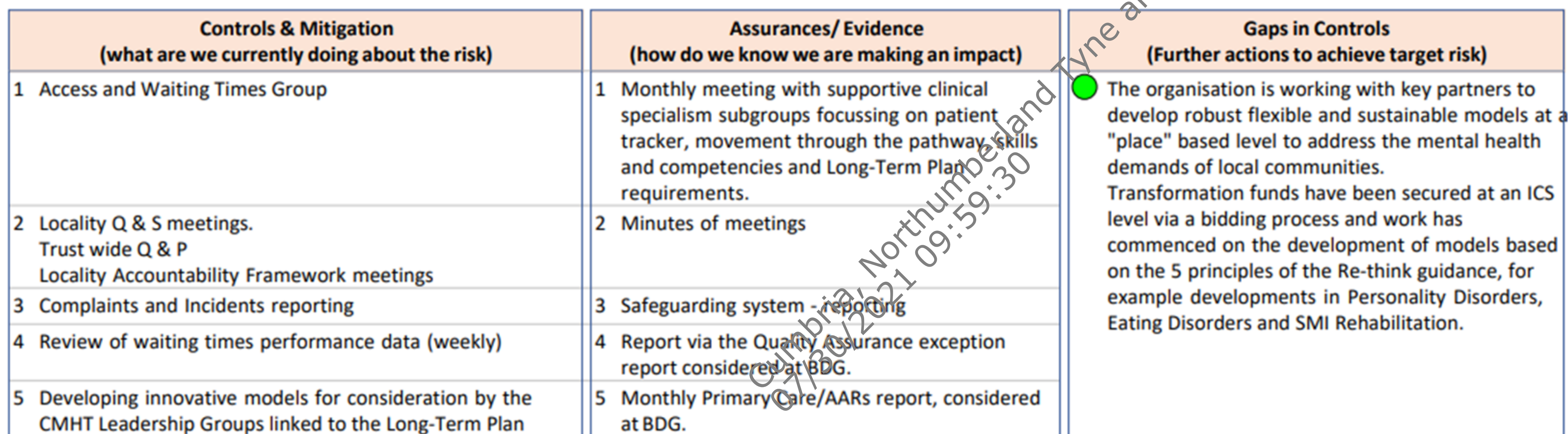
Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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. (SA4)	Risk on identification (01/06/2020):	3	4	12	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	1	4	4	Very Low
SA4 The Trust's Mental Health and Disability services will be sustainable and deliver real value to the people who use them	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Breach



Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Access and Waiting Times Group	1 Monthly meeting with supportive clinical specialism subgroups focussing on patient tracker, movement through the pathway, skills and competencies and Long-Term Plan requirements.	The organisation is working with key partners to develop robust flexible and sustainable models at a "place" based level to address the mental health demands of local communities. Transformation funds have been secured at an ICS level via a bidding process and work has commenced on the development of models based on the 5 principles of the Re-think guidance, for example developments in Personality Disorders, Eating Disorders and SMI Rehabilitation.
2 Locality Q & S meetings. Trust wide Q & P Locality Accountability Framework meetings	2 Minutes of meetings	
3 Complaints and Incidents reporting	3 Safeguarding system - reporting	
4 Review of waiting times performance data (weekly)	4 Report via the Quality Assurance exception report considered at BDG.	
5 Developing innovative models for consideration by the CMHT Leadership Groups linked to the Long-Term Plan	5 Monthly Primary Care/AARs report, considered at BDG.	

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Risk Report

Cumbria, Northumberland,
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NHS Foundation Trust

deliverables.	Leadership Meeting minutes Associated business cases	

Ref: 1836v.8

Risk Owner: Ramona Duguid

Next Review Date: 06/10/2021

Review/Comments:

28/06/2021 - Ramona Duguid
Risk has been reviewed - Controls and actions have been updated

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Risk Report

NHS
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NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
There is a risk that the Trust 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. (SA4) SA4 The Trust's Mental Health and Disability services will be sustainable and deliver real value to the people who use them	Risk on identification (21/09/2020):	3	4	12	Moderate
	Residual Risk (with current controls in place):	2	4	8	Low (Yellow)
	Target Risk (after improved controls):	1	4	4	Very Low
	Risk Appetite (the amount of Risk NTW will accept)	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 IPC Board Assurance Framework	1 Infection Prevention and Control (IPC) Board Assurance Framework Board of Directors Meeting	Preparing for increase of wave 3 of COVID 19
2 Gold Command	2 Operational Services	
3 Twice weekly Gold Command IMG's	3 Notes of meetings	

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Risk Report

NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Ref: 1852 v.5

Risk Owner: Gary O'Hare

Next Review Date: 08/09/2021

Review/Comments:
10/06/2021 - Lindsay Hamberg Risk has been updated: Risk Handler - Anne Moore

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Risk Report

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
If the Trust were to acquire service level and additional geographical areas this could have a detrimental impact on CNTW as an organisation. SA1.10	Risk on identification (09/10/2018):	4	4	16	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
SA1 Working together with service users and carers we will provide excellent care. Supporting people on their personal journey to wellbeing.	**Risk Appetite (the amount of Risk NTW will accept)**	Compliance/Regulatory			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Joint Programme Board	1 Minutes of meetings	Review CQC improvement requirements through Board on a Quarterly basis
2 Due Diligence	2 Due Diligence report	Review of all outstanding CQC Improvement Areas for North Cumbria Services
3 Exec Leadership	3 Identified Exec Lead	Review of all outstanding CQC improvement areas for CYPS
4 Specific Capacity Identified	4 Identified CNTW Team	
5 Clear Oversight by Trust Board	5 Board Development sessions and Papers	
6 Secured workforce to deliver services	6 Identified staff	
7 Implementation plan developed	7 Implementation planning paper	
8 Contract agreed and completed	8 Contract report- Reviewed RBAC	
9 Monthly Implementation Group Chaired by Gary O'Hare	9 Minutes and reports from meeting	
Maintain oversight for West Lane	Closed Trust Board	

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Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Ref: 1680v.33

Risk Owner: Lisa Quinn

Next Review Date: 12/07/2021

Review/Comments:

02/06/2021 - Lisa Quinn
Risk has been reviewed - 1 action closed and 2 new actions added

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Risk Report

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
That we do not manage our resources effectively in the transition from COVID planning to ongoing sustainability and delivery of our transformation programme. SA4.2	Risk on identification (15/03/2018):	3	5	15	Moderate
	Residual Risk (with current controls in place):	3	5	15	Moderate
	Target Risk (after improved controls):	2	5	10	Low (Yellow)
SA4 The Trust's Mental Health and Disability Services will be sustainable and deliver real value to the people who use them	**Risk Appetite (the amount of Risk NTW will accept)**	Financial/Value For Money			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated governance framework	1 Annual Governance Statement, Quality Account ,Annual plans	(Green) One year plan to be approved by the Board March 2021 with long term strategy presented by october 21
2 Financial Strategy/FDP	2 Operational Plan 19/20 submitted	(Red) Routine reporting against delivery of operational plan to be incorporated into CDT-B from June 2020. Review of resource planning underway to be completed by December and presented to cdt b in December and rabac January 21. Revised reporting to board from may 21
3 Financial and Operating procedures	3 Policy/PGN NTW1718 26 Payroll expenditure ,NTW 1718 39 Cashier	
4 Quality Goals and Quality Account	4 External audit of Quality Account	
5 Accountability Framework	5 Accountability Framework Reports	
6 Quarterly review of financial delivery	6 Quarterly review delivered at RBAC	(Green) Trust working in interim financial regime through COVID-long term implications to be assessed within long term strategy
7 Programme agreed for capacity to care and Trust Innovations capacity expanded	7 Capacity to care programme report to BDG and CDT-B	
8 Going Concern Report	8 Going Concern Report - Audit Committee April 2019	(Red) Monitor and Manage the increase in demand of services due to COVID

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Risk Report

NHS
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1 NTW 18/19 Internal Audit	1 NTW 1819 25 Single Oversight Framework, Substantial, April 2019 NTW 1819 37 Procurement: Good, July 2019 NTW 1819 38 Compliance Review of Key Financial Systems: Good, May 2019 NTW 18/19 43 Risk based audit of charitable funds - Substantial, August 2018 NTW18/19 41 Risk based audit payroll - Substantial, November 2018 NTW18/19 40 Central arrangements managing patient monies - Substantial, February 2019	

Ref: 1687v.25

Risk Owner: James Duncan

Next Review Date: 24/07/2021

Review/Comments:

24/05/2021 - Christopher Cressey
Risk has been reviewed - action updated

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Risk Report

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NHS Foundation Trust

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Restrictions in Capital expenditure imposed nationally may lead to increasing risk of harm to patients when continuing to use sub optimal environments. (SA1)	Risk on identification (07/11/2019):	3	5	15	Moderate
	Residual Risk (with current controls in place):	3	5	15	Moderate
	Target Risk (after improved controls):	1	5	5	Very Low
SA1 Working together with service users and carers we will provide excellent care. Supporting people on their personal journey to wellbeing	**Risk Appetite (the amount of Risk NTW will accept)**	Financial/Value for Money			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Financial planning budgets	1 Reported and in minutes of CDT-B and RBAC	(Green) Project team to be established to update the Capital and Estates strategy during 2021/22 alongside financial strategy. To be presented to the Board October 2021. Updated strategy by March 2022
2 Working capital management	2 Reported through and in minutes of CDT-B and RBAC	
3 Going Concerns Reporting	3 Discussed and in minutes of Audit Committee	
4 OBC approved nationally - CEDAR business case including inherent improvement to revenue position	4 Agreement of long term plan as part of CEDAR OBC - Approved by the Board (minutes)	(Red) CEDAR FBC -bridging loan under consideration to give cash headroom.
5 CEDAR Programme Board established with key partners	5 Minutes of CEDAR Programme Board	(Red) Developing strategic outline cases for LD assessment and treatment services, North Cumbria Inpatients and Older Adults Inpatients Newcastle and North Tyneside
6 Business case approved interim solutions for WAA, Newcastle and Gateshead - Building programme in place	6 Business Case document	
7 Operational mitigations: Additional staffing at Rose Lodge. Interim funding for North Cumbria. Integrated Care Facility in Newcastle	7 Minutes of CDT-B meeting	(Green) Capital Strategy for Cumbria to be developed, to be incorporated into ICS strategy prioritisation for

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1 ICS support nationally and funding identified	1 ICS bid document	national capital funding
2 Asset sales now identified	2 Standard reporting at CDT-B and RBAC	

Ref: 1762 v.10

Risk Owner: James Duncan

Next Review Date: 26/07/2021

Review/Comments:

27/04/2021 - James Duncan
Risk has been reviewed and updated following the Board Review of BAF risks. Risk combined with risk 1819 as broadly the same issue. Risk description updated. Controls with assurances added and actions added

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Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
The climate and ecological change is effecting the physical and mental health of current and future generations and adaptation plan to be in place regarding the infrastructure and preparedness for extreme weather. The delivery of the Green Plan is paramount to reduce the impact of climate change. (SA4) SA5 The Trust will be the centre of excellence for Mental Health and Disability	Risk on identification (24/09/2020):	4	4	16	Moderate
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
	Risk Appetite (the amount of Risk NTW will accept)	Climate & Ecological Sustainability			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)
1 Commitment of CNTW - Declared Climate Emergency	1 CNTW Climate Health Programme
2 Plan to reduce carbon omission to net zero by 2040	2 Minutes of CDT-C
3 CDT-Climate meeting - bi-monthly	3 Minutes of meetings
4 The Trust has approved a Green Plan and acknowledged the climate emergency.	4 Green Plan report

Gaps in Controls (Further actions to achieve target risk)
(Green) Progressing a staff engagement programme
(Red) To establish the climate health steering group
(Red) business case process are being revised. The impact of decision making on community and climate issues is being included to ensure there is as much emphasis given to the climate implications as quality, workforce and financial implications.
(Green) Meet the requirements of the NHS Net zero plan. reporting to CDT-C
(Green) Develop a training resource to incorporate climate, ecological and social business into a business case

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Ref: 1853 v.5

Risk Owner: James Duncan

Next Review Date: 15/08/2021

Review/Comments:
17/05/2021 - Anna Foster Risk has been reviewed. Risk description updated, Controls and actions updated.

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Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services. SA1.3	Risk on identification (15/03/2018):	3	4	12	Moderate
	Residual Risk (with current controls in place):	2	4	8	Low (Yellow)
	Target Risk (after improved controls):	1	4	4	Very Low
SA1 Working together with service users and carers we will provide excellent care. Supporting people on their personal journey to wellbeing.	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Integrated Governance Framework	1 Independent review of governance- amber/green rating.	Review whole risk as an action in line with new sub-committee of Board for new provider collaborative
2 Agreed contracts signed and framework in place for managing change	2 Contract monitoring and contract change	
3 Locality Partnership arrangements	3 Updates from Locality Partnership meetings	
4 Well Led Action Plan Complete	4 Well Led Action Plan document	
5 All CCG Contracts Agreed	5 Contract documentation	
6 Lead/ prime provider models and alliance contracts	6 Provider models and alliance contract documentation	

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Ref: 1682 v.17

Risk Owner: Lisa Quinn

Next Review Date: 14/09/2021

Review/Comments:
16/06/2021 - Lisa Quinn Risk has been reviewed. Risk 1682 and 1685 will be closed and a new risk will be created to combine both risks (To be approved by the Board)

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Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
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. SA3.2	Risk on identification (15/03/2018):	4	5	20	High (Red)
	Residual Risk (with current controls in place):	3	4	12	Moderate
	Target Risk (after improved controls):	2	4	8	Low (Yellow)
SA3 Working with partners there will be 'no health without mental health' and services will be 'joined up'.	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Breach

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Executive and Group leadership embedded in each CCG/LA area to ensure MH and disability services are sustainable	1 Successfully influenced service models across a number of localities	Work with ICS on agreeing a Provider Collaborative Model for Mental Health and Learning Disabilities
2 Leadership of ICS MH workstream	2 Established close relationships with senior clinicians, managerial leaders across acute trusts and some GP practices. Regular updates/monitoring of ICS via Exec/CDT/Board. Papers from MH ICS workstream	
3 Involvement in DTDT programme for OP and acute MH services	3 Regular updates via Execs/CDT/Board	
4 Member of Gateshead care partnership	4 Regular updates via Execs/CDT/Board	
5 Member of Exec group for MCP in Sunderland	5 regular updates via Execs/CDT/Board	
6 Member of the ICS Health Strategy Group	6 Regular updates via Execs/CDT/Board	
7 Member of North and Central ICP's	7 Regular updates via Execs/CDT/Board	

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1 Member of Northumberland Transformation Board	1 Regular updates via Execs/CDT/Board	
2 Member of the Newcastle Joint Exec Group	2 Regular updates via Execs/CDT/Board	
3 Provider Collaborative arrangements approved by Trust and partner organisations	3 Newly established Provider Collaborative sub-committee of the Board to commence January 2021 PC model of assurance	

Ref: 1685 v.22

Risk Owner: Lisa Quinn

Next Review Date: 16/07/2021

Review/Comments:

16/06/2021 - Lisa Quinn
Risk has been reviewed. Risk 1682 and 1685 will be closed and a new risk will be created to combine both risks (To be approved by the Board)

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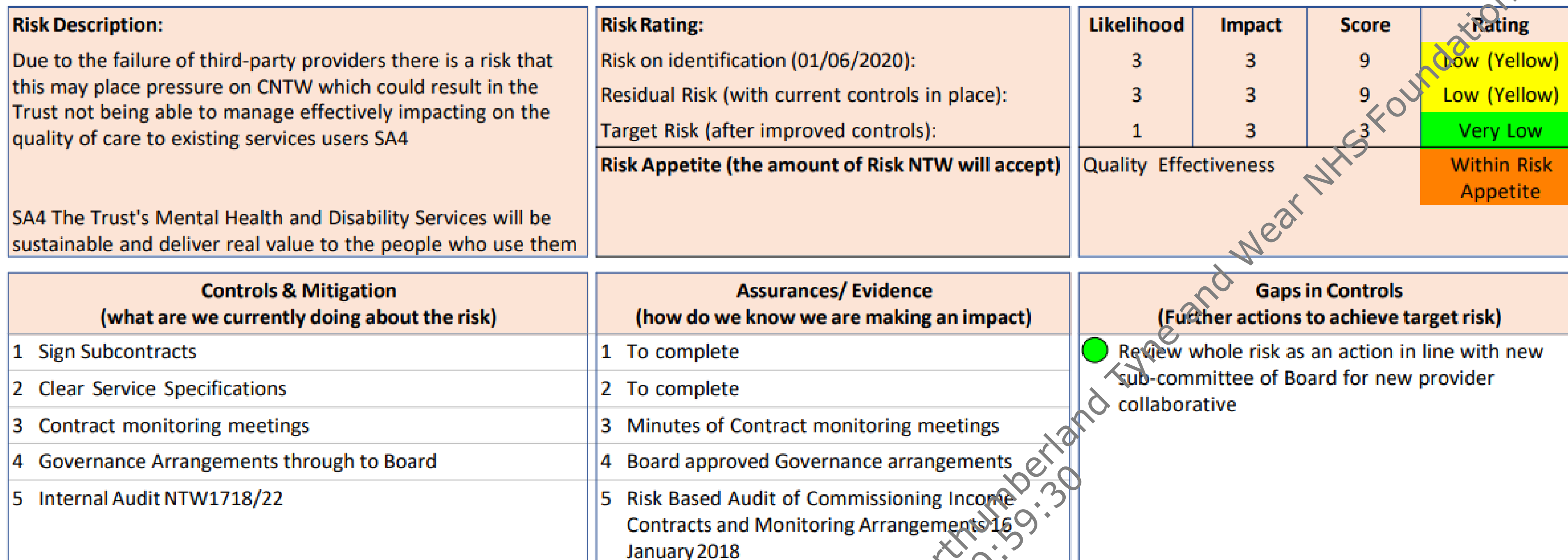

Risk Description:	Risk Rating:	Likelihood	Impact	Score	Rating
Due to the failure of third-party providers there is a risk that this may place pressure on CNTW which could result in the Trust not being able to manage effectively impacting on the quality of care to existing services users SA4	Risk on identification (01/06/2020):	3	3	9	Low (Yellow)
	Residual Risk (with current controls in place):	3	3	9	Low (Yellow)
	Target Risk (after improved controls):	1	3	3	Very Low
SA4 The Trust's Mental Health and Disability Services will be sustainable and deliver real value to the people who use them	**Risk Appetite (the amount of Risk NTW will accept)**	Quality Effectiveness			Within Risk Appetite

Controls & Mitigation (what are we currently doing about the risk)	Assurances/ Evidence (how do we know we are making an impact)	Gaps in Controls (Further actions to achieve target risk)
1 Sign Subcontracts	1 To complete	Review whole risk as an action in line with new sub-committee of Board for new provider collaborative
2 Clear Service Specifications	2 To complete	
3 Contract monitoring meetings	3 Minutes of Contract monitoring meetings	
4 Governance Arrangements through to Board	4 Board approved Governance arrangements	
5 Internal Audit NTW1718/22	5 Risk Based Audit of Commissioning Income Contracts and Monitoring Arrangements 16 January 2018	

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Risk Report

Ref: 1831v.12

Risk Owner: Lisa Quinn

Next Review Date: 16/07/2021

Review/Comments:
16/06/2021 - Lisa Quinn Risk Reviewed today by Lisa Quinn and Michael Johnson - Risk description to be revised and approved by the Board

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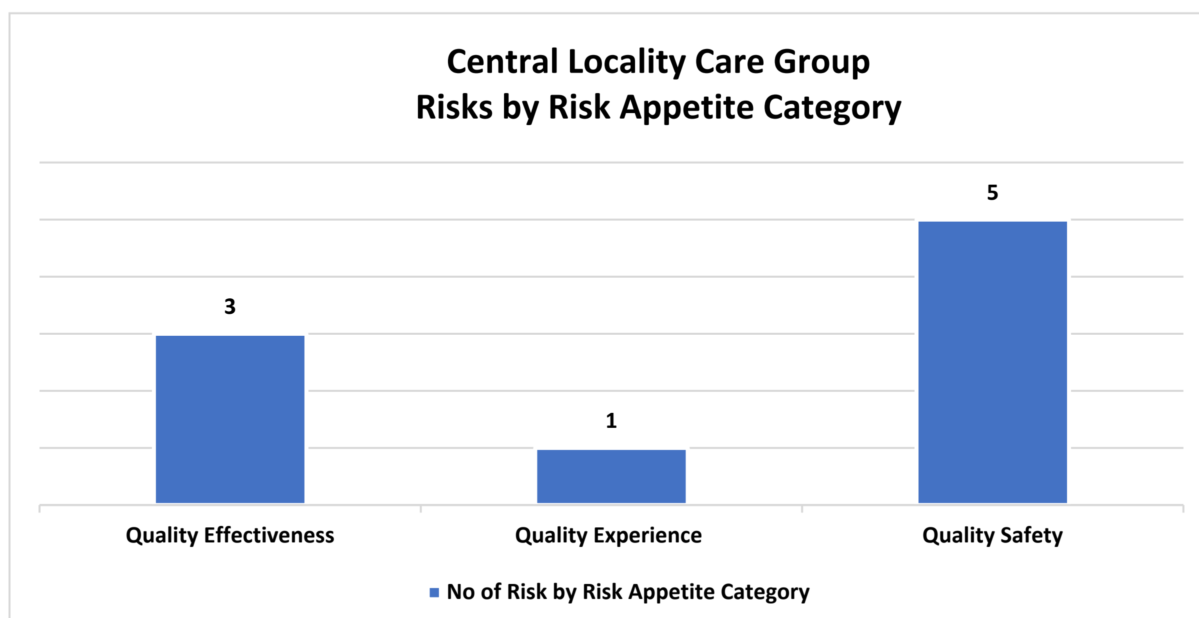
Appendix 3

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 June 2021 Central Locality Care Group hold 9 risks, 9 risks 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.23	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

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1284v.27	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.20	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.15	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.10	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 regards 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.12	Current staffing pressures within the Secure Care service	Quality Safety (6-10)	15	5	3	Karen Worton

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	currently being experienced due to each of the secure care learning disability 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.6	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 2 risks.

1.3 Community Central CBU

There are no risks for Community Central CBU.

1.4 Inpatient Central CBU

Inpatient Central CBU has 1 risk exceeding the risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1839v.11	Senior Medical workforce recruitment - Currently vacancy with no success for several months to be able to replace the retiring consultant with a substantive permanent post holder. Leaving the vacancy as such with no cover would have meant Almost certain high risk in domains of effectiveness, service user experience, safety, possible breach of standards around MH Act and training requirements for junior doctors.	Quality Safety (6-10)	12	4	3	David Hately

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	This was unacceptable. Currently being mitigated through cover but this opens up risks in area of staff health and wellbeing and this needs to be recognised, with potential mitigations in future of international recruitment, Non Medical AC/RC development and acting up of SpRs.					

1.5 Secure Care Services CBU

There are no risks for Secure Care Services CBU.

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.8	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

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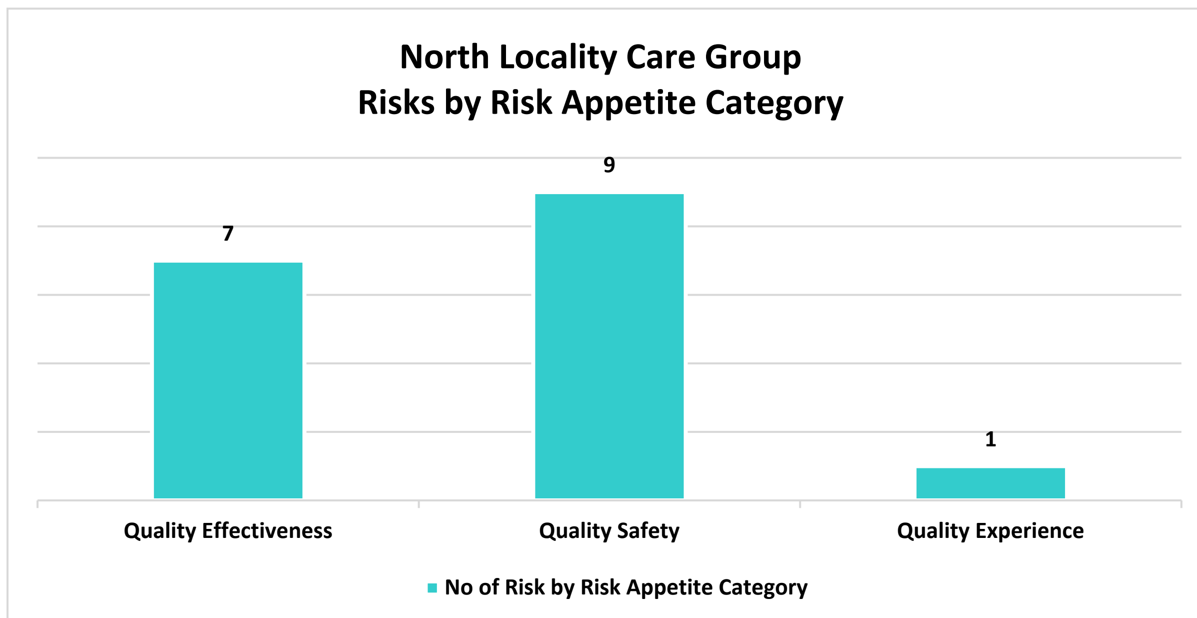
2.0 North Locality Care Group



North Locality Care Group as at end of June 2021 hold 17 risks, 8 risks within the risk appetite and 9 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 5 risks on the North Corporate Group risk register. 1 risk is within the risk appetite and 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.61	Significant staffing pressures due to vacancies and difficulties recruiting and retaining permanent medical, qualified nursing, SALT staff within the North Locality.	Quality Effectiveness (6-10)	20	4	5	Kedar Kale
1198v.45	Sickness absence levels continue to be monitored formally through the Locality LMG.	Quality Effectiveness (6-10)	12	4	3	Vida Morris
1287v.36	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.15	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	Quality Safety (6-10)	16	4	4	Pam Travers

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	admin areas. The lack of/poor provision makes SGP an outlier within the Trust in terms of security and compromised patient safety.					

2.1 North Locality Corporate Business Units

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

2.2 Community North CBU

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

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1920v1	Significant staffing pressures across the North Community CBU due to difficulties recruiting and retaining staff . This is across all service areas with current hotspots being Medical Staffing in Northumberland North Tyneside CTT CYPS. Current impact is on waiting times to Assessment & Treatment Risk to those patients waiting for allocation to Treatment Absence of senior clinical leadership and medical cover. Staff morale and resilience due to level of workload.	Quality Safety (6-10)	16	4	4	Rebecca Campbell

2.3 Inpatient North CBU

Inpatient North CBU is currently holding 3 risks. 2 risks are within risk appetite and 1 risk is 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

2.4 Access North CBU

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

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Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1701v.27	Environments in Greenacres/ Sextant House/Wallace Green are not fit for purpose and pose a number of safety issues 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
1861v.4	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

2.4 Learning Disabilities & Autism CBU

Learning Disabilities & Autism CBU is currently holding 4 risks – 3 risks are within risk appetite. 1 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
1971v1	CERA report for Mitford Bungalows in 2020 identified that a lack of CCTV within the Bungalows was an issue. Risk to safety in terms of staff allegation and complaint and ability to learn from incidents.	Quality Safety (6-10)	12	3	4	Lisa Long

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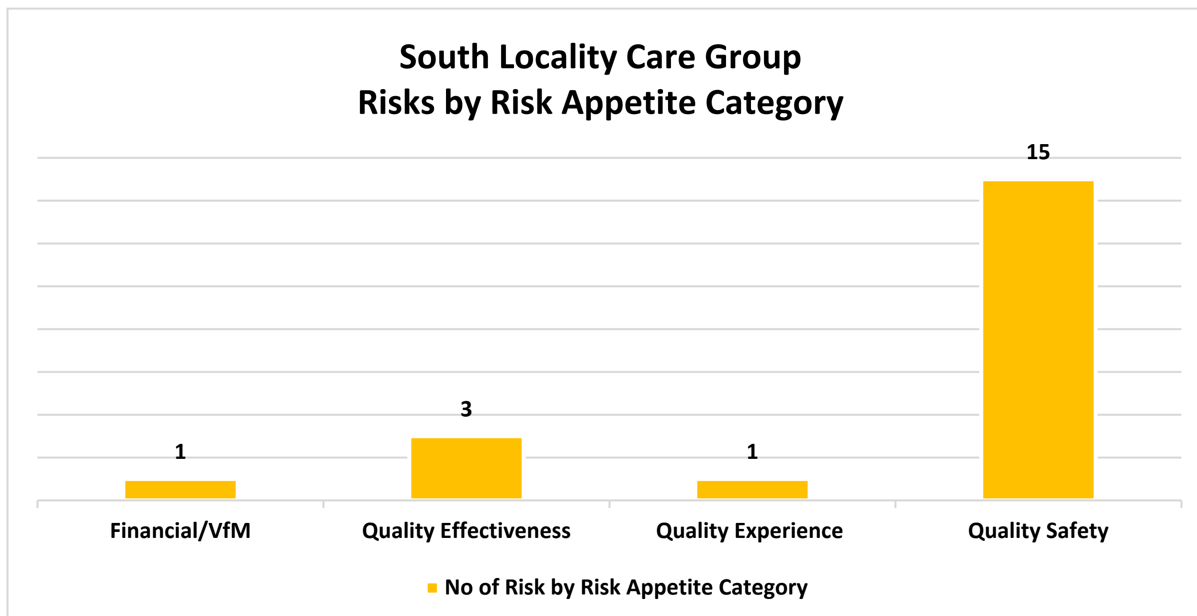
3.0 South Locality Care Group



In total as at end of June 2021 the South Locality Care Group hold 20 risks, 2 risks lower than the risk appetite, 5 risks within the risk appetite and 13 risks which have exceeded 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 – 7 risks 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
857v.28	Due to the Internal en-suite doors it has been identified that there is a potential ligature risk following incidents across the Group and this could cause harm to our patients.	Quality Safety (6-10)	16	4	4	Andy Airey
1160v.22	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.21	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.33	Medication page's on RiO are not being kept up to date as per CNTW policy. Information	Quality Safety (6-10)	16	4	4	Andy Airey

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	transferred to the MHDS may not be accurate.					
1497.v21	Staffing pressures due to vacancies and difficulties recruiting and retaining medical staff within the South Locality Group. Whilst recruitment has improved, there are ongoing pressures due to remote working during COVID and the impact of the Devon ruling regarding MHA assessments.	Quality Experience (6-10)	16	4	4	Andy Airey
1769v.11	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.6	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)	12	4	3	Andy Airey

3.1 South Locality Corporate Business Units

The four CBU's within the South locality currently hold a total of 13 risks.

3.2 Community South CBU

Community South CBU is currently holding 4 risks. 2 risk within the risk appetite and 2 risks 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	Quality Safety (6-10)	15	3	5	Suzanne Miller

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Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	electronically to a discharge letter. Non-compliant with KPI					
1880v2	EIP service is under significant pressure due to vacancies / sick leave / maternity leave, which is compromising the safe delivery of patient assessments and care.	Quality Safety (6-10)	12	4	3	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.27	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.17	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:-

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Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
1660v.34	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
1822v.11	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 is currently holding 1 risk, 1 risk is within the risk appetite

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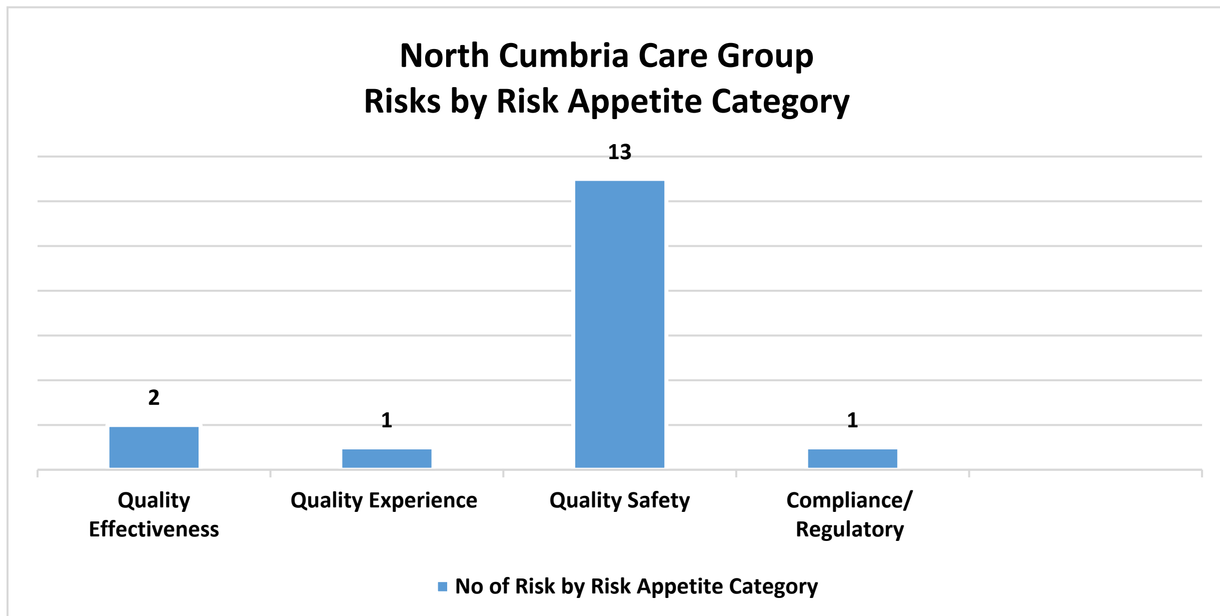
4.0 North Cumbria Locality Care Group



In total as at end of June 2021 the North Cumbria Locality Care Group hold 17 risks, 5 risks within the risk appetite and 12 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 6 risks on the North Cumbria Corporate Group risk register. 3 risks are within the risk appetite and 3 risks 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
1799v.13	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
1837v.8	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	Quality Experience (6-10)	12	3	4	David Muir

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	robust assessment and mitigation of risk is put in place".					
1946v.1	Due to the number of nursing vacancies across the three CBU's i.e. Specialist CYPS, Inpatients and Access and Community, there is a risk that staffing levels could reduce to levels which would compromise patient care and quality.	Quality Safety (6-10)	12	4	3	David Muir

4.1 North Cumbria Locality Corporate Business Units

The 3 CBU's within the North Cumbria locality currently hold a total of 11 risks.

4.2 Community/ Access North Cumbria CBU

Community/ Access North Cumbria CBU currently hold 2 risks, which have exceeding risk appetite.

Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
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 and litigation also cost of repairing damaged property	Quality Safety (6-10)	15	5	3	David Storm
1948v.1	Frequent connectivity issues highlighted in some areas of community services- especially in west of region. These relate to accessing GRIST Risk assessment. This leads to difficulties accessing GRIUST assessments in real time.	Quality Safety (6-10)	12	3	4	David Storm

4.3 Inpatient North Cumbria CBU

Inpatient North Cumbria CBU is currently holding 2 risks – 1 within the risk appetite and 1 risk exceeding the risk appetite. The risk which has exceeded the risk appetite is documented below:-

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Risk Reference	Risk Description	Risk Appetite	Risk Scor e	I	L	Owner
1801v.3	There is a risk that the current qualified vacancy rate is impacting across the inpatient units. This would lead to an impact on the use of agency staff being used.	Quality Effectiveness (6-10)	12	3	4	Andrea Cox

4.4 Specialist Children and Young People's CBU

Specialist Children and Young Peoples CBU is currently holding 7 risks – 1 risk is 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.21	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.	Quality Safety (6-10)	12	4	3	Jill Stewart
1613v.23	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	Jill Stewart
1725v.9	Due to the decant as part of CEDAR Project, PICU (Ferndene) is currently situated within Fraser ward. Due to this the environment is limited, in terms of accessibility to therapeutic space for young people, access to seclusion	Quality Effectiveness (6-10)	12	4	3	Jill Stewart

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	facilities and appropriate staff meeting areas / clinical rooms. This has also resulted in shared facilities for staff, eg staff room / MDT meeting room within Covid restrictions. 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.11	Reduced capacity within the CNTW 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 CNTW young people being admitted out of the CNTW area which potentially could impact on their experience, mental health and also their length of hospital stay. Beds are now available since Lotus ward has opened however the ward is operating on a reduced bed capacity at this time, as per the agreed incremental bed occupation plan.	Quality Safety (6-10)	12	4	3	Jill Stewart
1798v8	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	Jill Stewart
1882v.4	Because of a number of vacancies across wards within the specialist CYPS CBU, there is a risk that staffing levels cannot be maintained to a desirable level. This could impact ward ability to continually provide a safe and effective service to patients.	Quality Safety (6-10)	12	4	3	Jill Stewart

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5.0 Executive Corporate

The Chief Executive as at end of June 2021 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.

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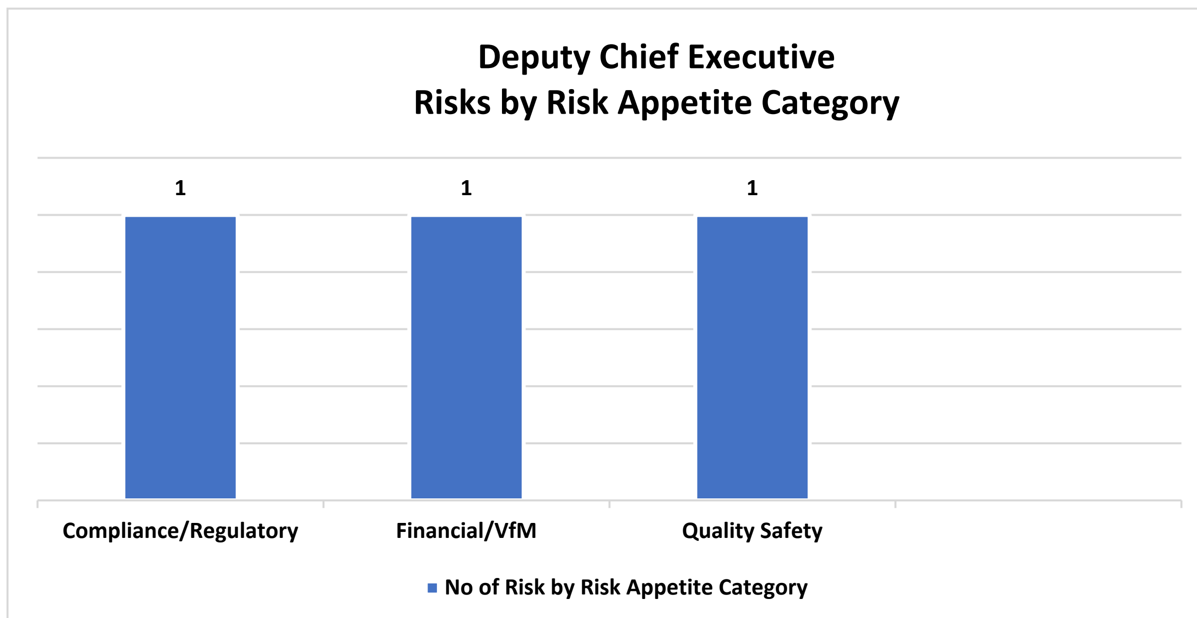
6.0 Deputy Chief Executive



The Deputy Chief Executive as at end of June 2021 holds 3 risks within 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.

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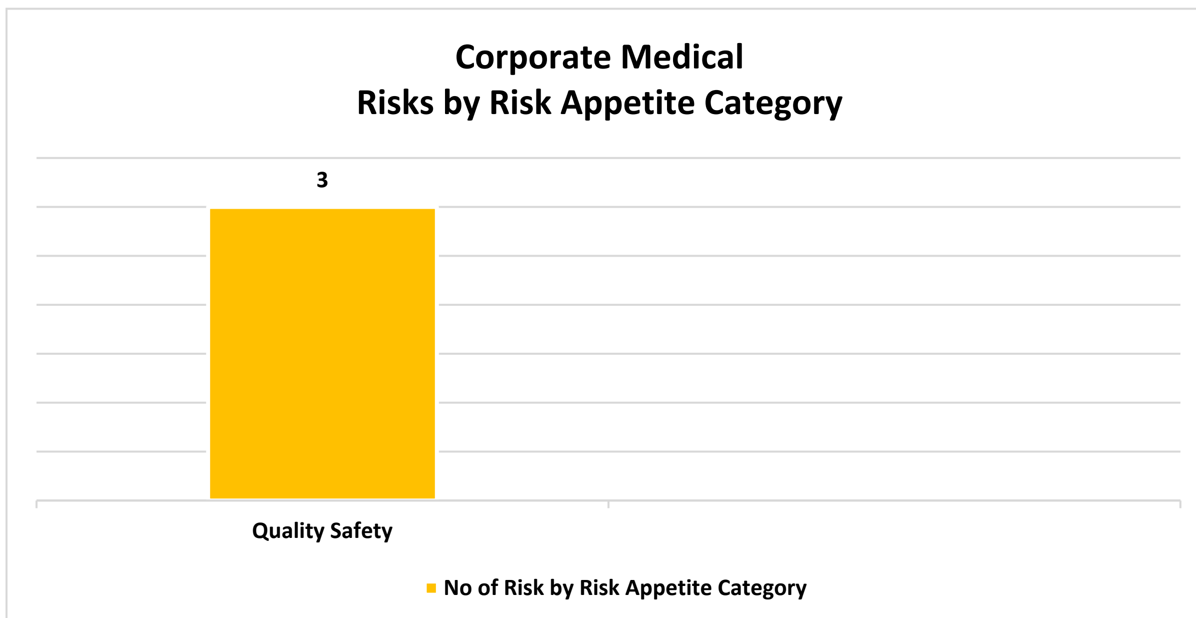
7.0 Corporate Medical



The Executive Medical Director as at end of June 2021 holds 3 risks, 3 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.

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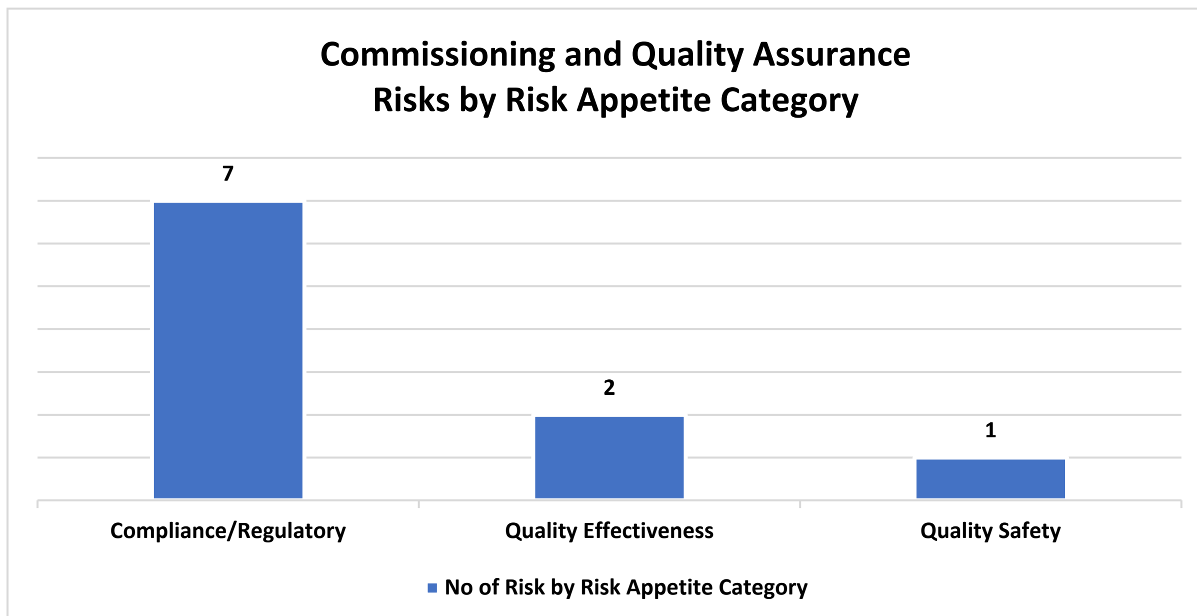
8.0 Commissioning and Quality Assurance



The Executive Director of Commissioning and Quality Assurance as at end of June 2021 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.25	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.14	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.21	Subject Access Requests: There is a risk of non-compliance with the reduced time frame (1 month). In the absence of electronic systems, the task is labour	Compliance/ Regulatory (6-10)	12	3	4	Angela Faill

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Risk Reference	Risk Description	Risk Appetite	Risk Score	I	L	Owner
	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.14	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.12	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. Cont.. on Web Risk	Compliance/ Regulatory (6-10)	16	4	4	Jon Gair

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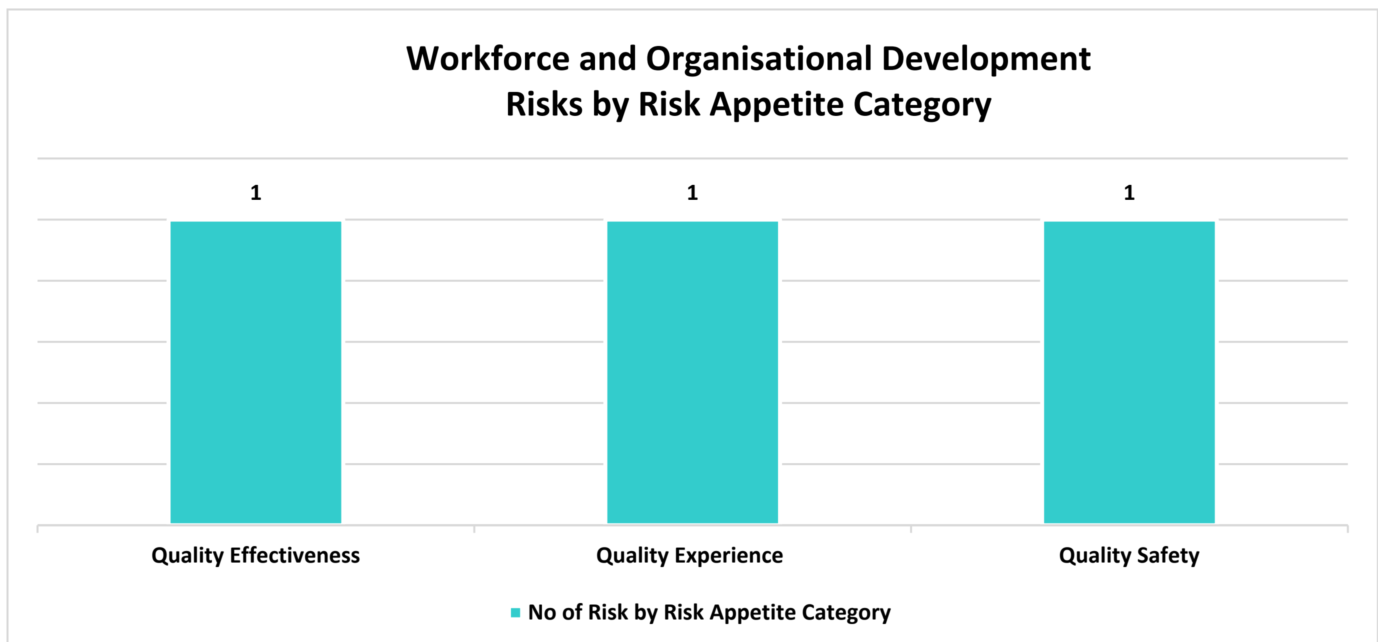
9.0 Workforce and Organisational Development



The Executive Director of Workforce and Organisational Development as at end of June 2021 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.9	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

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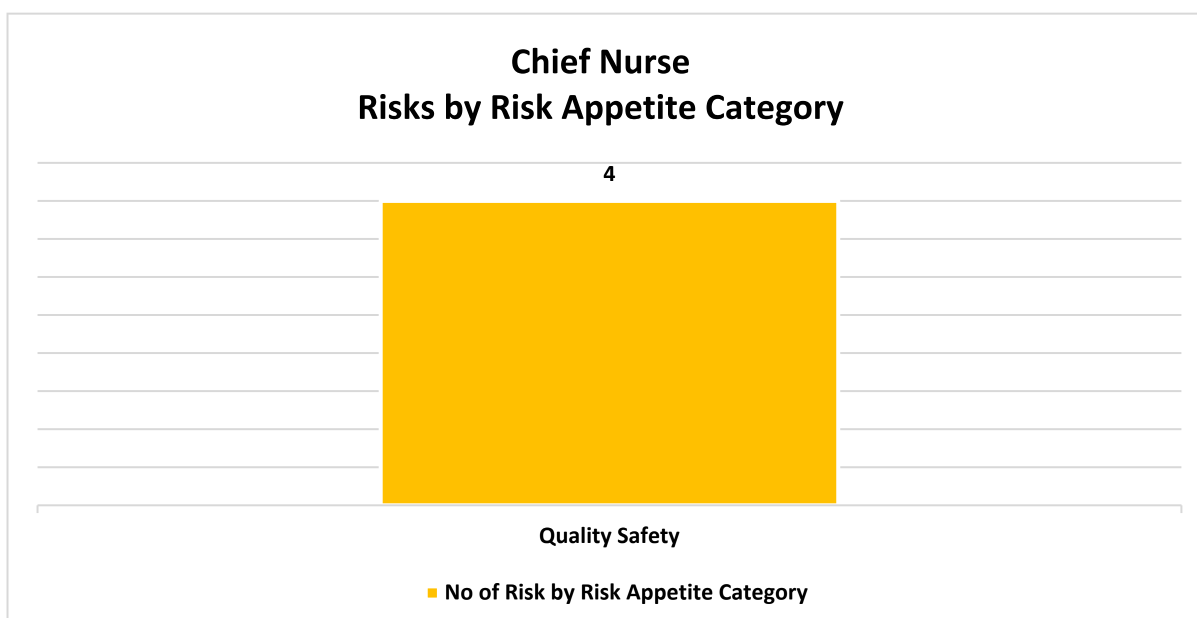
10.0 Chief Nurse



The Chief Nurse as at end of June 2021 holds 4 risks. 2 risks are within the risk appetite and 2 risks 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
1758v.12	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	Stewart Gee
1821v.8	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	Stewart Gee

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10.0 Chief Operating Officer

The Chief Operating Officer as at end of June 2021 holds 2 risks. 2 risks which exceed the risk appetite. All risks are being managed within 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.26	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	Ramona Duguid
1611v.22	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	Ramona Guguid

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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
8 July 2021

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NHS
Cumbria, Northumberland, Tyne and Wear
NHS Foundation Trust

Report to the Board of Directors
4th August 2021

Title of report	**Quarter 1 update - NHS Improvement Single Oversight Framework**
Report author(s)	**Allan Fairlamb, Deputy Director 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	
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

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BOARD OF DIRECTORS

4th August 2021

Quarterly Report – Oversight of Information Submitted to External Regulators

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 1 2021-22

BACKGROUND

NHS Improvement using the Single Oversight Framework have assessed the Trust for Quarter 1 of 2021-22 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 – Q4 20-21	Q1 21-22
Single Oversight Framework Segment	n/a	2	1	1	1	1	1	1
Use of Resources Rating	n/a	2	1	3	3	2	*2	*2
Continuity of Services Rating	2 (Q1) & 3 (Q2)	n/a	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	n/a

*Please note since Quarter 1 2020/21 the Use of Resources Rating is related to Quarter 4 2019/20 due to suspension of this rating during COVID-19.

Key Financial Targets & Issues

A summary of delivery at Month 3 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)	£0.4m	£0.2m	(£0.2m)
FDP - Efficiency Target	n/a	n/a	n/a
Agency Ceiling / Agency Spend	n/a	£4.5m	n/a
Cash	£55.9m	£57.1m	£1.2m
Capital Spend	£10.3m	£5.8m	(£4.5m)
Asset Sales	£4.0m	£0.0m	(£4.0m)

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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.

Workforce Numbers

The workforce template provides actual staff numbers by staff group. The table below shows a summary of the information provided for Quarter 1 2021-22. Workforce returns are submitted to NHSI on a monthly basis.

SUMMARY STAFF WTE DETAIL	M1	M2	M3
	Actual WTE	Actual WTE	Actual WTE
Total non-medical - clinical substantive staff	4,913	4,820	4,821
Total non-medical - non-clinical substantive staff	1,964	1,928	1,928
Total medical and dental substantive staff	384	394	394
Total WTE substantive staff	**7,261**	**7,142**	**7,143**
Bank staff	414	328	334
Agency staff (including, agency and contract)	348	330	321
Total WTE all staff	**8,023**	**7,800**	**7,798**

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 1 2021-22.

	April	May	June
Staff Group	**5/4 – 2/5**	**3/5 – 30/5**	**31/5 – 4/7**
Medical	129	196	226
Qualified Nursing	695	685	866
Nursing Support	334	232	452
TOTAL	**1,158**	**1,113**	**1,544**

At the end of June, the Trust was paying 8 medical staff above price caps (4 consultants, 2 associate specialists 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 June was 45 medical shifts, 173 qualified nursing shifts and 90 nursing support shifts.

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GOVERNANCE

There is no longer a requirement to submit a governance return to NHS Improvement; however, there are specific exceptions where the Trust are required to notify NHS Improvement and specific items for information, it is these issues that are included within this report.

Board & Governor Changes Quarter 1 2021-2022

Board of Directors:

Les Boobis, Non-Executive Director retired

Council of Governors:

Carer Governor, Adult Services

Outgoing Governors:	Present vacancies
Nil	Carer Governor (Neuro-disability Services)

Never Events

There were no never events reported in Quarter 1 2021 - 2022 as per the DH guidance document.

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.

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RECOMMENDATIONS

To note the information included within the report.

Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance

Dave Rycroft, Deputy Director of Finance & Business Development

July 2021

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